BALL STATE UNIVERSITY
College of Health
Interprofessional Community Clinics

Interprofessional Community Clinics
Application for Reduced Fees

The Interprofessional Community Clinics serve all clients regardless of their insurance or financial class. We provide outstanding, quality driven services, and products that are both accessible and affordable. Fees for our services are used to support and maintain the operational costs of our clinics and centers.

We are able to provide a sliding fee scale for our clinical services* for clients who qualify based on household size and annual gross income. Please evaluate the Sliding Fee Schedule below to determine if you qualify for reduced fees. If you are eligible, please read and complete the bottom of this form and turn it in to our front office. *NOTE: our office staff are available to assist you in determining whether you are eligible for discounted services and we can work with you on a payment plan.*

2023 Sliding Fee Schedule for Services*

Based on 2022 Federal Poverty Guidelines

Family Size	**Plan 1**	**Plan 2**	**Plan 3**	**Plan 4**
	At or below 100%	125%	150%	175%
1	$0 - $13,590	$13,591 - $20,385	$20,386 - $25,142	$25,143 - $27,180
2	$0 - $18,310	$18,311 - $27,465	$27,466 - $33,874	$33,875 - $36,620
3	$0 - $23,030	$23,031 - $34,545	$34,546 - $42,606	$42,607 - $46,060
4	$0 – $27,750	$27,751 - $41,625	$41,626 - $51,338	$51,339 - $55,500
5	$0 – $32,470	$32,471 - $48,705	$48,706 - $60,070	$60,071 - $64,940
6	$0 - $37,190	$37,191 - $55,785	$55,786 - $68,802	$68,803 - $74,380
7	$0 - $41,910	$41,911 - $62,865	$62,866 - $77,534	$77,535 - $83,820
8	$0 – $46,630	$46,631 - $69,945	$69,946 - $86,266	$86,267 - $93,260
Each additional member over 8	Add $4,540	Add $6,810	Add $8,399	Add $9,080
Fee per session (1 session = 1 hr. of service/therapy)	$1	$5	$10	$20

***Reduced fees may only be applied to services (not products or devices)**

By signing below, I attest that I meet the requirements for receiving reduced fees through the clinic. I also understand that I may be asked to verify my qualification at any point by providing proof of income documentation.

Patient Name:_____ Date of Birth:_____
Name of person completing form:_____
Relationship to Patient:_____ Today's Date:_____

Please circle the Plan that you attest to qualifying for based on the information provided above:

Plan 1 **Plan 2** **Plan 3** **Plan 4**

Please return this completed form to one of our team members at the front desk