

DOCUMENTED VERIFICATION OF INCOME/FAMILY SIZE

Patient Sticker

(Attach copies of proof of income, such as paycheck stubs,
income tax returns, etc.)

**Always make copies, never hand over originals you may
need for use later.**

ANNUAL INCOME _____

FAMILY SIZE _____

A PREGNANT WOMAN WILL COUNT AS TWO IN THE FAMILY

SLIDING FEE _____

<p>I certify that the information I have provided is correct, to the best of my knowledge. I understand that I will be held responsible for any consequences (e.g. payments, fines, legal action, etc.) resulting from intentionally providing false or misleading information.</p>	<p align="center">Signature of person responsible for this account. _____</p> <p align="right">Today's Date _____</p>
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WCCHC Sliding Fee Scale 2024. All income categories are from the 2024 Federal Poverty Guidelines

Family Size	Level 1 Slide	Level 2 Slide	Level 3 Slide	Level 4 Slide	Level 5 Slide	Level 6 No Discount Full Fee
	Medical or BH* \$30 Flat Fee Dental Schedule 1 Fees: \$35 Schedule 2 Fees: \$200	Medical or BH* \$35 Flat Fee Dental 20% of Full Fee	Medical or BH* \$50 Flat Fee Dental 40% of Full Fee	Medical or BH* \$70 Flat Fee Dental 60% of Full Fee	Medical or BH* \$90 Flat Fee Dental 80% of Full Fee	
1	\$0 \$15,060	\$15,061 \$18,825	\$18,826 \$22,590	\$22,591 \$26,355	\$26,356 \$30,120	\$30,121
2	\$0 \$20,440	\$20,441 \$25,550	\$25,551 \$30,660	\$30,661 \$35,770	\$35,771 \$40,880	\$40,881
3	\$0 \$25,820	\$25,821 \$32,275	\$32,276 \$38,730	\$38,731 \$45,185	\$45,186 \$51,640	\$51,641
4	\$0 \$31,200	\$31,201 \$39,000	\$39,001 \$46,800	\$46,801 \$54,600	\$54,601 \$62,400	\$62,401
5	\$0 \$36,580	\$36,581 \$45,725	\$45,726 \$54,870	\$54,871 \$64,015	\$64,016 \$73,160	\$73,161
6	\$0 \$41,960	\$41,961 \$52,450	\$52,451 \$62,940	\$62,941 \$73,430	\$73,431 \$83,920	\$83,921
7	\$0 \$47,340	\$47,341 \$59,175	\$59,176 \$71,010	\$71,011 \$82,845	\$82,846 \$94,680	\$94,681
8	\$0 \$52,720	\$52,721 \$65,900	\$65,901 \$79,080	\$79,081 \$92,260	\$92,261 \$105,440	\$105,441
For each additional family member	\$5,380	\$6,725	\$8,070	\$9,415	\$10,760	
CHC Target Population	Up to and Including 100% of Poverty	To 125% of Poverty	To 150% of Poverty	To 175% of Poverty	Up to and Including 200%	Over 200% of Poverty

*The nominal fee is \$30 for Medical and Behavioral Health Services. The Nominal fee is \$35 for Schedule 1 Dental services per visit, and the Nominal fee \$200 for Schedule 2 Dental services per visit. Additional Behavioral Health grants and adjustments may apply.

Interviewer's Signature _____