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: _____

_____

City State Zip Code Mailing address if different from above: _____

Please check if any of these apply to you:

Housing Insecurity_____ Food insecurity_____ Veteran_____ Financial Strain _____

Lack of Transportation/Access to Public Transportation _____

Possible Medicaid Eligibility: Please check any of the following that apply

You have legal custody of a child under 18 ____ You are legally blind ____ You are a legal resident ____

You have been diagnosed with breast or cervical cancer ____ You have very low or no income ____

You are over the age of 65 ____

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:_____ Other Household Income:_____

Other Household Income: _____

Total Monthly Gross Income: _____

Source of Income: _____

Source of Income: _____

Source of Income: _____

Rosa Clark Sliding Fee Scale 2026

	Plan 1	Plan 2	Plan 3	Plan 4
Persons in Household	**At or below 100% FPL or below**	**At 101% - 125% FPL**	**At 126% - 150% FPL**	**At 151% - 200% of FPL**
1	0 to $15,960	$15,961 to $19,950	$19,951 to $23,940	$23.941 to $31,920
2	0 to $21,640	$21,641 to $27,050	$27,051 to $32,460	$32,461 to $43,280
3	0 to $27,320	$27,321 to $34,150	$34,151 to $40,980	$40,981 to $54,640
4	0 to $33,000	$33,001 to $41,250	$41,251 to $49,500	$49,501 to $66,000
5	0 to $38,680	$38,681 to $48,350	$48,351 to $58,020	$58,021 to $77,360
6	0 to $44,360	$44,361 to $55,450	$55,451 to $66,540	$66,541 to $88,720
7	0 to $50,040	$50,041 to $62,550	$62,551 to $75,060	$75,061 to $100,080
8	0 to $55,720	$55,721 to $69,651	$69,652 to $83,580	$83,581 to $111,440
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 02/11/2026