Sunrise Clinics
Providing Exceptional Rural Healthcare

Sliding Fee Discount Program Application

Applicant's Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip _____

Sunrise Clinics is committed to providing primary healthcare services to patients regardless of their ability to pay. Discounts are offered to members of households with a combined income of 200% and below the Federal Poverty Level. Please look at the chart below[1] to see if you qualify.

	A		B		C		D		E		F
Family Size	100% & Below		101% - 125%		126% - 150%		151% - 175%		176% - 200%		Above 200%
	No Fee		$1		$5		$8		$10		No Discount
	From	To	From	To	From	To	From	To	From	To	Equal to or Above
1	$-	$ 15,060	$ 15,061	$ 18,825	$ 18,826	$ 22,590	$ 22,591	$ 26,355	$ 26,356	$ 30,120	$ 30,121
2	$-	$ 20,440	$ 20,441	$ 25,550	$ 25,551	$ 30,660	$ 30,661	$ 35,770	$ 35,771	$ 40,880	$ 40,881
3	$-	$ 25,820	$ 25,821	$ 32,275	$ 32,276	$ 38,730	$ 38,731	$ 45,185	$ 45,186	$ 51,640	$ 51,641
4	$-	$ 31,200	$ 31,201	$ 39,000	$ 39,001	$ 46,800	$ 46,801	$ 54,600	$ 54,601	$ 62,400	$ 62,401
5	$-	$ 36,580	$ 36,581	$ 45,725	$ 45,726	$ 54,870	$ 54,871	$ 64,015	$ 64,016	$ 73,160	$ 73,161
6	$-	$ 41,960	$ 41,961	$ 52,450	$ 52,451	$ 62,940	$ 62,941	$ 73,430	$ 73,431	$ 83,920	$ 83,921
7	$-	$ 47,340	$ 47,341	$ 59,175	$ 59,176	$ 71,010	$ 71,011	$ 82,845	$ 82,846	$ 94,680	$ 94,681
8	$-	$ 52,720	$ 52,721	$ 65,900	$ 65,901	$ 79,080	$ 79,081	$ 92,260	$ 92,261	$ 105,440	$ 105,441
9	$-	$ 58,100	$ 58,101	$ 72,625	$ 72,626	$ 87,150	$ 87,151	$ 101,675	$ 101,676	$ 116,200	$ 116,201
10	$-	$ 63,480	$ 63,481	$ 79,350	$ 79,351	$ 95,220	$ 95,221	$ 111,090	$ 111,091	$ 126,960	$ 126,961

☐ **Yes**, I would like to be considered for the Sliding Fee Discount. I warrant that based on the chart above, based on family size and income, I quality for the following Discount: A B C D E

☐ **No**, I do not want to be considered for the Sliding Fee Discount. I understand that I will be responsible for full payment of all charges at the time of service.

Print Name: _____ Sign Name: _____ Date: _____

For Office Use Only

Applicant's Gross Income: _____ **Circle One:** Daily Weekly Bi-weekly Monthly Annually

Family Size: _____ **Proof of Income (Circle One):** Paystub or other documentation Self-Attestation

Proof of Income (Circle One): Paystub or other documentation Self-Attestation

[1] Based on 2024 Federal Poverty Guidelines for family size and income.