



**DESOTO MEMORIAL HOSPITAL  
INCOME CERTIFICATION STATEMENT**

DeSoto Memorial Hospital  
900 N. Robert Avenue  
Arcadia, FL 34266  
(863)494-3535  
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**DESOTO MEMORIAL HOSPITAL USES THE "SLIDING SCALE METHOD" TO DETERMINE  
THE DOLLAR AMOUNT TO BE CONSIDERED AS REDUCTION IN FEES FOR ELIGIBLE PATIENTS**

**REDUCTION IN FEES DETERMINATION IS BASED ON  
2026 FEDERAL POVERTY GUIDELINES**

% FPG	GROSS INCOME IS USED IN FLORIDA								PATIENT PAYS
	Family Size 1	2	3	4	5	6	7	8	
100%	\$15,960	\$21,640	\$27,320	\$33,000	\$38,680	\$44,360	\$50,040	\$55,720	0%
150%	\$23,940	\$32,460	\$40,980	\$49,500	\$58,020	\$66,540	\$75,060	\$83,580	0%
200%	\$31,920	\$43,280	\$54,640	\$66,000	\$77,360	\$88,720	\$100,080	\$111,440	0%
250%	\$39,900	\$54,100	\$68,300	\$82,500	\$96,700	\$110,900	\$125,100	\$139,300	10%
300%	\$47,880	\$64,920	\$81,960	\$99,000	\$116,040	\$133,080	\$150,120	\$167,160	20%
350%	\$55,860	\$75,740	\$95,620	\$115,500	\$135,380	\$155,260	\$175,140	\$195,020	30%
400%	\$63,840	\$86,560	\$109,280	\$132,000	\$154,720	\$177,440	\$200,160	\$222,880	40%

FOR FAMILIES/HOUSEHOLDS WITH MORE THAN 8 PERSONS, ADD \$5,680 FOR EACH ADDITIONAL PERSON.

Date: \_\_\_\_\_ Account Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
Street Apt Number

\_\_\_\_\_ City State Zip Code

Guarantor Name: \_\_\_\_\_

Number of persons in family: \_\_\_\_\_  
(Based on income tax returns)

MOST RECENT BANK STATEMENT, PAY STUBS FOR ONE MONTH, AND YOUR MOST  
RECENT TAX RETURN ARE REQUIRED FOR YOU TO QUALIFY FOR CHARITY.  
ANY EXCEPTION IS TO BE APPROVED BY THE DIRECTOR OF PATIENT ACCOUNTS.

I am making specific representations as to my financial circumstances and affirm that the statements I have made to DeSoto Memorial Hospital are true and correct. Further, I hereby authorize my employer and my financial institutions (banks, saving and loan, credit union or financial company) to release any and all financial information to DeSoto Memorial Hospital concerning me or my financial accounts, including joint accounts, employment history, and loan agreements. I hereby acknowledge that, in accordance with Florida Statute 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree and I attest to the fact that the information above is accurate.

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Guarantor Signature