Ho'ola Cares

LEVEL F
Dental Sliding Fee Discount Program - Eligibility Form

Patient Name _____

(Last) **(First)** **(Middle)**

☐ Homeless (Check box if patient is homeless)

$ _____

_____ **Monthly Income of the family**

Total number of people in family

Level: (Check income category from table below) ☐ F

_____ _____ _____

Type of documentation Reviewed **Verified by** **Date Signed**

***Must receive income document(s) within 7 days from signed or patient will pay full charges*

By signing this, I attest that the above information is correct to the best of my knowledge

_____ _____

Patient's Signature (if Child, then Parent's signature) **Date**

MONTHLY INCOME - SLIDING FEE SCHEDULE

Persons in Family	Level F 201% to 250% Above Poverty
1	$2311 - $2,888
2	$3,113 - $3,890
3	$3,914 - $4,892
4	$4,716 - $5,894
5	$5,517 - $6,896
6	$6,318 - $7,898
7	$7,121 - $8,900
8	$7,923 - $9,902
Patient Pays Dental	Patient Receives 25% Discount on Procedures

Effective March 1, 2017 @Ho'ola Lahui Hawai'i/Kauai Community Health Centers

Notes: For family units with more than 8 members, add $385 monthly to 100% or $4,310 annually for each additional member at 150 percent of poverty

Monthly Income Conversion Calculations:

* To convert weekly pay, multiple gross pay by 52 and divide by 12 (sample week gross pay = $250 X52= $13,000/12 = $1,083.34
* To convert bi-weekly pay, multiple gross pay by 26 and divide by 12 (sample bi-weekly gross pay = $550 X26= $14,300/12 = $1,191.67
* To convert semi-monthly pay, multiply gross pay by 24 and divide by 12 (sample semi-monthly gross pay = $600 X24= $14,400/12 = $1,200.00)