ASK PEDIATRICS Payment Assistance Program Application

It is the policy of ASK Pediatrics to provide essential services regardless of patient ability to pay.
As such, ASK Pediatrics offers patient discounts based on family size and annual income.
Please complete this application and return it and requested documents to the ASK Pediatrics front desk to determine whether you or members of your family are eligible for a discount. Eligibility will be based upon the enclosed Sliding Fee Discount Schedule. Approved discounts will apply to all services received at this office, but not those services or equipment purchased from outside such as reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, etc. You must complete this form every 12 months or immediately if your financial situation changes. Please list all household members, including those under age 18.

GUARANTOR NAME				
STREET	**CITY**	**STATE**	**ZIP**	**PHONE**

Household Members	Name	Date of Birth
SELF		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		
OTHER		

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Source	Self	Other	Total
Gross wages, salaries, tips, etc.			$ 0
Income from business and self-employment			$ 0
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income			$ 0
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; Child Tax Credit and other miscellaneous sources			$ 0
Total Income	$ 0	$ 0	$ 0

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

Name (Print)	
Signature	Date

********** Office Use Only **********

Patient Name: _____ **Approved Discount:_____**

Approved by: _____ **Date Approved:_____**

Verification Checklist	Yes	No
Identification/Address: Driver's license, utility bill, employmentID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		

Self-declaration of income may also be used.

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ASK Pediatrics Payment Assistance Program
Sliding Fee Discount Schedule (SFS)

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)

Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	Discount 100%	Discount 90%	Discount 80%	Discount 70%	Discount 60%	Discount 50%	Discount 40%	Discount 30%	Discount 20%	Discount 15%	Discount 10%	Discount 0%
1	$12,880	14,168	15,456	16,744	18,032	19,320	20,608	21,896	23,184	24,472	25,760	25,761+
2	$17,420	19,162	20,904	22,646	24,388	26,130	27,872	29,614	31,356	33,098	34,840	34,841+
3	$21,960	24,156	26,352	28,548	30,744	32,940	35,136	37,332	39,528	41,724	43,920	43,921+
4	$26,500	29,150	31,800	34,450	37,100	39,750	42,400	45,050	47,700	50,350	53,000	53,001+
5	$31,040	34,144	37,248	40,352	43,456	46,560	49,664	52,768	55,872	58,976	62,080	62,081+
6	$35,580	39,138	42,696	46,254	49,812	53,370	56,928	60,486	64,044	67,602	71,160	71,161+
7	$40,120	44,132	48,144	52,156	56,168	60,180	64,192	68,204	72,216	76,228	80,240	80,241+
8	$44,660	49,126	53,592	58,058	62,524	66,990	71,456	75,922	80,388	84,854	89,320	89,321
For each additional person, add	$4,540	4,994	5,448	5,902	6,356	6,810	7,264	7,718	8,172	8,626	9,080	9,080

*Based on the 2021 Federal Poverty Guidelines (FPG) for the 48 contiguous states and the District of Columbia.