FREE BALTIMORE

1120 North Charles St. |#303, Baltimore MD 21201

443.759.7075 PHONE| 443.687.8720 FAX
HELLO@FREEBALTIMORE.ORG

Discounted/Sliding Fee Application

Free Baltimore is committed to providing high quality services to all program participants. The goal of Behavioral Health services is to assure access to health care services by uninsured families and individuals at a cost based on eligible person's ability to pay. SFS is available to program participants whose documented income does not exceed 200% of current Federal Poverty Level (FPL) Guidelines (attached) which are updated each year by the federal government. Participants who have either no third-party reimbursement or inadequate insurance coverage will be placed on a sliding scale fee scale according to household size and proof of income.

The discount will apply to all services received at this clinic, but not those services which are purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. In the hope that your financial situation improves, discounts apply only to current, not future services. This form must be completed for each visit. Please inquire at the front desk if you have questions.

Number of related persons living in your household: _____

Total Household Income

Note: Include income from all sources including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self- employment, alimony, child support, military, unemployment, and public aid.

Patient Name:_____ Discount:_____

Date of Service: _____ Approved by:_____

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FAMILY ASSISTANCE PLAN APPLICATION

Name of Head of Household		Place of Employment		
Street	City	State	Zip	Phone
Health Insurance Plan		Social Security Number		

Please List Spouse & Dependents Under 18

Name		Date of Birth	Name		Date of Birth
Self			Dependent		
Spouse			Dependent		
Dependent			Dependent		
Dependent			Dependent		

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self-employment and dependents				
Total Income				

Verification Checklist (attach copies)	Yes	No
Id/Address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance card(s)		
Medicaid: Application made or evidence of rejection.		

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Name (Print) Signature/Date

Patient Name:_____ Discount:_____

Date of Service: _____ Approved by:_____

SLIDING FEE SCALE

Poverty Level	At or Below 100%	138%	150%	200%	Above 200%

Family Size	Nominal Fee $5	20% Pay	40% Pay	80% Pay	100% Pay

Persons in family/household	**Poverty guideline (annual income)**	138%	150%	200%	Above 200%
1	**$12,880**	$17,774	$19,320	$25,760	$32,200
2	**$17,420**	$24,040	$26,130	$34,840	$43,550
3	**$21,960**	$30,305	$32,940	$43,920	$54,900
4	**$26,500**	$36,570	$39,750	53,000	$66,250
5	**$31,040**	$42,835	$46,560	$62,080	$77,600
6	**$35,580**	$49,100	$53,370	$71,160	$88,950
7	**$40,120**	$55,366	$60,180	$80,240	$100,300
8	**$44,660**	$61,631	$66,990	$89,320	$111,650
After 8 persons, add $4,540 for each additional person.					