



Ho'ola Cares

LEVEL E Medical Sliding Fee Discount Program - Eligibility Form

Patient Name _____

(Last)

(First)

(Middle)

Homeless (Check box if patient is homeless)

\$

Total number of people in family _____

Monthly Income of the family

Level: (Check income category from table below) E

Type of documentation Reviewed

Verified by

Date Signed

***Must receive income document(s) within 7 days from signed or patient will lose Courtesy Discount*

By signing this, I attest that the above information is correct to the best of my knowledge

Patient's Signature (if Child, then Parent's signature) _____

Date _____

MONTHLY INCOME - SLIDING FEE SCHEDULE

Persons in Family	Level E 201% to 250% Above Poverty
1	\$2,311 - \$2,888
2	\$3,113 - \$3,890
3	\$3,914 - \$4,892
4	\$4,716 - \$5,894
5	\$5,517 - \$6,896
6	\$6,318 - \$7,898
7	\$7,121 - \$8,900
8	\$7,923 - \$9,902
Patient Pays Medical	Patient Pays: \$75 / Visit plus 25% Discount on Procedures
Behavioral Health	\$75 / Visit

Effective March 1, 2017 @Ho'ola Lahui Hawaii'i/Kauai Community Health Centers

Notes: For family units with more than 8 members, add \$385 monthly to 100% or \$4,310 annually for each additional member

Monthly Income Conversion Calculations:

- * To convert weekly pay, multiple gross pay by 52 and divide by 12 (sample week gross pay = \$250 X52= \$13,000/12 = \$1,083.34
- * To convert bi-weekly pay, multiple gross pay by 26 and divide by 12 (sample bi-weekly gross pay = \$550 X26= \$14,300/12 = \$1,191.67
- * To convert semi-monthly pay, multiply gross pay by 24 and divide by 12 (sample semi-monthly gross pay = \$600 X24= \$14,400/12 = \$1,200.00)