

**2025 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	\$15,650	\$15,651	\$23,474	\$23,475	\$27,387	\$27,388	\$31,299	\$31,300
	Monthly	\$1,304	\$1,305	\$1,955	\$1,956	\$2,281	\$2,282	\$2,607	\$2,608
2	Annual	\$21,150	\$21,151	\$31,724	\$31,725	\$37,012	\$37,013	\$42,299	\$42,300
	Monthly	\$1,763	\$1,764	\$2,643	\$2,644	\$3,083	\$3,084	\$3,524	\$3,525
3	Annual	\$26,650	\$26,651	\$39,974	\$39,975	\$46,637	\$46,638	\$53,299	\$53,300
	Monthly	\$2,221	\$2,222	\$3,330	\$3,331	\$3,886	\$3,887	\$4,441	\$4,442
4	Annual	\$32,150	\$32,151	\$48,224	\$48,225	\$56,262	\$56,263	\$64,299	\$64,300
	Monthly	\$2,679	\$2,680	\$4,018	\$4,019	\$4,688	\$4,689	\$5,357	\$5,358
5	Annual	\$37,650	\$37,651	\$56,474	\$56,475	\$65,887	\$65,888	\$75,299	\$75,300
	Monthly	\$3,138	\$3,139	\$4,705	\$4,706	\$5,490	\$5,491	\$6,274	\$6,275
6	Annual	\$43,150	\$43,151	\$64,724	\$64,725	\$75,512	\$75,513	\$86,299	\$86,300
	Monthly	\$3,596	\$3,597	\$5,393	\$5,394	\$6,292	\$6,293	\$7,191	\$7,192
7	Annual	\$48,650	\$48,651	\$72,974	\$72,975	\$85,137	\$85,138	\$97,299	\$97,300
	Monthly	\$4,054	\$4,055	\$6,080	\$6,081	\$7,094	\$7,095	\$8,107	\$8,108
8	Annual	\$54,150	\$54,151	\$81,224	\$81,225	\$94,762	\$94,763	\$108,299	\$108,300
	Monthly	\$4,513	\$4,514	\$6,768	\$6,769	\$7,896	\$7,897	\$9,024	\$9,025

	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 \$5,380 for each additional person)