ShoCare Application Form

Effective January 1, 2022

Shodair Children's Hospital

Patient Name: _______________________ Birthdate: _______________________

2022 FPL	Family Size	A (100% Discount) Income Level From	To *	B (60% Discount) Income Level From	To	C (40% Discount) Income Level From	To	F (20% Discount) Income Level From	To
$13,590	1	$0	$27,180	$27,181	$40,770	$40,771	$54,360	$54,361	$62,450
$18,310	2	$0	$36,620	$36,621	$54,930	$54,931	$73,240	$73,241	$84,550
$23,030	3	$0	$46,060	$46,061	$69,090	$69,091	$92,120	$92,121	$106,650
$27,750	4	$0	$55,500	$55,501	$83,250	$83,251	$111,000	$111,001	$128,750
$32,470	5	$0	$64,940	$64,941	$97,410	$97,411	$129,880	$129,881	$150,850
$37,190	6	$0	$74,380	$74,381	$111,570	$111,571	$148,760	$148,761	$172,950
$41,910	7	$0	$83,820	$83,821	$125,730	$125,731	$167,640	$167,641	$195,050
$46,630	8	$0	$93,260	$93,261	$139,890	$139,891	$186,520	$186,521	$217,150

$4720 for addtional family members

* 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**

____
Signature

Shodair Approvals:

__________ **Dept/Staff Sponsor**
__________ **Percent Approved by CFO**
____________________ **Date Approved/CFO initials**
____________________ **Account(s) approved**