Hyndman Area Health Center
144 Fifth Avenue
Hyndman, PA 15545
814-842-3206 Fax: 814-842-3746

Hyndman Area Health Center
104 Railroad St
Bedford, PA 15522
814-263-5804

Family Planning Coverage and Income Assessment Form for Clients 18 Years and Over

□ I am covered by insurance and have no concerns about confidentiality. It is okay for Hyndman Area Health Center, Inc. to bill my insurance company.

□ I am covered by insurance, but want to keep my visit with Hyndman Area Health Center, Inc. private. I **do not** want Hyndman Area Health Center, Inc. to bill my insurance company.

□ I have no insurance coverage

This facility receives federal monies to provide free and reduced fee services to low-income, uninsured, and underinsured individuals.

1. In the table below, find the NUMBER OF PEOPLE that live in your household in the column labeled "Family size."
2. Circle the "Annual Income" range in the row that applies to your family's household. All income received by your household should be included in that number.
3. Household is defined as anyone living in the home that is dependent of the applicant.

2020 Annual Poverty Guidelines

Family Size	No Fee 0-100%	101%-125%	126%-150%	151%-175 %	176%-200%	201%-220%	221%- 250%	>250% and Above
1	12,760	15.950	19,140	22,330	25,520	28,072	31,900	31,901
2	17,240	21,550	25,860	30,170	34,480	37,928	43,100	43,101
3	21,720	27,150	32,580	38,010	43,440	47,784	54,300	54,301
4	26,200	32,750	39,300	45,850	52,400	57,640	65,500	65,501
5	30,680	38,350	46,020	53,690	61,360	67,496	76,700	76,701
6	35,160	43,950	52,740	61,530	70,320	77,352	87,900	87,901
7	39,640	49,550	59,460	69,370	79,280	87,208	99,100	99,101
8	44,120	55,150	66,180	77,210	88,240	97,064	110,300	110,301

** In reference to the above table the income ceiling for the no fee schedule is equal to the federal poverty level. The 2020 federal poverty level guideline increases by $4,480 for each additional family member above 8.

□ I decline to give this information. I understand that I may pay the full fee for these services and supplies if my insurance cannot be billed.

Please sign and date below.

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Patient Signature

Date