



Syracuse Community Health Center, Inc.  
 819 South Salina Street  
 Syracuse, New York 13202  
 (315) 476- 7921

SCHC East  
 1938 E. Fayette Street  
 Syracuse, NY 13210  
 (315) 474-4077

SCHC West  
 603 Oswego Street  
 Syracuse, NY 13204  
 (315) 424-0800

SCHC South  
 1700 South Ave.  
 Syracuse, NY 13207  
 (315) 234-8336

**SLIDING FEE DISCOUNT PROGRAM**

The Syracuse Community Health Center offers a Sliding Fee Discount Program. This means we can adjust your charges for medical and dental services based upon your family size and household income. If you have insurance, completing a sliding fee application will ensure that you receive a discount should you experience a loss in coverage or incur charges for services not covered by your insurance.

Our Sliding Fee Discount Program **DOES NOT APPLY** to the following:

- To adult immunizations or injection; these are charged to you at cost.

Please check the income chart below. If your gross income (defined as before taxes are taken) appears on the line that shows the number of household members who live with you, **that you are responsible for**, you may be eligible for a reduced charge.

Complete the application form on the reverse side and provide the necessary income verification so that our Billing Department staff can review your application. You may also mail the form with necessary income verification, as stated on the reverse side, to the above address and will notify you of your status. If you have any questions, please do not hesitate to call the Syracuse Community Health Center at (315) 476-7921.

HOUSEHOLD #									DENTAL	
Discount %	1	2	3	4	5	6	7	8		
<b>Nominal Fee</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	<b>\$10.00</b>	
Family income at or below 100% of FPI										
<b>80%</b> (100-140% of FPL)										↑ 18% Discount ↓
From income amount	\$12,490	\$16,910	\$21,330	\$25,750	\$30,170	\$34,590	\$39,010	\$43,430		
To income amount	\$17,486	\$23,674	\$29,862	\$36,050	\$42,238	\$48,426	\$54,614	\$60,802		
<b>60%</b> (140-160% of FPL)										↑ 16% Discount ↓
From income amount	\$17,487	\$23,675	\$29,863	\$36,051	\$42,239	\$4,427	\$54,615	\$60,803		
To income amount	\$19,984	\$27,056	\$34,128	\$41,200	\$48,272	\$55,344	\$62,416	\$69,488		
<b>40%</b> (160-180% of FPL)										↑ 16% Discount ↓
From income amount	\$19,985	\$27,057	\$34,129	\$41,201	\$48,273	\$53,345	\$62,417	\$69,489		
To income amount	\$31,477	\$42,615	\$53,753	\$64,892	\$76,030	\$87,169	\$98,307	\$109,445		
<b>20%</b> (180-200% of FPL)										↑ 16% Discount ↓
From income amount	\$31,478	\$42,616	\$53,754	\$64,893	\$76,031	\$87,170	\$98,308	\$109,446		
To income amount	\$39,970	\$54,114	\$68,258	\$82,402	\$96,546	\$110,690	\$124,834	\$138,978		
<b>0%</b>										↑ 0% Discount ↓
From income amount and above	\$39,971	\$54,115	\$68,259	\$82,403	\$96,547	\$110,691	\$124,835	\$138,979		



Patient MR# \_\_\_\_\_

**APPLICATION FOR SLIDING FEE DISCOUNT PROGRAM**

Please complete and return to: Syracuse Community Health Center, Inc.  
819 South Salina Street • Syracuse, NY 13202 • Attn: Billing Department

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Current Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_

**List income for household from:**

SOURCE OF INCOME	CURRENT MONTH	LAST 12 MONTHS
Wages or self-employment income	\$	\$
Public Assistance	\$	\$
Unemployment or Worker's Compensation	\$	\$
Alimony or Child Support	\$	\$
Pensions	\$	\$
All other income including dividends or interest	\$	\$
<b>TOTALS:</b>	\$	\$

**NOTE:** Verification of all income sources must be submitted with this application. Acceptable verification includes a copy of your most recent tax return (**ONLY if self-employed**), one month of paycheck stubs from employer or unemployment statement from Public Assistance or Social Security, etc. If you do not have, or are unaware of what to send for verification, please call 315-476-7921 and select Billing Department.

**HOUSEHOLD INFORMATION**

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP

I certify that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for the Syracuse Community Health Center's sliding fee discount program. I also understand that if I intentionally misrepresent my family's income, I will not be eligible for future discounts.

Applicant's Signature: \_\_\_\_\_

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

**VERIFICATION OF INCOME MUST ACCOMPANY APPLICATION**

For office use only: Qualifies for _____ % discount Date of determination: _____ Account Number: _____ Employee Signature: _____	Does not qualify because: _____ _____ _____
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