

2026 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	\$15,960	\$15,961	\$23,940	\$23,941	\$27,930	\$27,931	\$31,920	\$31,921
	Monthly	\$1,330	\$1,331	\$1,995	\$1,996	\$2,328	\$2,229	\$2,660	\$2,661
2	Annual	\$21,640	\$21,641	\$32,460	\$32,461	\$37,870	\$37,871	\$43,280	\$43,281
	Monthly	\$1,803	\$1,804	\$2,720	\$2,721	\$3,156	\$3,157	\$3,607	\$3,608
3	Annual	\$27,320	\$27,321	\$40,980	\$40,981	\$47,810	\$47,811	\$54,640	\$54,641
	Monthly	\$2,277	\$2,278	\$3,415	\$3,416	\$3,984	\$3,985	\$4,552	\$4,553
4	Annual	\$33,000	\$33,001	\$49,500	\$49,501	\$57,750	\$57,751	\$66,000	\$66,001
	Monthly	\$2,750	\$2,751	\$4,125	\$4,126	\$4,813	\$4,814	\$5,500	\$5,501
5	Annual	\$38,680	\$38,681	\$58,020	\$58,021	\$67,690	\$67,691	\$77,360	\$77,361
	Monthly	\$3,223	\$3,224	\$4,835	\$4,836	\$5,641	\$5,642	\$6,447	\$6,448
6	Annual	\$44,360	\$44,361	\$66,540	\$66,541	\$77,630	\$77,631	\$88,720	\$88,721
	Monthly	\$3,697	\$3,698	\$5,544	\$5,545	\$6,468	\$6,469	\$7,393	\$7,394
7	Annual	\$50,040	\$50,041	\$75,060	\$75,061	\$87,570	\$87,571	\$100,080	\$100,081
	Monthly	\$4,170	\$4,171	\$6,255	\$6,256	\$7,298	\$7,299	\$8,340	\$8,341
8	Annual	\$55,720	\$55,721	\$83,580	\$83,581	\$97,510	\$97,511	\$111,440	\$111,441
	Monthly	\$4,643	\$4,644	\$6,965	\$6,966	\$8,126	\$8,127	\$9,286	\$9,287

	A	B	C	D	E
Sliding Fee Discount	100%	75%	50%	25%	0%
Patient Time of service fee Office Visit	\$20	\$20, will be billed remaining 25% of charges	\$20, will be billed remaining 50% of charges	\$20, will be billed remaining 75% of charges	\$20, will be billed remaining 100% of charges
Patient Time of service fee Dental Services	\$30	\$30, will be billed remaining 25% of charges	\$30, will be billed remaining 50% of charges	\$30, will be billed remaining 75% of charges	\$30, will be billed remaining 100% of charges
Lab Fees Patient will be Billed, not collected at time of service	\$0	\$0	\$0	\$0	No direct bill – pay Quest full fee
Patient Time of service fee Optometry Visit	\$20	\$20, will be billed remaining 25% of charges	\$20, will be billed remaining 50% of charges	\$20, will be billed remaining 75% of charges	\$20, will be billed remaining 100% of charges
Optometry Frame and Lens fees are collected in full prior to ordering	\$45	\$60	\$75	\$90	100% of charges

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)**