COMMUNITY HEALTH CENTER OF BUFFALO, INC.
REDUCED FEE DETERMINATION SCHEDULE

	2020 Annual Family Income Reduced Fee Guidelines*					
Household Size	At or Below Federal Poverty Level	Up to 125% of Poverty Level	Up to 150% of Poverty Level	Up to 175% of Poverty Level	Up to 200% of Poverty Level	Up to >200% of Poverty Level
1	12,760	15,950	19,140	22,330	25,520	25,521
2	17,240	21,550	25,860	30,170	34,480	34,481
3	21,720	27,150	32,580	38,010	43,440	43,441
4	26,200	32,750	39,300	45,850	52,400	52,401
5	30,680	38,350	46,020	53,690	61,360	61,361
6	35,160	43,950	52,740	61,530	70,320	70,321
7	39,640	49,550	59,460	69,370	79,280	79,281
8	44,120	55,150	66,180	77,210	88,240	88,241
For Each Additional Family Member Add: $4,480						
	A	B	C	D	E	F
You Pay	**$15.00**	**20%**	**40%**	**60%**	**80%**	**100%**

The Federal Register notice for the 2020 Poverty Guidelines were published January 17,2020
updated 1/25/2020-Raquel H

COMMUNITY HEALTH CENTER OF BUFFALO, INC.
Community Health Center of Niagara/Buffalo
Family Planning Program
Patient Cost- Shared Schedule
02/01/2020

FAMILY SIZE	FREE	25%			50%			75%			100%
	UP TO	FROM		TO	FROM		TO	FROM		TO	Over
ONE	12,760	12,761	-	19,140	19,141	-	25,520	25,521	-	31,900	31,901
TWO	17,240	17,241	-	25,860	25,861	-	34,480	34,481	-	43,100	43,101
THREE	21,720	21,721	-	32,580	32,581	-	43,440	43,441	-	54,300	54,301
FOUR	26,200	26,201	-	39,300	39,301	-	52,400	52,401	-	65,500	65,501
FIVE	30,680	30,681	-	46,020	46,021	-	61,360	61,361	-	76,700	76,701
SIX	35,160	35,161	-	52,740	52,741	-	70,320	70,321	-	87,900	87,901
SEVEN	39,640	39,641	-	59,460	59,461	-	79,280	79,281	-	99,100	99,101
EIGHT	44,120	44,121	-	66,180	66,181	-	88,240	88,241	-	110,300	110,301

These rates are applied to all self-pay visit charges in CHCN/B FP Clinic 2/1/2020

Free is annual income up to 100% FPL.
25% is annual income 101-150% FPL.
50% is annual income 151-200% FPL.
75% is annual income up to 201-250% FPL.
100% is annual income over 250% FPL.

FPBP now extends to 233% of FPL.

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HEALTH CENTER OF BUFFALO, INC.

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Sliding Fee Discount Application

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.

It is the policy of the CHCB to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

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.

If you have further questions about the Sliding Fee Program, please contact our billing department at 716-986-9199 x 3600.

Please provide the following information.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	**CITY**	**STATE**	**ZIP**	**PHONE**

Please list self, spouse, and household members and relationship.

Name	Date of Birth	Name	Date of Birth
SELF			
SPOUSE			

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Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above are correct.

Name (Print)	
Signature	
Date	

For Office Use Only

Patient Name: ____

Approved Discount: ____

Approved by: ____

Date Approved: ____

Verification List	**Yes**	**No**
Identification/Address: Driver’s license, utility bill, employment ID, or other		
Income: Prior year tax return, three most recent pay stubs, or other		
Insurance: Insurance Cards		

CHCB Self-Declaration Form

Patient Information	
Patient's Name:	Patient D.O.B:
Address:	Phone Number

Declaration of Employment:

I ____ declare that my principal

employment is in _________________ and that presently: [ ] I am working [ ] I am not

working

Employer Name:____

Employer Address:____

Declaration of Income and Family size:

I declare that my household income for last year was $_____________________ and that my

monthly family income is $____________________. I also certify that a total of ___________

people--including spouse, children, parents, grandparents, etc--are living in my household.

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive a temporary discount for health services for 90 days.

I have been informed that I must provide the required documentation within 90 days in order to continue to receive the Sliding Fee Discount.

I understand that if I do not provide the required documentation, I can continue to receive my health care services at this center but I will have to pay 100% of my medical bill.

Applicant Signature:_________________________________ **Date:_________________**