INDIANA CARE NETWORK

SLIDING FEE SCALE APPLICATION

Indiana Care Network (ICN) is working towards becoming a Federally Qualified Health Center. Therefore, we are able to offer a discount on some services based on a household's income and size. Sliding fee calculations are determined by using an applicant's total annual income provided by the complete Federal Income Tax return(s), W-2(s) or 1099(s), most recent pay stubs spanning four weeks, Social Security or Pension Income, Public Assistance award letters, and unemployment compensation. ICN uses the Federal Poverty Guidelines to determine your eligibility.

Your household discount will be assessed once per year. You must reapply for the Sliding Fee discount and provide updated income documentation at this time.

PLEASE NOTE: You may be responsible for the payment of some procedures, labs, and medications.

If you wish to qualify for the sliding fee, you must show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please speak with a staff member.

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

- **Previous year's tax return, W-2's or 1099's**
- **Most recent pay stubs spanning four weeks**
- **Social Security or Pension Income**
- **Public assistance award letters for each adult age 18 and over living in the household.**
- **Unemployment compensation**

This will also include those members living outside the household but for whom the household is financially responsible (Income will come from the Total Income line on respective tax return).

Name: _____ **Date of Birth:** _____

Family Size (number of family members living in your household): _____

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

_____

_____

_____

Address:_____

Phone: _____ **Do you have insurance? YES NO**

If yes, please provide: Medical Plan Name: _____

Dental Plan Name:_____

DISCLAIMER: I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify Indiana Care 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.

I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service. To maintain discount, fees must be paid promptly.

_____ _____

Signature **Date**

FOR INTERNAL USE ONLY

Annual Gross Income _____

Patient is eligible for sliding fee discount category _____

__Proof of income verified
__Patient refused to complete
___Patient does not qualify for sliding fee

_____

Verified by **Date**

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SLIDING FEE SCALE
2025 Federal 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%	174.99%	175.00%	200%	> 200%
		Patient Fee: $0.00		Patient Fee: $10.00		Patient Fee: $20.00		Patient Fee: $30.00		Patient Fee: 100%
1	Annual	$0	$15,650	$15,652	$23,473	$23,475	$27,386	$27,388	$31,300	$31,301 +
	Monthly	$0	$1,304	$1,304	$1,956	$1,956	$2,282	$2,282	$2,608	$2,609 +
2	Annual	$0	$21,150	$21,152	$31,723	$31,725	$37,010	$37,013	$42,300	$42,301 +
	Monthly	$0	$1,763	$1,763	$2,644	$2,644	$3,084	$3,084	$3,525	$3,526 +
3	Annual	$0	$26,650	$26,653	$39,972	$39,975	$46,635	$46,638	$53,300	$53,301 +
	Monthly	$0	$2,221	$2,221	$3,331	$3,331	$3,886	$3,886	$4,442	$4,443 +
4	Annual	$0	$32,150	$32,153	$48,222	$48,225	$56,259	$56,263	$64,300	$64,301 +
	Monthly	$0	$2,679	$2,679	$4,018	$4,019	$4,688	$4,689	$5,358	$5,359 +
5	Annual	$0	$37,650	$37,654	$56,471	$56,475	$65,884	$65,888	$75,300	$75,301 +
	Monthly	$0	$3,138	$3,138	$4,706	$4,706	$5,490	$5,491	$6,275	$6,276 +
6	Annual	$0	$43,150	$43,154	$64,721	$64,725	$75,508	$75,513	$86,300	$86,301 +
	Monthly	$0	$3,596	$3,596	$5,393	$5,394	$6,292	$6,293	$7,192	$7,193 +
7	Annual	$0	$48,650	$48,655	$72,970	$72,975	$85,133	$85,138	$97,300	$97,301 +
	Monthly	$0	$4,054	$4,055	$6,081	$6,081	$7,094	$7,095	$8,108	$8,109 +
8	Annual	$0	$54,150	$54,155	$81,220	$81,225	$94,757	$94,763	$108,300	$108,301 +
	Monthly	$0	$4,513	$4,513	$6,768	$6,769	$7,896	$7,897	$9,025	$9,026 +
Each Additional family member	Annual +	$5,500		$5,500		$8,250		$9,625		$11,000 +
	Monthly +	$458		$458		$688		$802		$917 +