# 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