I. PURPOSE

Community Memorial Healthcare (CMH) is committed to providing financial assistance to persons who are uninsured (self-pay), under insured, ineligible for assistance through a government program or otherwise unable to pay, for health care services based on their individual financial situation. CMH provides, care of emergency medical conditions to all individuals regardless of their eligibility for financial assistance or for government assistance.

This policy applies to the following locations: Community Memorial Hospital – Ventura and Community Memorial Hospital – Ojai for all emergency, outpatient, and inpatient services provided with the exception of experimental or investigative care and professional medical fees.

II. POLICY

Community Memorial Healthcare's mission is to provide the best care to every patient every day through integrated clinical practice and education. CMH strives to benefit humanity through work in these areas, while supporting the communities in which we live and work. As part of that commitment, CMH serves, appropriately patients in difficult financial circumstances. Above all, CMH's guiding philosophy is that the needs of the patient comes first.

The purpose of this policy is to ensure a fair, nondiscriminatory, effective and uniform method for the provision of financial assistance to eligible individuals who are unable to pay in full or part for any emergency and other services provided by CMH. Financial Assistance is available for all patients and when approved may result in a full write-off of charges; a partial write-off (discount) of charges and/or creating a flexible monthly payment plan with the patient for their outstanding balance(s).

This policy applies to emergent, elective, inpatient and outpatient and all other medical services. Providers such as (i.e. physicians, radiologist, anesthesiologist, etc.) who perform services within the hospital are not covered under this policy, as they do not bill through our organization and will bill the patient independently for their services. Services provided at Community Memorial Healthcare's Health Centers (clinics) are not applicable for Financial Assistance. Patients are encouraged to contact the provider's office to discuss financial assistance for their services.

CMH will contact self-pay and under-insured patients in a number of ways. Financial Counselors are available at both locations to assist patients with completing Medi-cal applications and our financial assistance application as well as creating a payment plan with the patients. Patient may also receive information on local, state and federal assistance programs that are available to assist with medical expenses.

Financial Assistance is available to all patients and guarantors where such assistance is consistent with this policy and federal and state laws governing permissible benefits to patients. CMH will make a reasonable effort to determine the existence or nonexistence of third-party coverage which may be available, in whole or part, for the care provided by CMH, prior to directing any collection efforts at the patient. Uninsured patients may receive an uninsured discount. Eligible financial assistance balances include but are not limited to the following: self pay, charges for patients with coverage from an entity without a contractual relationship, coinsurance, deductible and copayment amounts related to insured patients. Deductible and coinsurance amounts claimed as a Medicare bad debt will be excluded from the reporting of charity care.

Patients seeking financial assistance must complete the CMH Financial Assistance application and eligibility will be based on financial need at the time or at any time CMH is in receipt of information regarding a patient's or their guarantor's income that may indicate a financial need. Reasonable efforts will be made to notify and inform patients of the availability of financial assistance by providing information during admission and discharge, on the patient's billing statement and in the patient accessible billing areas. CMH website, by oral notification during payment discussions, as well as on signage in inpatient and outpatient areas, including areas where patients are admitted or registered and in the emergency department. In addition, CMH will notify patients that there are community organizations that are available to help the patient understand the billing and payment process, as well as information regarding presumptive eligibility for financial assistance, and CMH will include the contact information for these organizations on its routine admissions forms presented to patients. CMH will retain information used to determine eligibility in accordance with its recordkeeping policies.

A. Eligibility And Processing Guidelines

Application Process

Patients or guarantors may request and submit a Financial Assistance Application, which is free of charge and available at CMH facilities or by the following means: advising patient financial services staff at or prior to the time of discharge or admission that assistance is requested and submitted with completed documentation; by mail, or by visiting www.mycmh.org, downloading and submitting the completed application with documentation. A person applying for financial assistance will be given a preliminary screening, which will include a review of whether the patient has exhausted or is not eligible for any third-party payment sources and if they may meet the criteria for charity care or our discount payment plan options.

CMH has designated Patient Financial Advocates and Patient Financial Representatives available to assist patients in completing the Financial Assistance application and determining eligibility for CMH financial assistance or financial assistance from government-funded insurance programs, if applicable. Interpretation services are available to address any questions or concerns and to assist in the completion of the Financial Assistance Application.

A patient or guarantor who may be eligible to apply for financial assistance may provide sufficient documentation to CMH to support eligibility determination at the time of learning that a party's income falls below the minimum FPL per the relevant Federal and State regulations. CMH will suspend any collection activities pending an initial determination of eligibility for financial assistance, provided that the patient or their guarantor is cooperative with CMH's reasonable efforts to reach an initial determination.

Emergency room physicians who provide emergency medical services at CMH are required by law to provide discounts to patients who are uninsured or have high medical costs if their income is at or below 400% of the federal poverty level. Emergency physicians may also choose to offer discounts to patients whose income is above 350% of the federal poverty level. For this policy, “high medical costs” means significant out-of-pocket expenses paid by the patient for emergency services received at CMH.

CMH acknowledges that a determination of eligibility of financial assistance or applying a discount can be made at any time upon learning that a party’s income is below 400% of the federal poverty standard, adjusted family size. In addition, CMH may choose to grant financial assistance solely based on an initial determination of a patient’s status as an indigent person. In these cases, documentation may not be required.

1. An application may be completed prior to receiving services if confirmation is received and the services and is determined that the patient will have a financial responsibility.
2. Financial Assistance is also available for cosmetic procedure that are determined to be medically necessary.
3. When an application form cannot be completed by the patient or their representative; the Director of Patient Access or the Director of Patient Financial Services may use discretion in identifying and authorizing the account as qualifying for financial assistance.
4. Upon receipt of the completed application, Director of Patient Access/Director of Patient Financial Services or their designee, will complete the Financial Assistance Program allowance worksheet and make a final determination for eligibility.
5. For patients that qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CMH may offer extended payment plans, see Payment Hierarchy, and will not impose wage garnishments or force a foreclosure on primary residences, will not impose actions that force bankruptcy and will not send unpaid bills to outside collections agencies.
6. After the completed application has been received a letter of acceptance or non acceptance for the program will be sent to the patient or guarantor within 30 days from the date of receipt.

Qualification Criteria and associated Debt Reduction: The Financial Assistance Application is used to determine the patient/guarantors' eligibility for:

1. Debt Reduction

a. Financial Assistance debt reduction write-offs will be based on a sliding fee schedule utilizing the current United States Federal Poverty Guidelines, income, family size, medical needs and catastrophic costs. Financial assistance ranges between Medicare Rates and 100% reduction and is available to all patients. Patients who have health insurance may qualify for assistance on their remaining balance (coinsurance/deductibles) after payment is received from insurance.

b. Verification may include, but not limited to, the applicant's most recent federal tax return for the year the applicant was first billed or the year before. CMH may also accept recent pay stubs within six months before or after the applicant was first billed by the hospital or in the case of preservice, when the application was submitted.

2. Uninsured, Under-insured or Financially Needy

a. Financial Assistance debt reduction write-offs will be based on a sliding fee schedule utilizing the current United States Federal Poverty Guideline, income, family size, medical needs and catastrophic costs. Financial Assistance ranges between Medicare Rates and 100% and is available to all patients regardless of whether or not they have health insurance. Patients who have health insurance may quality for assistance on their remaining balance (coinsurance/deductibles) after insurance pays. See Payment Hierarchy Policy.

b. Information from the applicant's financial application and supporting documentation will be applied to the list of exclusions to determine the amount of the qualified Financial Assistance to be granted.

c. Verification may include, but not limited to, the applicant's most recent federal tax return for the year the applicant was first billed or the year before. CMH may also accept recent pay stubs within six months before or after the applicant was first billed by the hospital or in the case of preservice, when the application was submitted.

3. Government Assistance: In determining whether an individual qualifies for Charity Care, other county or governmental assistance programs should also be considered.

a. Community Memorial Healthcare contracts with third party Patient Financial Advocates to help individuals determine eligibility for governmental or other assistance, as appropriate.

b. Persons who are eligible for programs (such as Medi-cal/ Medicaid) but who were not covered at the time that medical services were granted may be approved for charity care provided that the patient now applies for government assistance. This may be prudent, especially if the patient requires ongoing services.

c. For patients who are non-responsive to the application process, other sources of information should be used to make an individual assessment of financial need. This information will enable CMH to make an informed decision on the financial need of non-responsive patients.

d. For the purpose of helping financially needy patients, a third-party may be utilized to conduct a review of patient information to assess financial need. This review utilizes a predictive model that is based on public record databases. These public records enable CMH to assess the patient's propensity to pay for financial assistance under the traditional application process. In cases where there is an absence of information provided directly by the patient, and after efforts to confirm coverage availability, the predictive model provides a systematic method to grant presumptive eligibility to financially needy patients.

e. Financial Support granted under the Predictive Model is intended to be on a one-time basis. Patients granted presumptive support will be asked to complete the Financial Assistance Application for future services. In the event a patient does not qualify under the predictive model, the patient may still provide supporting information and be considered under the traditional financial assistance.

f. Patients granted presumptive eligibility status will be adjusted using specific Pre-Charity (PRECHAR) adjustment at such time the account is deemed uncollectible and prior to referral to collection or write-off to bad debt. The discount granted will be classified as financial support; the patient's account will not be sent to collection and will not be included in CMH bad debt expense.

g. Patient accounts granted presumptive eligibility status will be adjusted using specific Pre-Charity (PRECHAR) at such time the account is deemed uncollectible and prior to referral to collection or write-off to bad debt. The discount granted will be classified as financial support; the patient's account will not be sent to collection and will not be included in CMH bad debt expense.

Determinations and Approvals

Patient will receive notification of Financial Assistance Program eligibility determination within 30 days of submission of the completed Financial Assistance Application and necessary documentation. The Patient Financial Services Supervisor will review the Financial Assistance Applications on a weekly basis to determine a patient's eligibility. Any determination of ineligibility will include an explanation of the basis for denial along with information on the appeal process. Once an application is received, extraordinary collections efforts will be pended until a written determination of eligibility is sent to the patient. The hospital will not make a determination of eligibility for assistance based upon information which the hospital believes is incorrect or unreliable.

Dispute Process

The patient may appeal a determination of the ineligibility for financial assistance by providing relevant additional supporting documentation to CMH within 30 days of receipt of the letter of denial. In the event of a dispute, the patient may seek review from the Patient Business Services Director. CMH will suspend all collection activities pending review of appeal. All appeals will be reviewed and if the review affirms the denial, written notification will be sent to the guarantor and State Department of Health, where required and in accordance with the law. The final appeal process will conclude within 10 days of receipt of the denial by CMH. An appeal may be sent to Community Memorial Healthcare Business Office Attn: Financial Assistance 5855 Olivas Park Drive, Ventura, California 93003.

Reasonable Payment Plan

Once a patient is approved for the partial financial assistance and is granted a discount and still has a balance due, CMH will negotiate a payment plan arrangement. The reasonable payment plan shall consist of monthly payments (without interest or late fees) that are not more than 10 percent of a patient's or family's monthly income, excluding deductions for Essential Living Expenses that the patient listed on their financial assistance application. Payment plans will be interest free. Timelines of the payment plan will be extended for patients with pending appeals of coverage.

Billing and Collections

Any unpaid balances owed by patients or guarantors after application of available discounts, if any, may be referred to collections. CMH will provide, or require any third-party collection agencies to provide, the written notice required under HSC 127430 about the patient's rights under the Fair Debt Collection Practices Act prior to collection activities. Collection efforts on unpaid balances will cease pending final determination of FAP eligibility. Collection efforts on unpaid balances will cease pending final determination of FAP eligibility. CMH does not perform or allow collection agencies to perform any extraordinary collection actions. For information on CMH billing and collections practices for amounts owed by patients, please contact the CMH Business Office at 805-948-2850.

Patient Refunds

In the event a patient or guarantor has made a payment for services and subsequently is determined to be eligible for charity care or discounted care, any payments made related to those services during the FAP eligible time-period which exceed the payment obligation will be refunded, in accordance with state regulations.

B. Other Debt Reduction

1. Administrative write-offs will not be considered Charity Care.
2. Bad Debts will not be considered Charity Care.
3. Bad Debt accounts returned by third party collection agencies who have determined the patient/guarantor does not have the ability to pay, in accordance to the Financial Assistance Program policy, will be classified as Charity Care.
4. Accounts reduced to a zero balance as the result of the patient/guarantor being deceased with no estate will be considered Charity Care, as evidenced by supporting documentation.
5. Accounts reduced to a zero balance, as the result of bankruptcy will be considered Charity Care.
6. Approval for Financial Assistance and any care provided covered by the Financial Assistance Program does not obligate Community Memorial Health Healthcare to provide continuing care.

C. Debt Reduction Authorizations

Approval Level – All financial assistance applications must be approved according to the following

Minimum Amount	Maximum Amount	Role
$0	$10,000	Senior Patient Account Rep
$10,001	$100,000	Director of Patient Business Services
$100,001	$Over	CFO

D. Other Financial Assistance Program considerations

Approval for Financial Assistance and any care provided covered by the Financial Assistance Program does not obligate Community Memorial Healthcare to provide continuing care.

Factors Not Considered

The following factors will not be considered when making a recommendation for Financial Assistance and/or in granting of assistance: Bad Debt; contractual allowances; perceived underpayments for operations; cases paid through a charitable contribution; community service or outreach programs; or employment status. In other words, these monetary sources have no bearing on the patient's eligibility.

Equal Opportunity

When making decisions on Financial Assistance, Community Memorial Healthcare is committed to upholding the multiple federal and state laws that preclude discrimination on the basis of race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service or any other classifications protected by federal, state or local laws.

Coverage Period

Services provided by Community Memorial Healthcare hospitals are covered by the Financial Assistance Program.

Services incurred by the patient/guarantor and future services, not extending beyond 30 days, may be included in the reduction. Patients/guarantors receiving health care services 3 months beyond the initial Financial Assistance Program approval will re-verify their financial income information.

Entities not covered under the Financial Assistance Program policy: Long Term Care, Assisted Living Center, HME/DME and any other service not typically provide by the traditional hospital or clinics are not eligible for inclusion in the Financial Assistance Program.

The following services may be excluded from charity care but may qualify for a discounted payment if medically necessary.

A. **Abortion**: is the termination of a pregnancy by removal or expulsion of an embryo or fetus.

B. **Acupuncture**: Shiatsu, electrical stimulation to the periosteum, chelation therapy, immunoaugmentive therapy (IAT), thermograph, joint reconstruction therapy, joint sclerotherapy, prototherapy, or ligamentous injections with sclerosing agents, Osteopathic manipulative treatment, spinal manipulative treatment, and kebiozen.

C. **Complications**: Complications of Non-covered Procedures.

D. **Cosmetic surgery**: Cosmetic surgery or any complications arising from Cosmetic surgery including; laser treatment or ablation of benign skin lesions [except for condyloma acuminatum], dermabrasion, superficial chemical peels, and medium or deep chemical peels not directed at the treatment of precancerous skin lesions. This exclusion does not apply to: Cosmetic surgery required for correction of a condition arising from an Accidental Injury, or when rendered to correct a congenital anomaly where the correction restores a functional bodily process.

E. **Custodial care**: Care whose primary purpose is to meet personal rather than medical needs and which can be provided by persons with no special medical skills or training is considered as Custodial Care. Such care includes, but is not limited to:

    a. Helping a patient walk, get in or out of bed, and take normal self-administered Medicine. Domiciliary care and inpatient hospitalization are not covered for the purposes of Custodial Care.

F. **Dental treatment**: Routine dental treatment, unless medically necessary due to a serious medical condition or an accidental injury.

G. **Elective Surgery**: Surgery that is scheduled in advance because it does not involve a medical emergency

H. **Exercise programs**: Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy.

I. **Experimental or not Medically Necessary:** Care and treatment that is either Experimental/ Investigational or not Medically Necessary.

J. **Gastric surgery:** Any services, supplies, or programs involving gastric surgeries for weight loss.

K. I**mpotence:** Care, treatment, services, supplies or medication in connection with diagnosis and treatment for impotence.

L. **Infertility:** Care, supplies, services, diagnosis and treatment for infertility, sterility, artificial insemination, embryo transplants and storage, or in-vitro fertilization

M. **Massage:** Services from a masseur, physical culturist, physical education instructor, or health club attendant.

N. **No Physician recommendation:** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the patient is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or sickness.

O. **Obesity:** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another sickness.

P. **Occupational:** Charges for or in connection with an Injury or Illness, which is occupational, arises from work for wage or profit including self-employment. This exclusion applies even though the Participant waives or fails to assert his right under the law, or expenses resulting from wage or profit. One example of this is if the individual is self-employed and experiences an Injury or Illness, which arises out of or in the course of that employment, the charges will not be covered by the FAP if the self-employed individual elected not to participate in a Worker's Compensation program, as consistent with any applicable State or Federal Law.

Q. **Private duty nursing:** Charges in connection with care, treatment or services of a private duty nurse.

R. **Surgical sterilization:** Elective surgical sterilization procedures.

S. **Surgical sterilization reversal:** Care and treatment for reversal of surgical sterilization.

T. **Surrogacy:** Any service associated with any type of surrogacy agreement or arrangement, including traditional surrogacy, artificial insemination related to a surrogacy agreement or arrangement, or gestational or in-vitro fertilization surrogacy.

Request For Financial Assistance Uncompensated Charity Care / Discount Payment Program Application Instructions

Date _____

Patient Name _____

Account Number(s) _____

Total Balance for Consideration $ _____

This application is for Community Memorial Hospital charges only.

All physicians including Community Memorial Health Centers physicians, radiologists, pathologists, anesthesiologists, emergency room physicians and ambulance services are billed separately from Community Memorial Hospitals and are not covered by this application.

The hospital may only request recent paystubs and/or income tax for documentation of income. The hospital may accept other forms of documentation of income but shall not require such other forms.

It is important that the application be complete, and all requested information is provided in order to properly assess your ability to pay all or part of the hospital bill. Patients who only apply for discount payment program eligibility may receive less financial assistance than what may be available to them under the charity care program.

Although we do not require a completed Medi-cal application to determine your eligibility; it is recommended that you complete a Medi-cal screening to offset any additional charges that is not covered by this application. If you choose to do so, you can contact the local Department of Health Services at 888-472-4463 or https://benefitscal.com

The following documents are required to process your application

1. Fully completed charity care/discount payment program application (enclosed with this letter)
2. A copy of the applicant's most recent period payroll check stubs within 6 months before or after the applicant was first billed by the hospital or in the case of preservice, when the application was submitted. Note that this also includes public assistance (for example, Social Security, Unemployment, or Disability). If you receive your income in cash, please provide us with a written statement from your employer stating your income.

   If you currently are not receiving any income please write a brief paragraph on a separate sheet of paper stating your current financial situation. Be sure to include the date and signature. If you are receiving financial assistance or living with someone, please have him or her write a statement explaining the situation.
3. Rent or mortgage verification only required if seeking a payment plan. This is not required or considered for financial assistance eligibility.
4. Prior year's tax return for the year the applicant was first billed or the year before. (the completed and signed 1040)

Send copies of these documents because they will not be returned to you.

Please submit your completed application and supporting documentation in person at any of our hospital locations or at our Business Office located at 5855 Olivas Park Drive Ventura, CA 93003.

For any questions, please contact us at 805-948-5615 for assistance.

Thank you,

Patient Financial Services Department
Community Memorial Healthcare

Request For Financial Assistance Uncompensated Charity Care / Discount Payment Program Application

Patient Name _____

Patient Account Number(s) _____

Guarantor Name _____

Date of Birth _____ SS# _____

Phone _____

Address _____

City, State, Zip _____

Spouse Name _____ SS#_____

Are you a U.S. Citizen? _____ Yes _____ No

If not, a resident alien? _____ Yes _____ No

If not, nonresident alien? _____ Yes _____ No

FAMILY STATUS List all dependents who you support

Name	Age	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Community Memorial HEALTHCARE®

Employer _____

Position _____

If self-employed, Name of business _____

Employer Address _____

Phone Number _____ How long employed _____

Spouse Employer _____ Position _____

If self employed, name of business _____

Statement of Current Income and Expenditures

Current Monthly Income	**Patient**	**Spouse**
Gross Pay	$_____	$_____
Income from business (if self-employed)	$_____	$_____
Interest and dividends	$_____	$_____
Income from real estate or personal property	$_____	$_____
Social Security/Retirement Income	$_____	$_____
Alimony, support payments	$_____	$_____
Unemployment compensation	$_____	$_____
Other Income	$_____	$_____
Total Monthly Income	$_____	$_____

Current Monthly Expenses	Patient	Spouse
Rent or House Payment	$_____	$_____
Real Estate Taxes	$_____	$_____
Utilities	$_____	$_____
Alimony, support payments	$_____	$_____
Education	$_____	$_____
Food	$_____	$_____
Payroll Deductions	$_____	$_____
Medical, dental and medicines	$_____	$_____
Other_____	$_____	$_____
Total Monthly Expenses	$_____	$_____
Net Monthly Income after Expenses	$_____	$_____

I understand that Community Memorial may verify my information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Patient or Guarantor Date

_____ _____

Signature of Co-applicant Date

Attachment A

Persons in Family or Household	2026 FPG Gross Income 6 Months	200% of FPG Adjustment	201% – 300% of FPG Adjustment	301% and over Refer to Financial Assistance Charity Policy
1	$15,960.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
2	$21,640.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
3	$27,320.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
4	$33,000.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
5	$38,680.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
6	$44,360.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
7	$50,040.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
8	$55,720.00	100%	Medicare Rates	*Refer to Financial Assistance Charity Policy*
Each additional	$5,680.00			

2026 SCHEDULE 1

200% of Poverty Guidelines Equals Charity Write Off No Patient Responsibility

Size of Family	Income Guidelines	Income Guidelines	Income Guidelines
Unit	**Three Months**	**Six Months**	**One Year**
1	$7,980.00	$15,960.00	$31,920.00
2	$10,820.00	$21,640.00	$43,280.00
3	$13,660.00	$27,320.00	$54,640.00
4	$16,500.00	$33,000.00	$66,000.00
5	$19,340.00	$38,680.00	$77,360.00
6	$22,180.00	$44,360.00	$88,720.00
7	$25,020.00	$50,040.00	$100,080.00
8	$27,860.00	$55,720.00	$111,440.00

For Family units with more than eight (8) members, add $11,360.00 for each additional member.

2026 SCHEDULE 2

200% – 301% of Poverty Guidelines Equals 25% of Charges or Medicare DRG for Inpatient whichever is less

Size of Family	Income Guidelines	Income Guidelines	Income Guidelines
Unit	**Three Months**	**Six Months**	**One Year**
1	$11,970.00	$23,940.00	$47,880.00
2	$16,230.00	$32,460.00	$64,920.00
3	$20,490.00	$40,980.00	$81,960.00
4	$24,750.00	$49,500.00	$99,000.00
5	$29,010.00	$58,020.00	$116,040.00
6	$33,270.00	$66,540.00	$133,080.00
7	$37,530.00	$75,060.00	$150,120.00
8	$41,790.00	$83,580.00	$167,160.00

For Family units with more than eight (8) members, add $17,040.00 for each additional member.

2026 SCHEDULE 3

301% – 700% and above Poverty Guidelines Equals a 40% of Charges or Medicare DRG whichever is less

Size of Family	Income Guidelines	Income Guidelines	Income Guidelines
Unit	**Three Months**	**Six Months**	**One Year**
1	$15,960.00	$31,920.00	$63,840.00
2	$21,640.00	$43,280.00	$86,560.00
3	$27,320.00	$54,640.00	$109,280.00
4	$33,000.00	$66,000.00	$132,000.00
5	$38,680.00	$77,360.00	$154,720.00
6	$44,360.00	$88,720.00	$177,440.00
7	$50,040.00	$100,080.00	$200,160.00
8	$55,720.00	$111,440.00	$222,880.00

For Family units with more than eight (8) members, add $22,720.00 for each additional member.