Missouri Ozarks Community Health – Sliding Fee Discount Program Application

Our Sliding Fee Discount Program is designed to help you pay for services provided by Missouri Ozarks Community Health. This includes medical, dental, and behavioral health care services.

Sliding Fee applications are valid from March 1st through February 28th each year and are based on the most recent federal poverty guidelines available. A new application must be submitted yearly, even if your income has not changed.

Each person applying should provide proof of household income. Proof of income may include, but is not limited to, recent paystubs, IRS tax filings, social security statements, bank statements showing the deposited amount of income, proof of unemployment income, survivor's benefits, rental income, and/or retirement income.

Additionally, please let us know your family size. Your family size should include yourself, your spouse, your children, and any legal guardian, if living with the family members.

If you have insurance, MOCH will file your claim for you. If you have a copay or deductible with your insurance plan, a sliding fee discount may be applied to that copay or deductible balance.

All information provided by applicants must be true, accurate, and reflect the applicant's household, legal names, and annual income for each member of the household.

Any questions? Please call our office at 417.683.5739 or come into one of our locations to speak to our staff about the Sliding Fee Discount Program.

HOUSEHOLD INFORMATION

Please list ALL members of your household

1. Patient Name_______________________ Date of Birth __/__/____ Annual Income_________
2. Name____________________ Date of Birth __/__/____ Annual Income_________ Relationship________
3. Name____________________ Date of Birth __/__/____ Annual Income_________ Relationship________
4. Name____________________ Date of Birth __/__/____ Annual Income_________ Relationship________
5. Name____________________ Date of Birth __/__/____ Annual Income_________ Relationship________
6. Name____________________ Date of Birth __/__/____ Annual Income_________ Relationship________
7. Name____________________ Date of Birth __/__/____ Annual Income_________ Relationship________
8. Name____________________ Date of Birth __/__/____ Annual Income_________ Relationship________

I have read the information above and I agree that the information I have provided is true and correct.

Patient Signature____ **Date:**________________

For office use only:

Total annual income:____________ Number of People in Household:_____ Sliding Fee Level:___________

MOCH Employee Signature____________________________ Effective Date:_________ Expiration Date:_________

FAMILY SIZE AND INCOME

Patient Name:____________________________________ **Chart Number:**____________________

Instructions: Please select the **family size** in the far left column. Then circle your **income range** to the right of your selected family size (in the same row).

Missouri Ozarks Community Health
2024 Federal Poverty Guidelines

Family Size	PERCENT OF POVERTY GUIDELINE				
	A	B	C	D / E	F
	< 100% FPG	101-125% FPG	126-150% FPG	151-200% FPG	> 200% FPG
1	15,060 and below	15,061 18,825	18,826 22,590	22,591 30,120	30,121 and over
2	20,440 and below	20,441 25,550	25,551 30,660	30,661 40,880	40,881 and over
3	25,820 and below	25,821 32,275	32,276 38,730	38,731 51,640	51,641 and over
4	31,200 and below	31,201 39,000	39,001 46,800	46,801 62,400	62,401 and over
5	36,580 and below	36,581 45,725	45,726 54,870	54,871 73,160	73,161 and over
6	41,960 and below	41,961 52,450	52,451 62,940	62,941 83,920	83,921 and over
7	47,340 and below	47,341 59,175	59,176 71,010	71,011 94,680	94,681 and over
8	52,720 and below	52,721 65,900	65,901 79,080	79,081 105,440	105,441 and over

For each additional person, add $5,380 to the income range.