Sliding Fee Discount Program

As a Community Health Center, we offer a Sliding Fee Discount Program based on household income and family size, which reduces the amount you pay for healthcare services. If you qualify, you may pay only 20 – 80% of the cost for most services. You may be eligible for this program even if you have insurance.

The Sliding Fee Discount Program application is available in English and Spanish at check-in at each health center site and on our website. All information on the application is kept confidential. We have designated staff available to help you with completing the application.

The Federal Poverty Guidelines will be used for the Sliding Fee Discount Program. If your income falls within the guidelines, we encourage you to apply.

Proof of income is required to process your application. The documents listed below are acceptable proof of income:

- W-2 Form
- Income tax returns
- Current pay stubs
- Bank statement showing direct deposits
- Unemployment award notice
- Social Security notice
- Child support and/or alimony
- Pension or retirement income
- Disability or workers' compensation determination letter
- Letter from employer establishing income

For questions, please inquire at the check-in desk at each clinic location.

Schedule an Appointment
800-720-9553

LOCATIONS:

Banning Community Health Center
3055 West Ramsey
Banning
951-849-6794

Corona Community Health Center
505 S. Buena Vista Ave.
Corona
951-272-5445

Hemet Community Health Center
880 N. State St.
Hemet
951-766-2450

Indio Community Health Center
47-923 Oasis St.
Room 1-CL
Indio
760-863-8283

Jurupa Community Health Center
9415 Mission Blvd.
Jurupa
951-360-8795

Lake Elsinore Community Health Center
2499 E. Lakeshore Dr.
Suite B
Lake Elsinore
951-471-4200

Palm Springs Community Health Center
1515 North Sunrise Way
Palm Springs
760-778-2210

Dr. Robert Bruce Reid Health Center
Perris Community Health Center
308 E. San Jacinto Ave.
Perris
951-940-6700

Riverside Neighborhood Community Health Center
7140 Indiana Ave.
Riverside
951-358-6000

Don Schroeder Family Care Center
Rubidoux Community Health Center
5256 Mission Blvd.
Riverside
951-955-0840
951-955-5360
(Dental Office)

Administrative Offices
Mission Grove Corporate Plaza
7888 Mission Grove Parkway, Suite 120
Riverside, CA 92508
951-358-5222
www.RUhealth.org/CHC

4-2018-300

Sliding Fee Schedule

Riverside University HEALTH SYSTEM Community Health Centers

Our Sliding Fee Discount Program is available to all patients who qualify based on their annual household income and family size even if they have insurance. Fees, co-pays, co-insurance, and deductibles are eligible for a sliding fee discount. Please inquire at check-in if you would like to apply for our Sliding Fee Discount Program.

Sliding Fee Discount Schedule

Based on the 2018 Federal Poverty Level (FPG) | All Community Health Center Eligible Patients

PAYMENT OBLIGATION						
	Slide A 0-100% FPG	**Slide B** 101-125% FPG	**Slide C** 126-150% FPG	**Slide D** 151-175% FPG	**Slide E** 176-200% FPG	**Slide F** Over 200% FPG
Medical	Patient Pays $20.00 Nominal Fee	Patient Pays $25.00 Nominal Fee	Patient Pays $30.00 Nominal Fee	Patient Pays $35.00 Nominal Fee	Patient Pays $40.00 Nominal Fee	No Discount
Pharmacy	Patient Pays $2.00 Nominal Fee	Patient Pays $5.00 Nominal Fee	Patient Pays $10.00 Nominal Fee	Patient Pays $15.00 Nominal Fee	Patient Pays $15.00 Nominal Fee	No Discount
Dental Preventative	Patient Pays $30.00 Nominal Fee	Patient Pays $35.00 Nominal Fee	Patient Pays $40.00 Nominal Fee	Patient Pays $45.00 Nominal Fee	Patient Pays $50.00 Nominal Fee	No Discount
Dental Restorative (Procedure Only)**	Patient Pays $50.00 Nominal Fee	Patient Pays $60.00 Nominal Fee	Patient Pays $70.00 Nominal Fee	Patient Pays $80.00 Nominal Fee	Patient Pays $85.00 Nominal Fee	No Discount
FAMILY SIZE*	**ANNUAL INCOME**					
1	$0 - $12,140.00	$12,141.00 - $15,175.00	$15,176.00 - $18,210.00	$18,211.00 - $21,245.00	$21,246.00 - $24,280.00	$24,280.00 -↑
2	$0 – $16,460.00	$16,461.00 - $20,575.00	$20,576.00 - $24,690.00	$24,691.00 - $28,805.00	$28,806.00 - $32,920.00	$32,920.00 -↑
3	$0 - $20,780.00	$20,781.00 - $25,975.00	$25,976.00 - $31,170.00	$31,171.00 -$36,365.00	$36,366.00 - $41,560.00	$41,560.00 -↑
4	$0 - $25,100.00	$25,101.00 - $31,375.00	$31,376.00 - $37,650.00	$37,651.00 -$43,925.00	$43,926.00 - $50,200.00	$50,200.00 -↑
5	$0 - $29,420.00	$29,421.00 - $36,775.00	$36,776.00 - $44,130.00	$44,131.00 - $51,485.00	$51,486.00 - $58,840.00	$58,840.00 -↑
6	$0 - $33,740.00	$33,741.00 - $42,175.00	$42,176.00 - $50,610.00	$50,611.00 - $59,045.00	$59,046.00 - $67,480.00	$67,480.00 -↑
7	$0 – $38,060.00	$38,061.00 - $47,575.00	$47,576.00 - $57,090.00	$57,091.00 - $66,605.00	$66,606.00 - $76,120.00	$76,120.00 -↑
8	$0 – $42,380.00	$42,381.00 - $52,975.00	$52,976.00 - $63,570.00	$63,571.00 - $74,165.00	$74,166.00 -$84,760.00	$84,760.00 -↑

For family members greater than 8, add $4,320.00 per additional family member to the annual. Example: Family of 9 FPG = $41,320.00 + $4,320.00 = $46,700.00
*****When applicable, patient is responsible for all outside lab costs.***