Your Partner for Quality Care
CHCB
COMMUNITY
HEALTH CENTER OF BUFFALO, INC.
BUFFALO · NIAGARA FALLS
SANBORN · CHEEKTOWAGA · LOCKPORT

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

	2021 Annual Family Income Reduced Fee Guidelines*					
		Up to	Up to	Up to	Up to	Up to
		125%	150%	175%	200%	>200%
Household Size	At or Below Federal Poverty Level	of Poverty Level	of Poverty Level	of Poverty Level	of Poverty Level	of Poverty Level
1	12,880	16,100	19,320	22,540	25,760	25,761
2	17,420	21,775	26,130	30,485	34,840	34,841
3	21,960	27,450	32,940	38,430	43,920	43,921
4	26,500	33,125	39,750	46,375	53,000	53,001
5	31,040	38,800	46,560	54,320	62,080	61,361
6	35,580	44,475	53,370	62,265	71,160	71,161
7	40,120	50,150	60,180	70,210	80,240	80,241
8	44,660	55,825	66,990	78,155	89,320	89,321
For Each Additional Family Member Add: $4,480						
	A	B	C	D	E	F
You Pay	**$15.00**	**20%**	**40%**	**60%**	**80%**	**100%**

The 2020 poverty guidelines are in effect as of January 21,2021
The Federal Register notice for the 2020 Poverty Guidelines was published January 17, 2021

COMMUNITY HEALTH CENTER OF BUFFALO, INC.
Community Health Center of Niagara/Buffalo
Family Planning Program
Patient Cost- Shared Schedule
01/21/2021

FAMILY SIZE	FREE	25%			50%			75%			100%
	UP TO	FROM		TO	FROM		TO	FROM		TO	Over
ONE	12,880	12,881	-	19,320	19,321	-	25,760	25,761	-	32,200	32,201
TWO	17,420	17,421	-	26,130	26,131	-	34,840	34,841	-	43,550	43,551
THREE	21,960	21,961	-	32,940	32,941	-	43,920	43,921	-	54,900	54,901
FOUR	26,500	26,501	-	39,750	39,751	-	53,000	53,001	-	66,250	66,251
FIVE	31,040	31,041	-	46,560	46,561	-	62,080	62,081	-	77,600	77,601
SIX	35,580	35,581	-	53,370	53,371	-	71,160	71,161	-	88,950	88,951
SEVEN	40,120	40,121	-	60,180	60,181	-	80,240	80,241	-	100,300	100,301
EIGHT	44,660	44,661	-	66,990	66,991	-	89,320	89,321	-	111,650	11,651

These rates are applied to all self-pay visit charges in CHCN/B FP Clinic 1/21/2021

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.

COMMUNITY HEALTH CENTER OF BUFFALO, INC.
Community Health Center of Niagara
Family Planning Program
Sliding Fee Scale
Contraception and STD Pharmacy

TYPE	0%	25%	50%	75%	100%
CONDOMS	FREE	FREE	FREE	FREE	FREE
ORAL CONTRACEPTIVES	FREE	$ 5.00	$ 10.00	$ 15.00	$ 20.00
IUD-PARAGARD	FREE	$ 61.75	$ 123.50	$ 185.25	$ 247.00
IUD-MIRENA/SKYLA	FREE	$ 58.75	$ 117.50	$ 176.25	$ 235.00
IMPLANON/NEXPLANON	FREE	$ 37.25	$ 74.50	$ 111.75	$ 364.00
LILETTA	FREE	$ 12.50	$ 25.00	$ 37.50	$ 50.00
TERAZOL	FREE	$ 4.00	$ 8.00	$ 12.00	$ 16.00
DOXYCYCLINE	FREE	$ 1.25	$ 2.50	$ 3.75	$ 5.00
METROGEL	FREE	$ 9.00	$ 18.00	$ 27.00	$ 36.00
ROCEPHIN	FREE	$ 3.75	$ 7.50	$ 11.25	$ 15.00
DIFLUCAN	FREE	$ 2.25	$ 4.50	$ 6.75	$ 9.00
FLAGYL	FREE	$ 1.75	$ 3.50	$ 5.25	$ 7.00
DIAPHRAGM	FREE	$ 6.25	$ 12.50	$ 18.75	$ 25.00
FEM CAP	FREE	$ 6.25	$ 12.50	$ 18.75	$ 25.00
EC-PLAN B ONE STEP	FREE	FREE	FREE	FREE	FREE
EC-NEXT CHOICE	FREE	FREE	FREE	FREE	FREE
EC-ELLA	FREE	FREE	FREE	FREE	FREE
ORTHO EVRA	FREE	$ 21.00	$ 42.00	$ 63.00	$ 84.00
NUVARING	FREE	$ 19.50	$ 39.00	$ 58.50	$ 78.00
AZITHROMYCIN	FREE	$ 4.50	$ 9.00	$ 13.50	$ 18.00
ACYCLOVIR	FREE	$ 6.50	$ 13.00	$ 19.50	$ 26.00
DEPO PROVERA	FREE	$ 10.50	$ 21.00	$ 31.50	$ 42.00

COMMUNITY HEALTH CENTER OF BUFFALO
Community Health Center of Niagara
Family Planning Program
Visists, Labs and Procedures

Family Planning Visit		0%	25%	50%	75%	100%
INITIAL VISIT		FREE	$37.50	$75.00	$112.50	$150.00
REVISIT		FREE	$20.75	$41.50	$62.25	$83.00
ANNUAL VISIT		FREE	$33.50	$67.00	$100.50	$134.00
COUNSELING ONLY		FREE	FREE	FREE	FREE	FREE
PREGNANCY TEST ONLY		FREE	FREE	FREE	FREE	FREE
Lab Work						
HIV TESTING/COUNSEL		FREE	FREE	FREE	FREE	FREE
CBC		FREE	$13.75	$27.50	$41.25	$55.00
CHOLESTEROL (HDL only)		FREE	$11.00	$22.00	$33.00	$44.00
CHOLESTEROL (Total)		FREE	$11.50	$23.00	$34.50	$46.00
HEMATOCRIT		FREE	$4.50	$9.00	$13.50	$18.00
LIPID PROFILE		FREE	$22.00	$44.00	$66.00	$88.00
THYROID Test (TSH)		FREE	$30.75	$61.50	$92.25	$123.00
GLUCOSE		FREE	$11.50	$23.00	$34.50	$46.00
FSH (Follicle Stimulating Hormone)		FREE	$36.00	$72.00	$108.00	$144.00
HPV (DNA Typing)		FREE	$26.50	$53.00	$79.50	$106.00
PAP SMEAR (Thin Prep)		FREE	$11.50	$23.00	$34.50	$46.00
URINE DIPSTICK		FREE	$4.50	$9.00	$13.50	$18.00
URINALYSIS		FREE	$4.50	$9.00	$13.50	$18.00
URINE CULTURE		FREE	$14.00	$28.00	$42.00	$56.00
RUBELLA TITER		FREE	$12.50	$25.00	$37.50	$50.00
MMR/RUBELLA		FREE	$12.50	$25.00	$37.50	$50.00
SICKLE SCREEN		FREE	$4.75	$9.50	$14.25	$19.00
NAAT for GC & Chlamydia		FREE	FREE	FREE	FREE	FREE
WET MOUNT STAIN		FREE	FREE	FREE	FREE	FREE
RPR (Syphilis)		FREE	FREE	FREE	FREE	FREE
VIRAL(Herpes Culture)		FREE	FREE	FREE	FREE	FREE
HERPES ANTIBODIES (HSV-1or 2)		FREE	FREE	FREE	FREE	FREE
Procedures						
IUD REMOVAL		FREE	$31.75	$63.50	$95.25	$127.00
IUD INSERTION		FREE	$32.50	$65.00	$97.50	$130.00
IUD PARAGARD		FREE	$61.75	$123.50	$185.25	$247.00
IUD - MIRENA		FREE	$58.75	$117.50	$176.25	$235.00
LEEP		FREE	$106.25	$212.50	$318.75	$425.00
COLP (Explore)		FREE	$37.00	$74.00	$111.00	$148.00
COLP (Cerv Biopsy)		FREE	$47.50	$95.00	$142.50	$190.00
COLP (Endocervical-ECC)		FREE	$45.00	$90.00	$135.00	$180.00
COLP (Cerv Biop & ECC)		FREE	$55.50	$111.00	$166.50	$222.00
ENDOMETRIAL Biopsy		FREE	$36.50	$73.00	$109.50	$146.00
IMPLANON INSERTION		FREE	$37.25	$74.50	$111.75	$149.00
IMPLANON REMOVAL		FREE	$41.75	$83.50	$125.25	$167.00

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IMPLANON REMOVAL & INSERTION	FREE	$72.25	$144.50	$216.75	$289.00

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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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BUFFALO • NIAGARA FALLS • CHEEKTOWAGA • LOCKPORT

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:**_____