**Firefly Pediatrics**
**Acknowledgment of Sliding Scale Discounts**

Patient Name: _____ Patient ID: _____

I understand that Firefly Pediatrics offers a sliding scale discount to patients upon submission of a completed application. A completed application includes supporting documentation as requested by Firefly Pediatrics. I further understand that approval and the amount of discount is based on my verified income as it compares to the Federal Poverty Income Guideline (FPIG), which can be found below and at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

**Federal Poverty Level (FPL)**

| Family size | 2023 income numbers | 2024 income numbers |
|---|---|---|
| For individuals | $14,580 | $15,060 |
| For a family of 2 | $19,720 | $20,440 |
| For a family of 3 | $24,860 | $25,820 |
| For a family of 4 | $30,000 | $31,200 |
| For a family of 5 | $35,140 | $36,580 |
| For a family of 6 | $40,280 | $41,960 |
| For a family of 7 | $45,420 | $47,340 |
| For a family of 8 | $50,560 | $52,720 |
| For a family of 9+ | Add $5,140 for each extra person | Add $5,380 for each extra person |

<= 100% of FPIG = $10.00 or service fee, whichever is less
101% to 125% of FPIG = 80% discount
126% to 150% of FPIG = 60% discount
151% to 175% of FPIG = 40% discount
176% to 200% of FPIG = 20% discount

I understand that I am not required to submit a sliding scale discount application, only if I wish to be considered for a discounted rate. I also understand that I may decide to submit or withdraw my application for a sliding scale discount at any point now or in the future. If I choose not to apply for a discount or to withdraw my application for a discount, I will pay the full rates as outlined on the Good Faith Estimate provided to me.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature of Firefly Pediatrics Office Staff Date