

Plateau Pediatrics
Acknowledgment of Sliding Scale Discounts

Patient Name: _____ Patient ID: _____

I understand that Plateau Pediatrics offers a sliding scale discount to patients upon submission of a completed application. A completed application includes supporting documentation as requested by Plateau 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 Plateau Pediatrics Office Staff

Date