Sliding Fee Application

Please review the income eligibility table on the other side of this document. If you qualify, complete the application and return it to the Boundless Billing Department at 445 E. Dublin Granville Rd, Bldg. G, Worthington, OH 43085 or by email to slidingfeeprogram@boundlesshealth.org.

Name: _____

Date of Birth: _____ Family Size: _____

List the name(s) and date of birth of each family member/individual living in your household or individuals for whom you are financially responsible. Additional spots can be provided upon request.

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Address: _____

Phone Number: _____ Alternate Number: _____

Do you have insurance: _____ YES _____ NO

Medical Plan Name: _____

Disclaimer: I hereby attest that the information listed above is accurate and true to the best of my knowledge. I agree to notify Boundless if the above information changes within ten days of the change. I understand that I must complete a new Sliding Fee Application to re-qualify each year. Requalification is one year from the date of the previous application. The rates are based upon the Federal Poverty Guidelines and Ohio Medicaid Guidelines. Sliding fee payment is due at the time of service.

_____ _____

Application Signature Date

For Office Use Only

Annual Gross Income: _____

Patient is eligible for a discount in column: _____A _____B _____C _____D

_____ Proof of income verified

_____ Patient does not qualify for sliding fee

Verified by Boundless Health Staff: _____ Date _____

Boundless Health
445 E. Dublin Granville Rd
Worthington, OH 43085

1-800-409-2729
info@boundlesshealth.org
boundlesshealth.org

Boundless Health

SLIDING FEE SCHEDULE & APPLICATION

Boundless is committed to providing high-quality, affordable healthcare to the communities we serve.

To determine your sliding fee scale eligibility, we require proof of income for *all individuals currently living in your residence eighteen and older who are financially responsible for the household.* Please provide a copy of either of the two options listed with your application:

- two consecutive pay stubs
- the previous year's tax returns or W-2s

Our sliding fee schedule is based on a household's income and size. We review each application and supporting documents to determine eligibility and fee schedule. Applications must be submitted annually, and your fee may vary year to year. If your income qualifies you for Ohio Medicaid, we require that you apply before we consider your sliding fee application.

BOUNDLESS MEDICAL, BEHAVIORAL HEALTH, AND DENTAL SERVICES SLIDING FEE SCALE

% of FPG	At or Below 100%	101-125%	126-150%	151-175%	176-200%	Above 200%
Family Size	***Annual Family Income Maximum***					
1	$12,880.00	$12,881-$16,100	$16,101-$19,320	$19,321-$22,540	$22,541-$25,760	>$25,760
2	$17,420.00	$17,421-$21,775	$21,776-$26,130	$26,131-$30,485	$30,486-$34,840	>$34,840
3	$21,960.00	$21,961-$27,450	$27,451-$32,940	$32,941-$38,430	$38,431-$43,920	>$43,920
4	$26,500.00	$26,501-$33,125	$33,126-$39,750	$39,751-$46,375	$46,376-$53,000	>$53,000
5	$31,040.00	$31,041-$38,800	$38,801-$46,560	$46,561-$54,320	$54,321-$62,080	>$62,081
6	$35,580.00	$35,581-$44,475	$44,476-$53,370	$53,371-$62,265	$62,266-$71,160	>$71,160
7	$40,120.00	$40,121-$50,150	$50,151-$60,180	$60,181-$70,210	$70,211-$80,240	>$80,240
8	$44,660.00	$44,661-$55,825	$55,826-$66,990	$66,991-$78,155	$78,156-$89,320	>$89,320

For each additional family member, add $4,540.00 to the Annual Family Income Maximum to determine eligibility. Based on 2021 Federal Poverty Guidelines.

Charge Per Service	Nominal Fee ($25.00)	50% of Standard Rate	60% of Standard Rate	70% of Standard Rate	85% of Standard Rate	100% of Standard Rate