



Ho'ola Cares

2021
LEVEL F

Dental Sliding Fee Discount Program - Eligibility Form

Patient Name _____

(Last)

(First)

(Middle)

Homeless (Check box if patient is homeless)

\$

Total number of people in family _____

Monthly Income of the 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	\$2,471 - \$3,088
2	\$3,341 - \$4,175
3	\$4,211 - \$5,263
4	\$5,081 - \$6,350
5	\$5,951 - \$7,438
6	\$6,821 - \$8,525
7	\$7,691 - \$9,613
8	\$8,561 - \$10,700
Patient Pays Dental	Patient Receives 25% Discount on Procedures

Effective February 1, 2021 @ Ho'ola Lahui Hawai'i/Kauai Community Health Centers

Notes: For family units with more than 8 members, add \$435 monthly to 100% or \$5,220 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)