Hopscotch Primary Care

Patient Application for Sliding Fee Discount Program (2026)

Contact Information (please complete)

Patient's Full Name: _____

DOB: _____

HOUSEHOLD A "household" includes anyone that is found to be the applicant's (you) legal dependent, including children in your legal custody, a civil union partner or married spouse. Please list the name of individuals in your household.

Name of dependent	**Relation to you**

Total number in household _____

ANNUAL HOUSEHOLD INCOME

Source of Income	**Self**	**Other**	**Total**
Gross wages, salaries, tips, etc			
Income from business and self employment			
Unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement benefits			
Interest; dividends; royalties; income from rental properties, estates and trusts; alimony, child support, assistance from outside the household and other miscellaneous sources			
Other			
TOTAL INCOME			

Please read and sign

We may ask for evidence of financial need, including pay stubs, tax documents, government assistance, or evidence of other expenses. This information is used to assess financial need. All information will be kept confidential. Copies may be retained for our records.

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am required to notify Hopscotch Primary Care if my income level changes or if I become insured. If there are changes, I will be reassessed for the sliding fee scale. I understand that this program is only active for 12 months and I will have to reapply at the end of the 12-month period.

PATIENT SIGNATURE: _____

PATIENT NAME (PRINTED): _____ DATE: _____

-- OFFICE USE ONLY --

REVIEWER SIGNATURE: _____

REVIWER NAME (PRINTED): _____ DATE: _____

Sliding Fee Scale Eligibility

Poverty level	Sliding Scale Fee (Check One)
0-100%	❑ $0
101-125%	❑ $3
126-150%	❑ $6
151-175%	❑ $9
176-200%	❑ $12
201-300%	❑ $15
Greater than 300%	❑ Full fee/not eligible

A copy of the completed application will be provided for applicant's records.

Hopscotch Primary Care

2026 Sliding Fee Schedule (Per FPL Guidelines)

U.S. Dept of Health and Human Services						
Household #	**100%**	**125%**	**150%**	**175%**	**200%**	**300%**
1	$15,960.00	$19,950.00	$23,940.00	$27,930.00	$31,920.00	$47,880.00
2	$21,640.00	$27,050.00	$32,460.00	$37,870.00	$43,280.00	$64,920.00
3	$27,320.00	$34,150.00	$40,980.00	$47,810.00	$54,640.00	$81,960.00
4	$33,000.00	$41,250.00	$49.500.00	$57,750.00	$66,000.00	$99,000.00
5	$38,680.00	$48,350.00	$58,020.00	$67,690.00	$77,360.00	$116.040.00
6	$44,360.00	$55,450.00	$66,540.00	$77,630.00	$88,720.00	$133,080.00

U.S. Dept of Health and Human Services						
Household #	**100%**	**125%**	**150%**	**175%**	**200%**	**300%**
1	$1,330.00	$1,662.50	$1,995.00	$2,327.50	$2,660.00	$3,990.00
2	$1,803.33	$2,254.17	$2,705.00	$3,155.83	$3,606.67	$5,410.00
3	$2,276.67	$2,845.83	$3,415.00	$3,984.17	$4,553.33	$6,830.00
4	$2,750.00	$3,437.50	$4,125.00	$4,812.50	$5,500.00	$8,250.00
5	$3,223.33	$4,029.17	$4,835.00	$5,640.83	$6,446.67	$9,670.00
6	$3,696.67	$4,620.83	$5,545.00	$6,469.17	$7,393.33	$11,090.00

Complete Federal Guidelines: detailed-guidelines-2026.pdf