LINCOLN COUNTY HOSPITAL DISTRICT
GROVER C. DILS
MEDICAL CENTER

2026 SLIDING FEE/FINANCIAL ASSISTANCE APPLICATION

DISCOUNT SCHEDULE

Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	**Discount 100%**	**Discount 90%**	**Discount 80%**	**Discount 70%**	**Discount 60%**	**Discount 50%**	**Discount 40%**	**Discount 30%**	**Discount 20%**	**Discount 15%**	**Discount 10%**	**Discount 0%**
1	$15,960	$17,556	$19,152	$20,748	$22,344	$23,940	$25,536	$27,132	$28,728	$30,324	$31,920	$31,921
2	$21,640	$23,804	$25,968	$28,132	$30,296	$32,460	$34,624	$36,788	$38,952	$41,116	$43,280	$43,281
3	$27,320	$30,052	$32,784	$35,516	$38,248	$40,980	$43,712	$46,444	$49,176	$51,908	$54,640	$54,641
4	$33,000	$36,300	$39,600	$42,900	$46,200	$49,500	$ 52,800	$56,100	$59,400	$62,700	$66,000	$66,001
5	$38,680	$42,548	$46,416	$50,284	$54,152	$58,020	$61,888	$65,756	$69,624	$73,492	$77,360	$77,361
6	$44,360	$48,796	$53,232	$57,668	$62,104	$66,540	$70,976	$75,412	$79,848	$84,284	$88,720	$88,721
7	$50,040	$55,044	$60,048	$65,052	$70,056	$75,060	$80,064	$85,068	$90,072	$95,076	$100,080	$100,081
8	$55,720	$61,292	$66,864	$72,436	$78,008	$83,580	$89,152	$94,724	$100,296	$105,868	$111,440	$111,441
For each additional person, add	$5,680	$6,248	$6,816	$ 7,384	$7,952	$8,520	$9,088	$ 9,656	$10,224	$10,792	$11,360	$11,360

*Based on the 2026 Federal Poverty Guidelines for the 48 contiguous states and the district of Columbia.

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Sliding Fee Scale Intake Form

(Application must be complete & current income information attached for consideration)

Patient Name_____ Birth Date_____ Sex M F

Mailing Address_____ City_____ State_____ Zip_____

Phone _____

Are you eligible for Medicaid (Optional)? Y N Don't know
Are you eligible for Nevada Check-up (Optional)? Y N Don't know

Responsible Party _____ Single Married Divorced Separated (Optional)

Spouse/Significant Other_____

Mailing Address (if different from above) _____

City_____ State _____ Zip _____

Employer_____ Employer Phone_____

Number of adults living at home _____ Number of dependent children living at home _____

Income $_____ weekly/bi-weekly/monthly/yearly (Current income information for entire household must be attached).

INCOME INCLUDES: WAGES, CHILD SUPPORT, ALIMONY, UNEMPLOYMENT BENEFITS, SOCIAL SECURITY BENEFITS, AND/OR DISABILITY BENEFITS.

I authorize this office to obtain such information as may be required concerning statements made in this application. I/We certify that all statements in this application are true and complete, and request financial assistance from this office. If I/We give any false or misleading information, or if I do not follow the required guidelines, I understand that I will no longer be eligible for the Sliding Fee Program.
I authorize the members of this office to perform any and all treatment deemed necessary for the above named patient. I have read and understand the attached information sheet, and agree to the expectations and requirements of the program. This consent shall remain in effect until canceled by the patient or responsible party.

Patient/Parent/Guardian_____Date_____

Witness_____ Date_____