



Sliding Scale Fee Program
Determination Form

		Office Visit Co-Pay Determination						
Family Size	100%	133%	150%	200%	250%	300%	400%	
1	15,650	20,814.50	23,475	31,300	39,125	46,950	62,600	
2	21,150	28,129.50	31,725	42,300	52,875	63,450	84,600	
3	26,650	35,444.50	39,975	53,300	66,625	79,950	106,600	
4	32,150	42,759.50	48,225	64,300	80,375	96,450	128,600	
5	37,650	50,074.50	56,475	75,300	94,125	112,950	150,600	
6	43,150	57,389.50	64,725	86,300	107,875	129,450	172,600	
7	48,650	64,704.50	72,975	97,300	121,650	145,950	194,600	
8	54,150	72,019.50	81,225	108,300	135,375	162,450	216,600	
Discount	80%	70%	60%	50%	35%	25%	10%	
Pre-Pay Rate	\$15	\$25	\$35	\$45	\$60	\$70	\$85	
Co-Pay	\$20	\$30	\$40	\$50	\$65	\$75	\$90	

Patient Name: _____

Household Income: _____

of Members in Household: _____

Co-pay: _____

All patients are asked to pay their co-pay each time they visit Hopelight Medical appointment and see one of our providers for care. If you are unable to pay your co-pay, please speak with the front desk and she will arrange for one of our registration specialists to briefly speak with you to determine if your co-pay can be waived. If you are unable to pay for services we will see you at no cost.

Medicare and Medicaid Co-Pays are \$0.00

Above 400% is \$100.00 for the visit