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:_____

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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
2025 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	15,650 and below	15,651 – 19,563	19,564 – 23,475	23,476 – 31,300	31,301 and over
2	21,150 and below	21,151 – 26,438	26,439 – 31,725	31,726 – 42,300	42,301 and over
3	26,650 and below	26,651 – 33,313	33,314 – 39,975	39,976 – 53,300	53,301 and over
4	32,150 and below	32,151 – 40,188	40,189 – 48,225	48,226 – 64,300	64,301 and over
5	37,650 and below	37,651 – 47,063	47,064 – 56,475	56,476 – 75,300	75,301 and over
6	43,150 and below	43,151 – 53,938	53,939 – 64,725	64,726 – 86,300	86,301 and over
7	48,650 and below	48,651 – 60,813	60,814 – 72,975	72,976 – 97,300	97,301 and over
8	54,150 and below	54,151 – 67,688	67,689 – 81,225	81,226 – 108,300	108,301 and over

For each additional person, add $5,500 to the income range.