



## SLIDING FEE SCALE APPLICATION

**POLICY:** It is the policy of Cedar Point Health (CPH) to provide essential medical services regardless of the patient's insured status or ability to pay. Discounts are offered based upon household income and household size. A sliding fee schedule is used to calculate the basic discount and is updated each year using the federal poverty guidelines. Once approved, the discount will be honored for one year, after which the patient must reapply.

**DISCOUNT APPLICATION PROCESS:** Please complete the following information, including necessary proof of income, and return it to the front desk or email to the billing department at [slidingfee@cedarpointhealth.com](mailto:slidingfee@cedarpointhealth.com) to determine if you or members of your family are eligible. This sliding fee scale will apply to all services received at this clinic or any other primary care CPH clinic. The Sliding Fee Scale is not available for services provided at Cedar Point Health Urgent Care locations. **Any specimen taken and sent out for processing by an outside laboratory or an x-ray interpretation by a consulting radiologist will be billed separately and not covered by this application.**

**Proof of income approved documents are:**

- Two most recent pay stubs
- Most recent federal tax return (Form 1040)
- W-2 forms
- Social Security award letter or benefit statement
- Pension or retirement benefit statements
- Unemployment benefit statements
- Workers' compensation benefit statements
- Disability benefit statements
- Alimony or child support documentation
- Self-employment records (Schedule C, profit/loss statement, ledger, etc.)
- Bank statements showing regular income deposits
- Veteran's benefits statements
- SNAP, TANF, or other public assistance benefit letters
- Employer letter verifying wages and hours worked

For patients with **no income:**

- A signed self-attestation of no income
- A letter of support from the individual providing financial assistance
- Documentation showing enrollment in assistance programs
- A notarized statement, if applicable

Patient/Guardian Name			
Street Address			
City	State	Zip	Phone
Email			

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
Income from business and self-employment			
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income			
<b>TOTAL INCOME</b>			

Please list all household members, including those under age 18.

	Name	Date of Birth
SELF		
OTHER		
OTHER		
OTHER		

**I certify that the family size and income information shown above is correct.**

Name (Print)	
Signature	Date

**2026 Poverty Guidelines: 48 Contiguous States (all states except Alaska and Hawaii)**

**PER YEAR**

**Poverty Level**

Household/ Family Size	25%	50%	75%	100%	125%	150%	175%	200%
1	3,990	7,980	11,970	15,960	19,950	23,940	27,930	31,920
2	5,410	10,820	16,230	21,640	27,050	32,460	37,870	43,280
3	6,830	13,660	20,490	27,320	34,150	40,980	47,810	54,640
4	8,250	16,500	24,750	33,000	41,250	49,500	57,750	66,000
5	9,670	19,340	29,010	38,680	48,350	58,020	67,690	77,360
6	11,090	22,180	33,270	44,360	55,450	66,540	77,630	88,720
7	12,510	25,020	37,530	50,040	62,550	75,060	87,570	100,080
8	13,930	27,860	41,790	55,720	69,650	83,580	97,510	111,440
<b>Patient Responsibility</b>	\$15	\$15	\$15	\$15.00	30%	30%	60%	60%

**PER MONTH**

**Poverty Level**

Household/ Family Size	25%	50%	75%	100%	125%	150%	175%	200%
1	332.50	665.00	997.50	1,330.00	1,662.50	1,995.00	2,327.50	2,660.00
2	450.83	901.67	1,352.50	1,803.33	2,254.17	2,705.00	3,155.83	3,606.67
3	569.17	1,138.33	1,707.50	2,276.67	2,845.83	3,415.00	3,984.17	4,553.33
4	687.50	1,375.00	2,062.50	2,750.00	3,437.50	4,125.00	4,812.50	5,500.00
5	805.83	1,611.67	2,417.50	3,223.33	4,029.17	4,835.00	5,640.83	6,446.67
6	924.17	1,848.33	2,772.50	3,696.67	4,620.83	5,545.00	6,469.17	7,393.33
7	1,042.50	2,085.00	3,127.50	4,170.00	5,212.50	6,255.00	7,297.50	8,340.00
8	1,160.83	2,321.67	3,482.50	4,643.33	5,804.17	6,965.00	8,125.83	9,286.67
<b>Patient Responsibility</b>	\$15	\$15	\$15	\$15.00	30%	30%	60%	60%

update 6/22/2026

*For those patients falling 100% or below the Federal Poverty level, a flat rate of \$15 will be charged. Those falling 125% through 200% will be charged a percentage of the total appointment cost.*