Service Discount Application

Discounts are offered to families who have no means, or limited means, to pay for their medical care (uninsured or underinsured), depending upon annual income. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines (FPIG). The most recent FPIG can be found at https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines. Once approved, discounts will be honored for 30 days from application, after which the family must reapply.

The information contained herein will be held to Firefly Pediatrics' strict confidentiality policy and will be used only to determine payment options and hardship adjustments.

The guarantor must complete this application in its entirety and attach appropriate documentation. Incomplete applications will be denied, and collection policies will be followed.

You must attach the following information to your application.

- Copy of your last year's tax return – If you did not file taxes, you must provide a letter from the IRS stating that you did not file a return.
- Three current pay stubs from guarantor and co-parent, if applicable.

Please complete the information and return to Firefly Pediatrics. We will respond to your application within 14 days of receipt.

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

Guarantor Information

Name:_____ Phone #: _____

Address:_____

City:_____State:_____Zip_____

Co-Parent Information

Name:_____ Phone #: _____

Address:_____

City:_____State:_____Zip_____

Dependent Information

Using legal names, please list everyone (including yourself) living at your address. Please do not use nicknames. If needed, attach additional pages.

Name	Relationship	Age

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

Additional Comments

_____

_____

_____

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The information listed herein is true and complete to the best of my knowledge. I give permission to Firefly Pediatrics Accounting Department to verify any or all of the information listed above.

_____ _____

Signature Date

Office Use Only

Patient Account Numbers:
Approved Discount:
Approved by:
Date Approved:

Notes: