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:**_____

Your Partner for Quality Care

CHCB COMMUNITY HEALTH CENTER OF BUFFALO, INC.

BUFFALO • NIAGARA FALLS • CHEEKTOWAGA • LOCKPORT

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		

FREQUENTLY ASKED QUESTIONS ABOUT SLIDING FEE SCALE

As a Federally Qualified Health Center, Community Health Center of Buffalo, Inc. 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 time 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.

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

	2023 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	14,580	18,225	21,870	25,515	29,160	29,161
2	19,720	24,650	29,580	34,510	39,440	39,441
3	24,860	31,075	37,290	43,505	49,720	49,721
4	30,000	37,500	45,000	52,500	60,000	60,001
5	35,140	43,925	52,710	61,495	70,280	70,281
6	40,280	50,350	60,420	70,490	80,560	80,561
7	45,420	56,775	68,130	79,485	90,840	90,841
8	50,560	63,200	75,840	88,480	101,120	101,121
For Each Additional Family Member Add: $5140						
	A	B	C	D	E	F
You Pay	**$15.00**	**20%**	**40%**	**60%**	**80%**	**100%**