Sliding Fee Application

Please return the **completed form and proof of income** to the Boundless Billing Department
445 E. Dublin Granville Rd, Bldg. G, Worthington, OH 43085 or
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

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	$15,650.00	$15,651.00-$19,562.00	$19,563.00-$23,475.00	$23,476.00-$27,387.00	$27,388.00-$31,300.00	>$31,301.00
2	$21,150.00	$21,151.00-$26,437.00	$26,438.00 $31,725.00	$31,726.00 $37,012.00	$37,013.00 $42,300.00	>$42,301.00
3	$26,650.00	$26,651.00 $33,312.00	$33,313.00 $39,975.00	$39,976.00-$46,637.00	$46,638.00 $53,300.00	>$53,301.000
4	$32,150.00	$32,151.00 $40,187.00	$40,188.00.-$48,225.00	$48,226.00-$56,262.00	$56,263.00-$64,300.00	>$64,301.00
5	$37,650.00	$37,651.00-$47,062.00	$47,063.00-$56,475.00	$56,476.00-$65,887.00	$65,888.00-$75,300.00	>$75,301.00
6	$43,150.00	$43,151.00-$53,937.00	$53,938.00-$64,725.00	$64,726.00-$75,512.00	$75,513.00-$86,300.00	>$86,301.00
7	$48,650.00	$48,651.00-$60,812.00	$60,813.00-$72,975.00	$72,976.00-$85,137.00	$85,138.00-$97,300.00	>$97,301.00
8	$54,150.00	$54,151.00-$67,687.00	$67,688.00-$81,225.00	$81,226.00-$94,762.00	$94,763.00-$108,300.00	>$108,301.00

For each additional family member, add $5,500.00 to the Annual Family Income Maximum to determine eligibility.
Based on 2025 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