Rosa Clark Medical Clinic Association

PATIENT RE-ENROLLMENT APPLICATION

***You should complete only if you would like to qualify for the sliding fee scale.

Name:_____ Date of Birth:_____

SS#: _____

Phone #: _____ Alternate #:_____ Email Address:_____

Address: _____ _____

Street City State Zip Code

Mailing address if different from above:_____

Please check if any of these apply to you:

Homeless_____ Public Housing Resident_____ Food insecurity_____ Veteran_____

Housing Insecurity _____ Financial Strain _____

Lack of Transportation/Access to Public Transportation _____

If you have insurance please list here:_____

*****Please provide Insurance Card to Enrollment Coordinator to Copy

How many people live at the address above? _____

List the amount of monthly Gross Income for each person in the home:

Self $_____ Source of Income:_____

Other Household Income $_____ Source of Income:_____

Other Household Income $_____ Source of Income:_____

Total Monthly Gross Income $_____

Rosa Clark Sliding Fee Scale 2025

	Plan 1	Plan 2	Plan 3	Plan 4
Persons in House-hold	**At or below 100% FPL or below**	**At 101% - 125% FPL**	**At 126% - 150% FPL**	**At 151% - 200% of FPL**
1	0 to $15,650	$15,651 to $19,564	$19,565 to $23,475	$23,476 to $31,300
2	0 to $21,150	$21,151 to $26,439	$26,440 to $31,725	$31,726 to $42,300
3	0 to $26,650	$26,651 to $33,314	$33,315 to $39,975	$39,976 to $53,300
4	0 to $32,150	$32,151 to $40,189	$40,190 to $46,225	$48,226 to $64,300
5	0 to $37,650	$37,651 to $47,064	$47,065 to $56,475	$56,476 to $75,300
6	0 to $43,150	$43,151 to $53,939	$53,940 to $64,725	$64,726 to $86,300
7	0 to $48,650	$48,651 to $60,814	$60,815 to $72,975	$72,976 to $97,300
8	0 to $54,150	$54,151 to $67,689	$67,690 to $81,225	$81,226 to $108,300
For families/households with more than 8 persons, add $5,380 for each additional person.				
There is no discount for household income over 200% of the Federal Poverty Guidelines				
Office Visit	$0.00	$2.00	$5.00	$10.00
Pharmacy Co-pay Per RX	$0.00 per RX	$1.00 per RX	$2.00 per RX	$3.00 per RX

We are required to verify your income in order to provide the sliding fee scale. We can use ***any*** of the following to verify your income:

Prior Year Income Tax Returns

Last 4 Paystubs

Letter of Temporary Living Assistance

SNAP Eligibility Letter

Social Security Eligibility Letter

By signing below, I hereby attest:

That the above information is true and accurate and I hereby authorize treatment.

_____ _____

Date Patient Signature

_____ _____

Date Enrollment Coordinator

***Patients needing after hours assistance for health care, call 864-882-4664, ext. 6.

Revised 3/17/2025