ShoCare Application Form

Effective January 1, 2021

Shodair Children's Hospital

Shodair
CHILDREN'S HOSPITAL

Patient Name: _____ **Birthdate:** _____

2021 FPL	Family Size	A (100% Discount) Income Level From	A To *	B (60% Discount) Income Level From	B To	C (40% Discount) Income Level From	C To	F (20% Discount) Income Level From	F To
$12,880	1	$0	$25,760	$25,761	$38,640	$38,641	$51,520	$51,521	$62,450
$17,420	2	$0	$34,840	$34,841	$52,260	$52,261	$69,680	$69,681	$84,550
$21,960	3	$0	$43,920	$43,921	$65,880	$65,881	$87,840	$87,841	$106,650
$26,500	4	$0	$53,000	$53,001	$79,500	$79,501	$106,000	$106,001	$128,750
$31,040	5	$0	$62,080	$62,081	$93,120	$93,121	$124,160	$124,161	$150,850
$35,580	6	$0	$71,160	$71,161	$106,740	$106,741	$142,320	$142,321	$172,950
$40,120	7	$0	$80,240	$80,241	$120,360	$120,361	$160,480	$160,481	$195,050
$44,660	8	$0	$89,320	$89,321	$133,980	$133,981	$178,640	$178,641	$217,150

* Income is defined to include all sources of household income including but not limited to: gross wages, Social Security, governmental assistance, child support, alimony, unemployment compensation and business and investment income.

Please indicate family size: _____ Please indicate household income: _____

*** Shodair will also consider how much other medical debt you owe in determining your ShoCare discount.**
Please indicated how much other medical debt you owe, not including your current account with Shodair: $_____

By circling your income range and family size on the table above and signing your name below, you attest that you have provided true and verifiable income information and are willing to provide proof of income when when requested by Shodair.

_____ _____
Name (person responsible for bill) **Date**

_____ **Shodair Approvals:** _____ **Dept/Staff Sponsor**
Signature _____ **Percent Approved by CFO**
_____ **Date Approved/CFO initials**
_____ **Account(s) approved**