

Quality care is affordable care.

Our Sliding Fee Discount can help to make the care you and your family get at Prism Health North Texas (PHNTX) more affordable. The number of people in your household and your yearly household earnings will decide how much your discount will be.

What services does the Sliding Fee Discount cover?

The Sliding Fee Discounts lower the cost of many PHNTX services, such as:

- One-on-one and group counseling sessions
- Visits with your primary care provider and dentist
- Labs (blood tests)*
- Your prescription meds*
**Some restrictions apply*

The Sliding Fee Discount will not lower the cost of services from other providers, such as:

- Some lab tests
- Certain prescription meds

How much money can I make and still get the Sliding Fee Discount?

- Your total yearly earnings must be less than 200% (two times) the federal poverty guidelines.

What are the federal poverty guidelines?

Many government programs that lower the cost of healthcare have earnings limits. People who make more than the limit cannot use these programs. Each year the U.S. government sets these limits, which they call the federal poverty guidelines.

What happens if my family size or earnings change?

PHNTX will review your discount with you at least every 12 months or any time your earnings or the size of your family changes. You will need to share proof of your current earnings with PHNTX once every 12 months.

APPLICATION

Your answers to the questions on this form will help us figure out how much of a discount you can get for our services.

		Today's Date: / /	
What should we call you? First Name: _____		Last Name: _____	
Legal Name (Required) First Name: _____		Middle Initial: _____	Last Name: _____
Date of Birth (MM/DD/YYYY): _____		Social Security Number: _____	
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> In a relationship <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated/Widowed	
(Mailing Address) Street Address: _____			Apt Number: _____
City: _____		State: _____	Zip: _____
My housing is: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> I am experiencing homelessness		We believe it is important to communicate with you, PHNTX may send mail to the address listed above.	
Phone Number Cell: _____ Home: _____ Work: _____		Patient Portal The most secure way to communicate with us is through our patient portal. Please show us your identification and provide us with your email address to get access. Email: _____	
Gender Identity: <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Trans Man <input type="checkbox"/> Trans Woman <input type="checkbox"/> Genderqueer/Non-Binary <input type="checkbox"/> _____	Sex according to legal documents: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> _____ Do you identify as transgender? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender Pronouns: <input type="checkbox"/> He/Him/His <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> _____	Sexual Orientation: <input type="checkbox"/> Lesbian, Gay, Homosexual <input type="checkbox"/> Straight, Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> _____
Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No a. If yes, how many babies are you expected during this pregnancy? _____ b. If yes, due date (mm/dd/yyyy) _____			

Household Information

The number of people in your household will help us figure out how much your discount will be.

People in your household include:

- Legal children (under 18)
- A civil union partners.
- A married spouse (husband or wife)
- Legal dependents (qualifying child or person related by birth, marriage, or adoption)
- If you are pregnant, please include the number of children you are expecting (enter Due Date for Date of Birth).

Use the chart below to list all the people in your household.

	Name of Individuals Living in the Household (including yourself)	Date of Birth	Relation to You
	Example: Jeff Smith	01/01/09	Son
1	Self:		Self
2			
3			
4			
5			
6			
7			
8			
9			
10			


Count the number of people that you wrote down in the chart above and write that number here:

Yearly Household Earnings

Your Yearly Household Earnings are the money that you and the people in your household get each year.

In the chart below:

1. Write the dollar amount of ALL earnings that you and the people in your household get each year in the Amount column.
2. Add all the numbers in the Amount column together. This number is your Total Yearly Earnings.
3. Write your Total Yearly Earnings in the box next to the arrow.

Type of Income	Amount
Salary/wages earned before taxes	
Income from business, self-employment income, and dependents	
Child support/spousal support	
Retirement or pension, veteran's payments, survivor benefits	
Social Security (SSDI/SSA)	
Unemployment	
Worker's Compensation	
Interest from savings/trusts/estates, dividends from investments, rental income	
Seasonal employment income	
Any other source of money your family uses to live on	
Total Yearly Earnings 	\$

This is your Total Yearly Earnings. You will need this number later when you use the Sliding Fee Discount Calculator.

Note: You must provide copies of tax returns, pay stubs, or documents confirming earnings for all the people in your household before we approve your discount. You have 30 Days from the date of your application to provide earning documentation or your application will be denied. For your convenience, you can email your application and supporting financial documents to sfsdocs@prismntx.org or call our main office at 214-910-5065.

Legal Name (Print) _____

Legal Name Signature _____ Date _____

Chosen Name (Print) _____

Chosen Name Signature _____ Date _____

PLEASE NOTE: You have 30 Days from the date of your application to provide earning documentation or your application will be denied, and you will be responsible for all claims at the full Self Pay Rate. For your convenience, you can email your application and supporting financial documents to sfsdocs@prismntx.org or call our main office at 214-910-5065.

Declaration of Income

I, _____, (Legal name) swear or affirm that the information below is true. I understand that my income includes all money that I get from work, even if I do not report that work for tax purposes. My income also includes, but is not limited to, money I get from:

- Retirement
- Investments
- Unemployment
- Disability
- My spouse's income (if married)
- My parents' income (only considered if dependent is under 18)

My yearly income is: \$ _____

I do not have any documents to verify my income. The reasons are (check all that apply):

- I get paid in cash.
- I do not get pay checks or pay stubs.
- I did not file a tax return last year.
- I cannot get a letter from my employer.
- Other, please explain: _____

I currently live in Texas. The address I have is my current address.

Legal Name (Print) _____

Legal Name Signature _____ Date _____

Chosen Name (Print) _____

Chosen Name Signature _____ Date _____

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Approved Denied

Documents Provided: Copies of Tax Returns Pay Stubs Other documents confirming earnings.

Level of Determination: <100% FPL 101 -132% FPL 133-174% FPL 175-200% FPL >200% FPL

Signature _____ Date: _____

Federal Poverty Levels 2024

People in Family/Household	< 100%	101 - 132%	133 - 174%	175 - 200%	> 200%
1	\$0 - \$15,060	\$15,061 - \$19,879	\$19,880 - \$26,204	\$26,205 - \$30,120	\$30,121 or more
2	\$0 - \$20,440	\$20,441 - \$26,981	\$26,982 - \$35,566	\$35,567 - \$40,880	\$40,881 or more
3	\$0 - \$25,820	\$25,821 - \$34,082	\$34,083 - \$44,927	\$44,928 - \$51,640	\$51,641 or more
4	\$0 - \$31,200	\$31,201 - \$41,184	\$41,185 - \$54,288	\$54,289 - \$62,400	\$62,401 or more
5	\$0 - \$36,580	\$36,581 - \$48,286	\$48,287 - \$63,649	\$63,650 - \$73,160	\$73,161 or more

Note: For families/households with more than five persons, add \$5,380 for each additional person.

Sliding Fee Rates

Federal Poverty Level	Medical Visit	Psychiatry Visit	Counseling Visit	Preventative Dental Visit ¹	Other Dental Visit ²
< 100%	\$10*	\$10*	\$10*	\$10	\$100
101 - 132%	\$63	\$63	\$40	\$57	25%
133 - 174%	\$85	\$85	\$80	\$97	50%
175 - 200%	\$108	\$108	\$100	\$136	75%
> 200%	No Discount	No Discount	No Discount	No Discount	No Discount

* Effective on October 1st, 2024

¹ Preventive Dental Visits include basic cleanings, examination by a dentist, and x-rays.

² Other Dental Visits include dental services outside of Preventive Dental Visits which may be completed in a single visit. Dental prosthetics, such as dentures, are charged at their production fee.

Medical Laboratory: we are currently negotiating the Sliding Fee Rates for Labs with our partner. Once negotiations have been completed, PHNTX will release the Medical Laboratory Sliding Fee Rates.

Patients may be eligible for additional financial assistance if available through grant funds, including HRSA's Ryan White Program, and the Centers for Disease Control and Prevention Sexually Transmitted Infection funds.

All patients, including patients eligible for Sliding Fee discounts, are also eligible to receive a Prompt Pay Adjustment (40% of Total Charges), available with full payment at date of appointment or within 5 days of the date of appointment. Note: The Nominal Visit charge already includes the full Prompt pay Adjustment.

Note: The FPL is published annually by the US Department of Health and Human Services. The FPL is commonly used to determine eligibility for certain income-driven programs and benefits such as Medicaid and CHIP.