Ocean County Health Department

SLIDING FEE SCHEDULE

Financial Assistance Application

Date: / /

Patient Last Name Patient First Name

Section I: All information will be kept strictly confidential

Annual Family Income $ ______________________

Monthly Family Income (Divided annual by 12) $ ________________________________

Scale Level	**A**	**B**	**C**	**D**	**E**	**F**
Medical Visit	$10	$15	$20	$25	$30	$40
Nutrition Visit	$0	$0	$0	$10	$15	$20
Immunization Admin Fee (non-317B covered)	$0	$0	$0	$0	$5	$10
Vaccine (non -317B covered)	5%	5%	10%	10%	20%	20%

Scale Level	**A**	**B**	**C**	**D**	**E**	**F**
Poverty Level 2023	**100%**	**125%**	**150%**	**175%**	**200%**	**250%**
Family Size	**Maximum Annual Income**					
1	$ 14,580	$ 18,225	$ 21,870	$ 25,515	$ 29,160	$ 36,450
2	$ 19,720	$ 24,650	$ 29,580	$ 34,510	$ 39,440	$ 49,300
3	$ 24,860	$ 31,075	$ 37,290	$ 43,505	$ 49,720	$ 62,150
4	$ 30,000	$ 37,500	$ 45,000	$ 52,500	$ 60,000	$ 75,000
5	$ 35,140	$ 43,925	$ 52,710	$ 61,495	$ 70,280	$ 87,850
6	$ 40,280	$ 50,350	$ 60,420	$ 70,490	$ 80,560	$ 100,700
7	$ 45,420	$ 56,775	$ 68,130	$ 79,485	$ 90,840	$ 113,550
8	$ 50,560	$ 63,200	$ 75,840	$ 88,480	$ 101,120	$ 126,400
Each additional individual	**$ 5,140**	**$ 6,425**	**$ 7,710**	**$ 8,995**	**$ 10,280**	**$ 12,850**

** The NJ Aid discount Program for the income levels 200% -250% and is only available for NJ residents

Signature of Patient /Guardian : ________________________________ Date:____________

Signature of OCHD Staff : ____________________________________ Date: ____________