



Sliding Fee Discount Information

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It is the policy of Pearl Health Clinic to provide essential services regardless of the patient's ability to pay. Pearl Health Clinic offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form at the beginning of every new calendar year or if your financial situation changes.

Please check box if requesting TMS services, otherwise application will be processed for traditional services.

Patient Name:		Account #:		
Street:	City:	State:	Zip:	Phone:

Please list all household members, including those under age 18.

	Name	Date of Birth
SELF		
OTHER		



Sliding Fee Discount Information

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension, or retirement income			
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony, child support; assistance from outside the household; and other miscellaneous sources.			
Total Income			

IMPORTANT!

REQUIRED: COPY OF TAX RETURNS, 2 MONTHS WORTH OF PAYSTUBS, SSI LETTER, OR OTHER INFORMATION VERIFYING INCOME IS REQUIRED BEFORE THE SLIDING FEE IS APPROVED.

****APPLICATION CANNOT BE PROCESSED WITHOUT THIS INFORMATION****

IF APPLICATION IS APPROVED, YOU ARE RESPONSIBLE FOR THE DISCOUNTED AMOUNT AT THE TIME OF EACH APPOINTMENT. FAILURE TO PAY YOUR RESPONSIBLE AMOUNT MAY RESULT IN YOUR SLIDING FEE SCALE BEING DISCONTINUED.

I certify that the family size and income information shown above is correct.

Name (Print):

Signature:

Date:

Office Use Only

Patient Name: _____

Approved Discount: _____

Sliding Scale Effective: _____

Approved By: _____

Date Approved: _____



Sliding Fee Discount Information

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		

Self-declaration of income may also be used.

Sliding Fee Schedule (SFS) Example:

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except 0% discount)

2026 Annual Income By FPG Sliding Fee Discount Pay Class and Percent of Poverty

Poverty Level	Family Size	100% PG	125% PG	150% PG	175% PG	200% PG	300% PG	400% PG
	1	\$0 - \$15,960	\$15,961 \$19,950	\$19,951 \$23,940	\$23,941 \$27,930	\$27,931 \$31,920	\$31,921 \$47,880	\$47,881 \$63,840
	2	\$0 - \$21,640	\$21,641 \$27,050	\$27,051 \$32,460	\$32,461 \$37,870	\$37,871 \$43,280	\$43,281 \$64,920	\$64,921 \$86,560
	3	\$0 - \$27,320	\$27,321 \$34,150	\$34,151 \$40,980	\$40,981 \$47,810	\$47,811 \$54,640	\$54,641 \$81,960	\$81,961 \$109,280
	4	\$0 - \$33,000	\$33,001 \$41,250	\$41,251 \$49,500	\$49,501 \$57,750	\$57,751 \$66,000	\$66,001 \$99,000	\$99,001 \$132,000
	5	\$0 - \$38,680	\$38,681 \$48,350	\$48,351 \$58,020	\$58,021 \$67,690	\$67,691 \$77,360	\$77,361 \$116,040	\$116,041 \$154,720
	6	\$0 - \$44,360	\$44,361 \$55,450	\$55,451 \$66,540	\$66,541 \$77,630	\$77,631 \$88,720	\$88,721 \$133,080	\$133,081 \$177,440
	7	\$0 - \$50,040	\$50,041 \$62,550	\$62,551 \$75,060	\$75,061 \$87,570	\$87,571 \$100,080	\$100,081 \$150,120	\$150,121 \$200,160
	8	\$0 - \$55,720	\$55,721 \$69,650	\$69,651 \$83,580	\$83,581 \$97,510	\$97,511 \$111,440	\$111,441 \$167,160	\$167,161 \$222,880
Each additional person add:		\$5,680.00	\$7,100.00	\$8,520.00	\$9,940.00	\$11,360.00	\$17,040.00	\$22,720.00
Patient Responsibility		5%	10%	20%	30%	40%	50%	60%

*Based on the 2026 Federal Poverty Guidelines (FPG) for the 48 contiguous states and the District of Columbia. Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines.

Patient Name:
 DOB:
 Account Number: