



Sliding Scale Fee Discount Application (Financial Assistance Request)

Easterseals Capital Region & Eastern Connecticut is committed to providing access to essential services regardless of ability to pay. Sliding scale fee discounts are available based on **household size and gross annual household income**, consistent with Federal Poverty Level (FPL) guidelines.

Completion of this application does **not guarantee approval** of a discount. Eligibility is determined after review of required documentation.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address (Street / City / State / Zip): _____

HEAD OF HOUSEHOLD INFORMATION

Head of household is the adult who is primarily responsible for the household's income and expenses and whose income is used to determine sliding scale eligibility.

Name of Head of Household: _____

Relationship to Patient: Patient Spouse/Partner Parent Guardian Other, specify: _____

Address/City/State/Zip: Same as patient Other: _____

Telephone Number: Same as patient Other: _____

Name of Employer (if applicable): _____

Employer Address/City/State/Zip: _____

Employer Telephone Number: _____

HOUSEHOLD MEMBERS

List all members who live in the household and are supported by household income.

Relationship to Head of Household	Name	Date of Birth
Self		
Spouse/Partner		
Dependent		

ANNUAL HOUSEHOLD INCOME

Please report gross annual income (before taxes) for all household members. Enter "0" if does not apply.

Income Source	Head of Household	Spouse/ Partner	Other	Total
Gross wages, salaries, tips				
Business or self-employment income				
Unemployment compensation, workers' compensation, Social Security, SSI, public assistance, veterans' benefits, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates or trusts, educational assistance, alimony, child support, assistance from outside the household, or other income				
Total Annual Household Income				

Important Information About the Sliding Scale Discount

- Discounts apply only to medically necessary services provided directly by this clinic.
- Discounts do not apply to services or items billed by outside providers (such as laboratory testing, medications, imaging interpretation, or other third-party services).
- Approved discounts apply to all eligible services during the approval period.
- This application must be updated every 12 months, or sooner if household size or income changes.
- Patients are responsible for any remaining balance after the discount is applied.

Certification and Authorization

I certify that the household size and income information provided is complete and accurate to the best of my knowledge.

I understand that income and household documentation is required for review and that incomplete or inaccurate information may result in denial or loss of the sliding scale discount.

Signature: _____ **Print Name:** _____ **Date:** _____
Relationship to Patient: Patient Spouse/Partner Parent Guardian Other, specify: _____

Office Use Only

Patient Name: _____ Patient DOB: _____
 Approved Discount Percentage: _____ % Federal Poverty Level (FPL) % (if applicable): _____ %
 Approval Effective Date: _____ Expiration / Review Date: _____
 Approved By (Print): _____ Date of Approval: _____

Verification Checklist

- Identification / Address:** Driver's license Utility bill or other proof of address
Income Verification: Federal tax return (most recent calendar year) Two most recent pay stubs
 W-2 or Form 4506-T (if applicable) Other income documentation: _____
Insurance: Insurance card(s)

**Sliding Fee Schedule
Annual Income Thresholds by
Sliding Fee Discount Pay Class and Percent Poverty
January 1, 2026**

Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Charge					
	Nominal Fee (\$5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0 - \$15,960	\$15,961 - \$19,950	\$19,951 - \$23,940	\$23,941 - \$27,930	\$27,931 - \$31,920	\$31,921+
2	0 - \$21,640	\$21,641 - \$27,050	\$27,051 - \$32,460	\$32,461 - \$37,870	\$37,871 - \$43,280	\$43,281+
3	0 - \$27,320	\$27,321 - \$34,150	\$34,151 - \$40,980	\$40,981 - \$47,810	\$47,811 - \$54,640	\$54,641+
4	0 - \$33,000	\$33,001 - \$41,250	\$41,251 - \$49,500	\$49,501 - \$57,750	\$57,751 - \$66,000	\$66,001+
5	0 - \$38,680	\$38,681 - \$48,350	\$48,351 - \$58,020	\$58,021 - \$67,690	\$67,691 - \$77,360	\$77,361+
6	0 - \$44,360	\$44,360 - \$55,450	\$55,450 - \$66,540	\$66,541 - \$77,630	\$77,631 - \$88,720	\$88,721+
7	0 - \$50,040	\$50,041 - \$62,550	\$62,550 - \$75,060	\$75,061 - \$87,570	\$87,571 - \$100,080	\$100,081+
8	0 - \$55,720	\$55,721 - \$69,650	\$69,650 - \$83,580	\$83,581 - \$97,510	\$97,511 - \$111,440	\$111,441+
For each additional person, add	\$5,680	\$7,100	\$8,520	\$9,940	\$11,360	\$11,360

* Based on 2026 Federal Poverty Guidelines (<http://aspe.hhs.gov/poverty>)