Medical Sliding Scale Payment Agreement

Client Name (printed) : _____

Client Signature: _____

Family Yearly Gross Income: _____

Number of Dependents: _____

		Sliding Fee Discount			
Family Size	**Annual Income**	**No Fee**	**$35**	**$45**	**$55**
1	$13,590	$1,133	$1,506	$1,699	$2,265
2	$18,310	$1,526	$2,029	$2,289	$3,052
3	$23,030	$1,919	$2,552	$2879	$3,838
4	$27,750	$2,313	$3,076	$3,469	$4,625
5	$32,470	$2,706	$3,599	$4,059	$5,412
6	$37,190	$3,099	$4,122	$4,649	$6,198
7	$41,910	$3,493	$4,645	$5,239	$6,985
8	$46,630	$3,886	$5,168	$5,829	$7,772
For each additional person add	$4,720				

Daily Rate Determined: $ _____

Income Verification Documents: _____

FLACRA Staff Member: _____

Sliding Fee Scale to be used for Uninsured and Insurances who do not cover services provided

Finger Lakes Area Counseling & Recovery Agency
FLACRA™
Together We Will