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.

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 #**

| **Discount %** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | |
|---|---|---|---|---|---|---|---|---|---|
| **Nominal Fee** | **$10.00** | **$10.00** | **$10.00** | **$10.00** | **$10.00** | **$10.00** | **$10.00** | **$10.00** | **DENTAL** |
| Family income at or below 100% of FPI | | | | | | | | | |
| 80% (100-140% of FPL) | | | | | | | | | 18% Discount |
| From income amount | $12,760 | $17,240 | $21,720, | $26,200 | $30,680 | $35,160 | $39,640 | $44,120 | |
| To income amount | $17,864 | $24,136 | $30,408 | $36,680 | $42,952 | $49,224 | $55,496 | $61,768 | |
| 60% (140-160% of FPL) | | | | | | | | | |
| From income amount | $17,865 | $24,137 | $30,409 | $36,681 | $42,953 | $49,225 | $55,497 | $61,769 | |
| To income amount | $20,416 | $27,584 | $34,752 | $41,920 | $49,088 | $56,256 | $63,424 | $70,592 | |
| 40% (160-180% of FPL) | | | | | | | | | 16% Discount |
| From income amount | $20,417 | $27,585 | $34,753 | $41,921 | $49,089 | $56,257 | $63,425 | $70,593 | |
| To income amount | $32,157 | $43,447 | $54,736 | $66,026 | $77,315 | $88,605 | $99,895 | $111,184 | |
| 20% (180-200% of FPL) | | | | | | | | | |
| From income amount | $32,158 | $43,448 | $54,737 | $66,027 | $77,316 | $88,606 | $99,896 | $111,185 | |
| To income amount | $40,834 | $55,170 | $69,506 | $83,842 | $98,178 | $112,514 | $126,850 | $141,186 | |
| 0% From income amount and above | $40,835 | $55,171 | $69,507 | $83,843 | $98,179 | $112,515 | $126,851 | $141,187 | 0% |

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 | $ | $ |
| **TOTALS:** | $ | $ |

**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 | Does not qualify because: |
| Date of determination:______________ | ______________________________ |
| Account Number:______________ | ______________________________ |
| Employee Signature:______________ | ______________________________ |