



Sliding Fee Discount Information

It is the policy of One Cross Community Health & Wellness to provide essential services regardless of the patient's ability to pay. One Cross offers discounts based on family size and annual income.

Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic. You must complete this form every 12 months or if your financial situation changes.

Name

Street

City

State

Zip

Phone

	Name	DOB (mm / dd / yyyy)
Self		
Other		
Other		
Other		
Other		

Source	Self	Other	Total
Gross Wages, Salaries, Tips, Self-Employment			
Unemployment, workers comp, social security, supplemental security income, veterans payments, survivor benefit, pension or retirement			
Interest, dividends, royalties, income from rental properties, alimony, child support, assistance from outside the household, and other sources			
Total Income			
Other			

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

City _____

Signature _____

Date _____

OFFICE USE ONLY

Patient Name _____

Approved Discount _____

Approved By _____ **Date** _____

Approved By _____ **Date** _____

Verification Checklist	YES	NO
Identification/Address: Drivers license, utility bill, employment ID or other		
Income: Prior year tax return, three most recent pay stubs or other		



Exclusions – Category 0

Medical

The following will be billed at 100% of Health Center's actual costs:

- Injectables

Exclusions – Category 1 – 3

Medical

The following will be billed at 100% of the actual charge based on Health Center's fee schedule:

- Some in-office surgeries/procedures
- Certain injectables





2025 Sliding Fee Discount Scale

# of Persons in Household	Income	Category 1		Category 2		Category 3		Category 4		Category 5
		100% Poverty Level		101%-150%		151%-175%		176%-200%		Above 200%
		Slide A \$20		Slide B \$30		Slide C \$40		Slide D \$50		Full Pay
In Household	Income	From	To	From	To	From	To	From	To	From
1	Annual	0	15,560	15,561	23,340	23,341	27,230	27,231	31,120	31,121
	Per Month	0	1,297	1,298	1,945	1,946	2,269	2,270	2,593	2,594
	Per Week	0	299	300	449	450	524	525	598	599
2	Annual	0	21,150	21,151	31,725	31,726	37,013	37,014	42,300	42,301
	Per Month	0	1,763	1,764	2,644	2,645	3,084	3,085	3,525	3,526
	Per Week	0	407	408	610	611	712	713	813	814
3	Annual	0	26,650	26,651	39,975	39,976	46,638	46,639	53,300	53,301
	Per Month	0	2,221	2,222	3,331	3,332	3,886	3,887	4,442	4,443
	Per Week	0	513	514	769	770	897	898	1,025	1,026
4	Annual	0	32,150	32,151	48,225	48,226	56,263	56,264	64,300	64,301
	Per Month	0	2,679	2,680	4,019	4,020	4,689	4,690	5,358	5,359
	Per Week	0	618	619	927	928	1,082	1,083	1,237	1,238
5	Annual	0	37,650	37,651	56,475	56,476	65,888	65,889	75,300	75,301
	Per Month	0	3,138	3,139	4,706	4,707	5,491	5,492	6,275	6,276
	Per Week	0	724	725	1,086	1,087	1,267	1,268	1,448	1,449
6	Annual	0	43,150	43,151	64,725	64,726	75,513	75,514	86,300	86,301
	Per Month	0	3,596	3,597	5,394	5,395	6,293	6,294	7,192	7,193
	Per Week	0	830	831	1,245	1,246	1,452	1,453	1,660	1,661
7	Annual	0	48,650	48,651	72,975	72,976	85,138	85,139	97,300	97,301
	Per Month	0	4,054	4,055	6,081	6,082	7,095	7,096	8,108	8,109
	Per Week	0	936	937	1,403	1,404	1,637	1,638	1,871	1,872
8	Annual	0	54,150	54,151	81,225	81,226	94,763	94,764	108,300	108,301
	Per Month	0	4,513	4,514	6,769	6,770	7,897	7,898	9,025	9,026
	Per Week	0	1,041	1,042	1,562	1,563	1,822	1,823	2,083	2,084

**For Each Additional
Household Member Add:**

\$5,500.00 to annual Income
\$458 to monthly income
\$106 to weekly income

Sliding Scale is based upon the Total Gross Household Income and the number of persons residing in the household. An inability to pay WILL NOT be a barrier to services and/or care.

Board Approved: 2/25/25 Effective: 3/1/2025