Broad Top Area Medical Center, Inc.

2023 SLIDING FEE SCALE DISCOUNT PROGRAM – PATIENT EDUCATION & APPLICATION PACKET

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 on-line or at our reception desks.

Important discount program points are:

- The Sliding Fee Scale provides significant discounts for BTAMC's **Medical** and **Dental** services**.**
- The Sliding Fee Scale **is not** an insurance program – it is a benefit offered to ALL patients.
- You may qualify for the program, even if you have medical 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 process.
- Your eligibility is based on the gross income for your household and your household size.
- You are encouraged to re-apply anytime your household income or household size changes, such as when someone becomes unemployed, or you add a family member – even then the change is temporary.
- **You must renew applications and submit proof of income, annually.**
- The Sliding Fee Scale benefit year is from **March 1st to the last day of February**.
- Applications & questions can be submitted to the office in person, by mail or via secure Email to: enrollment@broadtopmedical.com

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

* For families/households with more than 8 persons, add **$5,140** for each additional person.

Please Circle Your Family Size & Estimated Household Income Level

We ask income information because we receive federal funding for assistance programs that benefit patients with lower incomes.

	Slide A (<=100%)	Slide B (101% - 125%)	Slide C (126% - 150%)	Slide D (151% - 175%)	Slide E (176% - 200%)	Above 200% FPL
Family Size	From To	From To	From To	From To	From To	
1	$0 - $14,580	$14,581 - $18,225	$18,226 - $21,870	$21,871 - $25,515	$25,516 - $29,160	$29,161 +
2	$0 - $19,720	$18,721 - $24,650	$24,651 - $29,580	$29,581 - $34,510	$34,511 - $39,440	$39,441 +
3	$0 - $24,860	$24,861 - $31,075	$31,076 - $37,290	$37,291 - $43,505	$43,506 - $49,720	$49,721 +
4	$0 - $30,000	$30,001 - $37,500	$37,501 - $45,000	$45,001 - $52,500	$52,501 - $60,000	$60,001 +
5	$0 - $35,140	$35,141 - $43,925	$43,926 - $52,710	$52,711 - $62,495	$62,496 - $70,280	$70,281 +
6	$0 - $40,280	$40,281 - $50,350	$40,351 - $60,420	$60,421 - $70,490	$70,491 - $80,560	$80,561 +
7	$0 - $45,420	$45,421 - $56,775	$56,776 - $68,130	$68,131 - $79,485	$79,486 - $90,840	$90,841 +
8	$0 - $50,560	$50,561 - $63,200	$63,201 - $75,840	$75,841 - $88,480	$88,481 - $101,120	$101,121 +

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

_____ _____

Print Name Date of Birth Signature Date

_____ _____

Witness Date

BOD/CFO/rah – 1.26.23

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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. To qualify for the Sliding Fee Scale Discount Program (SFS) we must verify your gross income every benefit year, from March 1 to the last day of February.

Proof of income can be verified by presenting us with your income tax return from 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.

Household Size:

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

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Wage Income that Contributes to the 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:		$
			ANNUAL HOUSEHOLD INCOME:		**$**

I do hereby swear or 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

_____

Signature of Applicant or Parent Guardian:

PLEASE INDICATE SERVICE TYPE:

MEDICAL _____
DENTAL _____
BOTH _____