

**2023 FEDERAL POVERTY GUIDELINES & JPCHC SLIDING FEE SCALE**

Family Size*	Income Presented	LEVEL A (<100%)	LEVEL B (101% - 149%)		LEVEL C (150% - 174%)		LEVEL D (175% - 200%)		LEVEL E (>200%)
		Less than/ Equal to	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum
1	Annual	\$14,580	\$14,581	\$21,869	\$21,870	\$25,514	\$25,515	\$29,159	\$29,160
	Monthly	\$1,215	\$1,216	\$1,822	\$1,823	\$2,125	\$2,126	\$2,429	\$2,430
2	Annual	\$19,720	\$19,721	\$29,579	\$29,580	\$34,509	\$34,510	\$39,439	\$39,440
	Monthly	\$1,643	\$1,644	\$2,464	\$2,465	\$2,875	\$2,876	\$3,286	\$3,287
3	Annual	\$24,860	\$24,861	\$37,289	\$37,290	\$43,504	\$43,505	\$49,719	\$49,720
	Monthly	\$2,072	\$2,073	\$3,107	\$3,108	\$3,624	\$3,625	\$4,142	\$4,143
4	Annual	\$30,000	\$30,001	\$44,999	\$45,000	\$52,499	\$52,500	\$59,999	\$60,000
	Monthly	\$2,500	\$2,501	\$3,749	\$3,750	\$4,374	\$4,375	\$4,999	\$5,000
5	Annual	\$35,140	\$35,141	\$52,709	\$52,710	\$61,494	\$61,495	\$70,279	\$70,280
	Monthly	\$2,928	\$2,929	\$4,392	\$4,393	\$5,124	\$5,125	\$5,856	\$5,857
6	Annual	\$40,280	\$40,281	\$60,419	\$60,420	\$70,489	\$70,490	\$80,559	\$80,560
	Monthly	\$3,357	\$3,358	\$5,034	\$5,035	\$5,873	\$5,874	\$6,712	\$6,713
7	Annual	\$45,420	\$45,421	\$68,129	\$68,130	\$79,484	\$79,485	\$90,839	\$90,840
	Monthly	\$3,785	\$3,786	\$5,677	\$5,678	\$6,623	\$6,624	\$7,569	\$7,570
8	Annual	\$50,560	\$50,561	\$75,839	\$75,840	\$88,479	\$88,480	\$101,119	\$101,120
	Monthly	\$4,213	\$4,214	\$6,319	\$6,320	\$7,372	\$7,373	\$8,426	\$8,427

	A	B	C	D	E
<b>Sliding Fee Discount</b>	<b>100%</b>	<b>75%</b>	<b>50%</b>	<b>25%</b>	<b>0%</b>
<b>Patient Time of service fee Office Visit</b>	<b>\$20</b>	<b>\$20, will be billed remaining 25% of charges</b>	<b>\$20, will be billed remaining 50% of charges</b>	<b>\$20, will be billed remaining 75% of charges</b>	<b>\$20, will be billed remaining 100% of charges</b>
<b>Patient Time of service fee Dental Services</b>	<b>\$30</b>	<b>\$30, will be billed remaining 25% of charges</b>	<b>\$30, will be billed remaining 50% of charges</b>	<b>\$30, will be billed remaining 75% of charges</b>	<b>\$30, will be billed remaining 100% of charges</b>
<b>Lab Fees Patient will be Billed, not collected at time of service</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>No direct bill – pay Quest full fee</b>

**HOW TO USE THIS SCALE:**

- (1) Determine the number of members in a Family Unit
- (2) Determine ALL income supporting the family and ALL sources of income (i.e. paystubs, alimony, SSI, retirement, etc.)
- (3) Find the number of family members in Column 1 ("Family Size").
- (4) Determine the range in which the patient's family income falls.
- (5) The column in which the patient's family income falls indicated the percentage of Sliding Fee Scale discount. \*Size of Family Unit (Add \$5,140 for each additional person)