Sliding Fee Discount Application

Primary Health Network, a Federally Qualified Health Center, offers income-based discounts on select services. Eligibility is determined by assessing your total household annual income in accordance with Federal Poverty Guidelines (see reverse side for the table).

To qualify for the sliding fee, please provide proof of income for all household members or those under your financial care. If you lack income, complete the self-attestation section. For Social Security Benefits, specify accordingly.

Applicants should provide a copy of the following documents, if applicable:

- Previous year's Federal Tax Return, W-2's, or 1099's (preferred method of verification)
- Social Security or Pension Income
- Most recent pay stubs spanning four weeks
- Unemployment compensation

Return the completed application(s) and income documentation to any PHN location or by either mail or email:
Primary Health Network, Attn: Billing Department, P.O. Box 716, Sharon, PA 16146 I billing@primary-health.net
PLEASE NOTE: If you have any questions, please contact the PHN Billing Department at 1-888-274-2043.

Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Household Size (number of individuals living in your household): _____

Annual Household Income: _____

List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible:

Household Member Name	Date of Birth	Relationship to Applicant	Patient ID (Internal Use Only)

If you have no sources of income, please explain how you provide for basic life essentials, food, and shelter.

_____

_____

_____

_____

_____

DISCLAIMER: I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify The Primary Health Network of any changes in this information within ten (10) days of such change.

I understand that I must re-qualify annually to maintain my eligibility.

_____ _____

Signature **Date**

FOR INTERNAL USE ONLY
Household Gross Income: _____
Date Received: _____
Patient is eligible for sliding fee discount category:
_____
☐ Proof of income verified
☐ Proof of income not received
_____
Approved by Date

Sliding Fee Scale

Based on Federal Register 2023 Poverty Guidelines

Family Size	Income Measure	Category 0	Category 1	Category 2	Category 3	Category 4
% of Federal Poverty Income Level		Up to 100%	100.01%-149.99%	150.00%-174.99%	175.00%-199.99%	200.00%+
		Patient Fee: $0.00	Patient Fee: $10.00	Patient Fee: $20.00	Patient Fee: $30.00	Patient Fee: 100%
1	Annual Monthly	$0 – $14,580 $0 – $1,215	$14,581 – $21,869 $1,216 – $1,822	$21,870 – $25,514 $1,823 – $2,126	$25,515– $29,160 $2,127 – $2,430	$29,161 + $2,431+
2	Annual Monthly	$0 – $19,720 $0 – $1,643	$19,721 – $29,579 $1,644 – $2,464	$29,580 – $34,509 $2,465 – $2,875	$34,510 – $39,440 $2,876 – $3,286	$39,441 + $3,287 +
3	Annual Monthly	$0 – $24,860 $0 – $2,072	$24,861 – $37,289 $2,073 – $3,108	$37,290– $43,504 $3,109 – $3,626	$43,505– $49,720 $3,627– $4,144	$49,721 + $4,145 +
4	Annual Monthly	$0 – $30,000 $0 – $2,500	$30,001 – $44,999 $2,501– $3,750	$45,000 – $52,499 $3,751 – $4,375	$52,500 – $60,000 $4,376– $5,000	$60,001 + $5,001 +
5	Annual Monthly	$0 – $35,140 $0 – $2,928	$35,141 – $52,709 $2,929– $4,392	$52,710 – $61,494 $4,393 – $5,124	$61,495 – $70,280 $5,125 – $5,856	$70,281+ $5,857+
6	Annual Monthly	$0 – $40,280 $0 – $3,357	$40,281 – $60,419 $3,358 – $5,035	$60,420 – $70,489 $5,036 – $5,874	$70,490 – $80,560 $5,875 – $6,714	$80,561 + $6,715 +
7	Annual Monthly	$0 – $45,420 $0 – $3,785	$45,421 – $68,129 $3,786 – $5,677	$68,130 – $79,484 $5,678 – $6,623	$79,485 – $90,840 $6,624 – $7,570	$90,841 + $7,571 +
8	Annual Monthly	$0 – $50,560 $0 – $4,213	$50,561 – $75,839 $4,214 – $6,319	$75,840– $88,479 $6,320 – $7,372	$88,480– $101,120 $7,373 – $8,426	$101,121 + $8,427+
Each additional family member		+ $5,140 A + $428 M	+ $5,140 A + $428 M	+ $7,710 A + $642 M	+ $8,995 A + $750 M	+ $10,280 A + $857 M

EXCLUSIONS - CATEGORY 0

DENTAL

The following will be billed at 100% of PHN's actual costs:

- Dental lab cost associated with dentures, crowns or bridge work

EXCLUSIONS - CATEGORY 1-3

DENTAL

The following will be billed at 75% of the actual charge based on PHN's fee schedule:

- Dentures
- Crowns
- Bridge Work
- Oral Surgery
- Resin Based Posterior Fillings