Broad Top Area Medical Center, Inc.

2024 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & INTEREST FORM

FEDERAL POVERTY GUIDELINES

Broad Top Area Medical Center Inc., (BTAMC) is a non-profit Federally Qualified Health Center, our Mission is to provide access to affordable, high-quality healthcare without discrimination based on one's race, color, sex, disability, age, creed, or national origin. BTAMC will provide in-scope services to all patients, regardless of their insurance status or ability to pay. Every patient may apply for our Sliding Fee Scale Discount Program (SFS) to determine qualification. Patients may choose to decline the benefit program.

Eligibility for Sliding Fee Discounts is based on the federal poverty level (FPL) income guidelines which are adjusted annually and operate in accordance with other federal program regulations. **ALL** patients are encouraged to apply. Uninsured and under-insured patients may qualify for the program based on their household size and their family's income. Sliding Fee Scale Discount Program applications are available at every BTAMC reception desk and on-line – visit **www.broadtopmedical.com**

Important discount program points are:

- The Sliding Fee Scale provides significant discounts for **Medical** and **Dental** services at every BTAMC location.
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL patients.
- The Sliding Fee Scale benefit year is from **March 1st to the last day of February**.
- Your eligibility is based only on your household size and the gross income for your household.
- You may qualify for the program, even if you have third-party insurance coverage.
- You must apply for the program to determine eligibility for Sliding Fee Scale Discounts.
- You must provide documentation for proof of income to complete the application and assessment process.
- You will qualify if your household income is below and/or up to **200 %** of the federal poverty level.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone becomes unemployed, or you add **or** lose a family member – even then the change is temporary.
- **You must renew applications and submit proof of income annually for approved Sliding Fee Scale Discounts.**
- Applications & questions can be submitted to the office in person, by mail or via secure Email to: **enrollment@broadtopmedical.com**

2024 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA
* For families/households with more than 8 persons, add **$5,380** for each additional person.

ON THE TABLE BELOW PLEASE CIRCLE FAMILY SIZE & ESTIMATED ANNUAL HOUSEHOLD INCOME FOR 2024

We ask every patient to share their annual household income. We only collect aggregate information because BTAMC receives federal funding for assistance programs that benefit patients with lower incomes. Your information is confidential. Thank you!

Family Size	Slide A (<=100%)	Slide B (101% - 125%)	Slide C (126% - 150%)	Slide D (151% - 175%)	Slide E (176% - 200%)	Above 200% FPL
1	$0 - $15,060	$15,061 - $18,825	$18,826 - $22,590	$22,591 - $26,355	$26,356 - $30,120	$30,121 +
2	$0 - $20,440	$20,441 - $25,550	$25,551 - $30,660	$30,661 - $35,770	$35,771 - $40,880	$40,881 +
3	$0 - $25,820	$25,821 - $32,275	$32,276 - $38,730	$38,731 - $45,185	$45,186 - $51,640	$51,641 +
4	$0 - $31,200	$31,201 - $39,000	$39,001 - $46,800	$46,801 - $54,600	$54,601 - $62,400	$62,401 +
5	$0 - $36,580	$36,581 - $45,725	$45,726 - $54,870	$54,871 - $64,015	$64,016 - $73,160	$73,161 +
6	$0 - $41,960	$41,961 - $52,450	$52,451 - $62,940	$62,941 - $73,430	$73,431 - $83,920	$83,921 +
7	$0 - $47,340	$47,341 - $59,175	$59,176 - $71,010	$71,011 - $82,845	$82,846 - $94,680	$94,681 +
8	$0 - $52,720	$52,721 - $65,900	$65,901 - $79,080	$79,081 - $92,260	$92,261 - $105,440	$105,441 +

☐ **I understand that I may qualify for the Sliding Fee Discount Program but at this time, I choose to decline.**

☐ **Yes, I would like to apply for the sliding fee discount program, please contact me at this Phone Number: _____**

_____ _____

Print Name of Patient/Applicant **or** Parent/Guardian Signature of Patient Date

_____ _____

Patient/Applicant's Date of Birth Signature of Staff/Witness Date

2024/rah – CAC

Broad Top Area Medical Center, Inc.

2024 SLIDING FEE SCALE DISCOUNT PROGRAM – APPLICATION FORM

Applicant's Information:

First Name: Middle: Last:

_____

Home Address: City: State: Zip:

_____

Mailing Address: City: State: Zip:

_____

Home Phone #: Cell Phone #: Work Phone #:

_____

Date of Birth: Social Security #: Marital Status: (Circle One)

_____ Single Married Domestic Partnership

Divorced Separated Widowed/Widower

_____

Note: To comply with federal regulations, and to determine eligibility for discounted services, it is necessary to ask some personal questions. Your answers will be kept on file in strict confidence. We must verify your gross income every benefit year to qualify for the Sliding Fee Scale Discount Program. The SFS Benefit period is from March 1 to the last day of February.

Proof of income can be verified by presenting us with your income tax return from the previous year, last month's paycheck stubs, copies of your unemployment or social security determination, or bank statement of deposit will be sufficient proof.

Your household size and household income will be used to calculate your eligibility for discount. For the purposes of income determination, a family is defined as an individual **or** a group of two or more persons related by birth, marriage, domestic partnership, adoption, or guardianship that live in your household. **Please indicate household size and family members.**

Household Size:

FAMILY MEMBER'S NAMES	DATE of BIRTH:	SOCIAL SECURITY NUMBER:
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____
_____	_____ / _____ / _____	_____ - _____ - _____

Broad Top Area Medical Center, Inc.

2024 SLIDING FEE SCALE DISCOUNT PROGRAM – APPLICATION FORM

Job or Wage Income that Contributes to Household:

NAME	EMPLOYER	FREQUENCY (Circle One)	AMOUNT
You:		Weekly Bi-Weekly Monthly Yearly	$
Spouse/Partner:		Weekly Bi-Weekly Monthly Yearly	$
Children:		Weekly Bi-Weekly Monthly Yearly	$
Other:		Weekly Bi-Weekly Monthly Yearly	$
Other:		Weekly Bi-Weekly Monthly Yearly	$
		Total Wage Income:	$

Other Income that Contributes to the Household:

	You	Spouse/Partner	Children	Other	Subtotal
Unemployment Benefits					$
Social Security Benefits					$
Retirement or Pension Benefits					$
Alimony or Child Support					$
Royalty or Annuity Payment					$
Other Income					$
Cash, Heat, or Food Assistance	YES	NO	(Not counted as taxable income for Sliding Fee Scale)		
			Total of Other Income:		$
			Total of Wage Income:		$
			ESTIMATED ANNUAL HOUSEHOLD INCOME:		**$**

Do you or any household member on this application need assistance with transportation expenses? YES / NO

Do you or any household member want to apply for the BTAMC Transportation Assistance Program? YES / NO

I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the SFS Program and may subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform BTAMC if there is a significant change in my income. If my application is approved and qualified for the SFS Program, I will comply with all BTAMC rules and regulations. I hereby acknowledge that I have read the foregoing disclosure and understand it.

_____ _____

Print Name of Applicant or Parent/Guardian Date

PLEASE INDICATE SERVICE TYPE:

_____ **MEDICAL** _____

Signature of Applicant or Parent Guardian: **DENTAL** _____

TRANSPORTATION _____