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 90 days from application, after which the family must reapply.

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

The family must complete this application in its entirety and attach appropriate documentation. Incomplete applications will be returned to you.

Please provide at least one of the following documents as proof of income for your household:

- Copy of last year's federal income tax return (1040 or 1040-EZ)
- Copy of IRS Verification of Nonfiling Letter (if you did not file federal income tax)
- Last year's W-2 form or 1099 from job(s)
- Current pay stub(s) from guarantor and co-parent, if applicable.
- Unemployment documentation
- Social Security award letter
- Documentation of court-ordered payments to you (like alimony payments and child support)

Please return this application and attachments to Plateau Pediatrics. We will respond to your application within 5 business days of receipt. If you do not receive a response, or you require assistance in completing this application, please call Plateau Pediatrics Accounting Department at (931) 707-8700 x 4.

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 (if applicable)

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 Plateau 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: