



## **Application for Sliding Fee Program**

We are pleased you have selected the Community Health Center of Buffalo, Inc. (CHCB) for your healthcare needs. Our goal is to provide you and your family with the best care possible.

If you do not have health insurance, then CHCB offers a Reduced Fee Program. The Sliding Fee Program is based on your household size and income. The reduced fee becomes effective as soon as your application is approved. The reduced cost applies to office visits three months prior to the approval of your application, and remains effective for one year. The reduced fee applies to services at all CHCB health center locations.

Under the Sliding Fee Program, **a nominal fee of \$15.00 is due at the time of the visit.** Additional charges will vary depending on the services performed, and the level of coverage you qualify for. The remaining balance will be billed to your home separately.

You will be eligible for the \$15.00 nominal fee pending approval of your Sliding fee application once you have submitted one item from each of the 5 qualifying categories.

We appreciate the opportunity to serve you. If you have further questions about the Reduced Fee Program, please contact our billing department at 716-986-9199 x 3600.

### **Acceptable Forms of Verification Needed for Reduced Fee Application**

#### Identity:

1. Government issued US Passport
2. State issued driver's license or photo ID
3. Immigration and Naturalization Service (INS) documentation

#### Dependents Relationship:

1. Birth certificate
2. Adoption paper

#### Marital Status:

1. Marriage certificate
2. Newspaper notice
3. Church records

#### Financial Resources:

1. Last four pay stubs
2. Your last year's income tax return
3. Pension statement
4. Employer statement
5. SSA check and/or letter

#### Residential:

1. Landlord statement or lease
2. Tax or Mortgage statement
3. Utility bill (fuel, electric, phone and/or cable)

**\*\*One form of verification from each applicable group is necessary\*\***

**Failure to provide sufficient documentation will result in the return of your application and delay in approval.**



**Application for Reduced Fee Program**

Date: \_\_\_\_\_

Patient Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Phone/Cell #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widow

**Please List All Household Members**

Household Members	Relationship	DOB	Employer (If applicable)	Income Weekly, Bi-weekly or Monthly (If applicable)	SS #

I hereby request the Community Health Center of Buffalo Inc. (CHCB) to make a determination of my eligibility for the Reduced Fee Program. I understand that the information I submit regarding my family income and size is subject to verification. I also understand that if the information is determined to be false, I will be liable for all services at full charge. In signing this application, I affirm to the best of my knowledge that the information provided above is true and correct. I understand that it is my responsibility to inform CHCB of all changes in my financial information. Should I fail to do so, payment in full will be my responsibility.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

<p>For Office Use Only:          Proof of income provided: Pay___ SS___ Tax___ WC/D___ Fee scale qualified for: _____          Annual income: _____ Date Verified: _____ Initials: _____</p>
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# SLIDING FEE SCALE

As a Federally Qualified Health Center, Community Health Center of Buffalo is able to offer patients a Sliding Discount on most clinic services based on household size and gross income.

**To apply**, submit a completed **application** along with last year's tax return or your most recent four pay stubs (showing one month's gross income.) proof of identity for everyone in your household ( even if they are not applying for program).

**Patients on the Sliding Fee Scale are expected to make at least a \$15 payment each visit to the clinic.**

## Sliding Fee Scale FAQ

1. *Just what is the sliding fee scale?* The sliding fee scale is a discount program the clinic offers through a federal grant for individuals and households who demonstrate financial need.
2. *I have health insurance, can I still apply for the sliding scale?* Yes. If you qualify, the discount will be applied to any balance that insurance doesn't cover.
3. *Do I need to bring my paystubs when I come in for my appointment?* Yes all documents need to be presented at time of your appointment
4. *I applied for the sliding fee scale last summer when I was working here. Do I have to do it again this year?* Yes, the sliding fee scale must be applied for every year even if your financial circumstances haven't changed. Once approved, the discount will be honored for 12 months after which you must reapply.
5. *I live with my boy/girlfriend. Do they and their income count as part of my "household"?* It depends. Your household is defined as yourself, spouse, and your dependent family or all people in your residence with whom you are pooling resources and therefore would be recognized as a family.
6. *I have roommates for the summer. Are they part of my household?* No, you do not need to include them on your application.
7. *I work 6 months out of the year. How is my income determined for the sliding fee scale?* Income is determined by multiplying your gross monthly wages by the number of months you will be working. Or you can provide your prior year's tax return.
8. *I am not a US citizen. Can I still apply for the sliding fee scale?* Yes, anyone can apply.
9. *Can I apply for the sliding fee scale AFTER a clinic visit?* Yes, you have 60 days from the date of your first visit to turn in your application.
10. *What services are covered under the sliding fee scale?* In general: your office visit, dental services including exams, x-rays, cleanings, and filling, physical therapy, x-rays, ultrasounds and lab tests (that are processed at the clinic), as well as any medications dispensed at the clinic.

11. *What services are not covered?* DOT physicals, vision appointments, some dental procedures, laboratory tests sent to an external lab, some medical equipment, and a few special order medications and vaccinations may not be covered in the sliding fee program. Patients will be notified in advance of any uncovered charges.
12. *If I am currently unemployed but expect to be working soon, how is my annual income determined?* Please provide documentation of your unemployment compensation. You may be approved for temporary placement on the Sliding Fee Scale. You will need to reapply each month you need to visit the clinic while unemployed.
13. *I own my own business, what financial documentation will I need?* Please provide your most recently filed 1040 tax form including all attachments. Your gross business income before deductions and expenses is used to determine eligibility for this program.