# 2022 Sliding Scale Worksheet
# Ruby Valley RHC / Twin Bridges RHC

***Payment is due at time of service to qualify for assistance.***

Family name: _____

Contact Person: _____

Number of Family Members: _____ Contact Phone #: _____

Family Members: _____

_____

Income: _____ Efective Date: From: _____ To: _____

Required Paperwork:

1. Copy of income tax return (NOTE: Assistance is based on **GROSS** yearly income.)
2. Copy of current paystub for all working family members

NOTE: Include income from all adult family members in household and income from all sources. These include, but are not limited to: Gross wages, tips, social security, disability, pensions, annuities, veterans payments, net business or self employment, alimony, child support, military, unemployment, public aid and any other form of income.

| Family Size | A Min **Pay ($10.00)** | | B **Pay ($25.00)** | | C **Pay 100%** | |
|---|---|---|---|---|---|---|
| | From | To | From | To | From | To |
| 1 | $0 | $20,385 | $20,386 | $27,180 | $27,181 | And over |
| 2 | $0 | $27,465 | $27,466 | $36,620 | $36,621 | And over |
| 3 | $0 | $34,545 | $34,546 | $46,060 | $46,061 | And over |
| 4 | $0 | $41,625 | $41,626 | $55,500 | $55,501 | And over |
| 5 | $0 | $48,705 | $48,706 | $64,940 | $64,941 | And over |
| 6 | $0 | $55,785 | $55,786 | $74,380 | $74,381 | And over |
| 7 | $0 | $62,865 | $62,866 | $83,820 | $83,821 | And over |
| 8 | $0 | $69,945 | $69,946 | $93,260 | $93,261 | And over |
| 9 | $0 | $77,025 | $77,026 | $102,700 | $102,701 | And over |
| 10 | $0 | $84,105 | $84,106 | $112,140 | $112,141 | And over |

Each Column represents the annual **GROSS** income of the family.

Patients pay 100% of the bill in Column C, but can set up long term payment plans.

Applications will be renewed each year by April 30th or when financial situations change.

**All payments must be made at time of service to qualify for discount.**
**No one will be turned away for inability to pay.**

**I certify that the information given to Ruby Valley Rural Health Clinics is true and correct to the best of my knowledge and further agree that falsification herein will disqualify me or my dependent(s) for charitable services. I understand the information submitted is subject to verification. I understand all information given to me regarding the sliding scale program & my payment responsibilities**

Patient Signature: _____

Date: _____

Clinic Authorization: _____

Date: _____ Effective: 2/01/2022