Serenity Care Health Group

Sliding Fee Discount Program

Serenity Care Health Group aims to provide the highest quality of comprehensive health care services, including primary care, pediatrics, behavioral health, psychiatric care, dental care, chiropractic care, acupuncture, and retinal screening services, for all patients regardless of their ability to pay. The sliding fee scale and nominal fee will apply to patients without health insurance who do not qualify for Medicaid or Medicare, to patients with health insurance when their insurance does not cover a particular service, and to cost-sharing amounts for insured patients who qualify for a discount. SCHG will inform all patients of the availability of discounts through such means as notifications on intake forms or notices on public places.

To apply for the sliding fee discount, you must be an eligible patient. Eligible patients are those whose annual individual or family income do not exceed 200% of the most current Federal Poverty Guidelines published by the Department of Health and Human Services ("DHHS"). Front office staff, and/or other health center staff, will assist patient in completing application form and will collect any relevant information verification documentation from patient. Completion of the application and collection of income verification documentation will occur prior to SCHG rendering health care services to the patient, or as soon thereafter is reasonable, but always prior to the application of the discount.

The sliding fee discount will be reviewed annually. New application and collection of income verification documentation will be required of patients on an annual basis or more frequently (e.g., upon a significant change in the patient's income status). Copies of all income verification forms, and documentation will be added to the patient's electronic health record.

Regardless of whether a patient qualifies for a discount, if a patient would be denied services due to inability to pay, the charges will be waived or reduced to the extent necessary to ensure that such patient receives health care services. This determination will be conducted on a case-by-case basis based on an individualized determination of need.

Sliding Fee Discount Application

I. Applicant Name: _____ DOB: _____

II. Household* Size Information (*Household members include those persons living in the same home who are related by birth, marriage, registered domestic partnership, or adoption.) Please list below **all** members of your household, including yourself.

	Name	Relationship	Date of Birth		Name	Relationship	Date of Birth
1.				5.			
2.				6.			
3.				7.			
4.				8.			

III. Household* Income Information

Please list below all sources of income of all adult members of your household, including yourself.
Adults are considered those persons 18 - years and older. Please attach to this application verification of each source. See reference list for acceptable as proof of income.

Name	Relationship	Source of Income	Amount Received	Frequency (ex. weekly, biweekly, monthly, yearly)	For office use only Total

Declaration: Completion of the application and self-certification are necessary to participate in Clinic services. I understand that Clinic cannot guarantee services provided outside of the Serenity Care Health Group to be free. I will be responsible for the bills incurred in receiving medical care not provided by Serenity Care Health Group.

_____ _____

Signature Date

SCHG
SLIDING FEE SCALE 2026

Services Discounted Rate	Federal Poverty Guideline	Self Pay I 0% - 100%	Self Pay II >101%-125%	Self Pay III >126%-150%	Self Pay IV >151%-175%	Self Pay V >176%-200%	Self Pay VI above 201%
	Medical	$10 nominal fee	$15	$20	$25	$30	Full Fee
	Behavioral Health	$10 nominal fee	$15	$20	$25	$30	Full Fee
	Chiropractic/Acupuncture	$30 nominal fee	$45	$60	$75	$90	Full Fee
	Dental (Evaluation & X-Rays)	$40 nominal fee	$55	$70	$85	$100	Full Fee
	Vision Services (Retinal Screening)	$40 nominal fee	$55	$70	$85	$100	Full Fee
	Additional Dental Procedures	40% of Fee Schedule	45% of Fee Schedule	55% of Fee Schedule	65% of Fee Schedule	75% of Fee Schedule	Full Fee
	Outside Laboratory Services	cost	cost	cost	cost	cost	cost

Family Size	Annual Income										
1	$15,960	0 - $15,960	$15,961	$19,950	$19,951	$23,940	$23,941	$27,930	$27,931	$31,920	$31,921 +
2	$21,640	0 - $21,640	$21,641	$27,050	$27,051	$32,460	$32,461	$37,870	$37,871	$43,280	$43,281 +
3	$27,320	0 - $24,860	$27,321	$34,150	$34,151	$40,980	$40,981	$47,810	$47,811	$54,640	$54,641 +
4	$33,000	0 - $33,000	$33,001	$41,250	$41,251	$49,500	$49,501	$57,750	$57,751	$66,000	$66,001 +
5	$38,680	0 - $38,680	$38,681	$48,350	$48,351	$58,020	$58,021	$67,690	$67,691	$77,360	$77,361 +
6	$44,360	0 - $44,360	$44,361	$55,450	$55,451	$66,540	$66,541	$77,630	$77,631	$88,720	$88,721 +
7	$50,040	0 - $50,040	$50,041	$62,550	$62,551	$75,060	$75,061	$87,570	$87,571	$100,080	$100,081 +
8	$55,720	0 - $55,720	$55,721	$69,650	$69,651	$83,580	$83,581	$97,510	$97,511	$111,440	$111,441 +

For families/households with more than 8 persons, add $5,680 to annual income for each additional person.

Para las familias y los hogares con más de 8 personas, agregue $5,680 a ingresos anuales por cada persona adicional.

For visits not covered by any special programs or insurance we offer a discount based on your gross income and family size.
Para visitas en que no califico para un programa especial o por seguro medico, ofrecemos descuentos basado en su ingreso bruto y por la medida de su familia.

Payment is requested on the date of service.
Su pago se require en el dia de servicio.