SLIDING FEE DISCOUNT PROGRAM

Sliding Fee Discount Program Application Instructions

Patients who are unable to pay for services at any of the Bronx Community Health Network, Inc. locations, may qualify for our Sliding Fee Discount Program (SFDP). The SFDP will cover all or a portion of the cost of care you receive. The amount of financial assistance received is based on income and household size following the Federal Poverty Guidelines.

To be considered for this program you must complete the attached application and provide one of the following to satisfy the proof of income requirement:

- Most recent income tax return with W-2(s) and/or 1099
- Most recent 2 pay stubs
- Earnings record from ssi.gov
- Proof of social security income, if applicable
- Proof of alimony, child support, unemployment, pension, etc.
- Other earning documents (provide to staff to be evaluated)

If you are unable to provide an acceptable form of proof of income, you may sign a self-attestation statement and are requested to provide one of the following documents for support of this statement:

- Verification letter if receiving food stamps
- Proof of family planning only, Medicaid
- If you receive no income and are being supported by relatives or friends, a letter explaining those arrangements is requested. The letter must be signed by person(s) lending assistance.

Once your application is completed, please return it and your proof of income documentation to any BCHN location, or mail it to:

Bronx Community Health Network, Inc.
1 Fordham Plaza #1108, Bronx, NY 10458
Attention: Practice Management
Coordinator

Bronx Community Health Network, Inc. will review your application to determine the level of assistance for which you are eligible. Once a decision is made, you will be notified of approval or denial of the SFDP. If approved, the level of financial assistance received will be based on household size and income on the Federal Poverty Guidelines.

If approved, this application will be good for one year and will be used for all locations you are being served. The discounted amount will be valid at all BCHN locations. You will need to inform BCHN if there are any changes in your financial situation during the year that may impact your eligibility for this program. If you need any assistance with the application, please contact us in person or by phone at (718) 405-7720.

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Discount Program Application

Patient Information:

Name: _____ DOB _____ _____ _____
(Last) (First) (MI) (MM/DD/YYYY)

Address: _____
(Street/Apt Number) (City) (State) (Zip)

Telephone Number: (_____)_____(_____)_____
(Home) (Cell)

Parent/Guardian Information 1:

Name: _____ DOB: _____/_____/_____
(Last) (First) (MI) (MM/DD/YYYY)

Address: _____
(Street/Apt Number) (City) (State) (Zip)

Relationship to Patient: _____ Telephone Number: (___)_____(___)_____
(Home) (Cell)

Parent/Guardian Information 2:

Name: _____ DOB: _____/_____/_____
(Last) (First) (MI) (MM/DD/YYYY)

Address: _____
(Street/Apt Number) (City) (State) (Zip)

Relationship to Patient: _____ Telephone Number: (___)_____(___)_____
(Home) (Cell)

Household and Income (List all persons living in the household, including yourself):

	Name	Relationship	Age	Annual Income	Source
1					
2					
3					
4					
5					
6					
7					
8					

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Self-Attestation Statement: I am unable to provide any proof of income as described above and have discussed this with staff. I am agreeing to provide requested documents to support this statement. I understand this information will be used to determine my eligibility for the Sliding Fee Discount Program. By signing this section, I am stating that I am providing truthful, to the best of my knowledge, information, and I self- attest to the income (or lack of income) stated in the household/income section above.

Signature of Patient/Guardian:_____ Date signed:_____

Witness: _____ Printed Name: _____

I hereby request that Bronx Community Health Network, Inc. to determine my eligibility for Sliding Fee Discount Program services. I hereby attest that I am not covered by any form of prescription insurance, nor am I covered by any form of government-sponsored health insurance, including Medicare, Medicaid, VA benefits, or other coverage.

I understand that the information, which I submit concerning my annual income and household/family size, is subject to verification by this organization and subject to review by state and/or federal enforcement agencies and others as required. I understand that the information given within this document is for the purpose of determining eligibility for the Sliding Fee Discount Program and that false or incomplete information will result in my disqualification for assistance.

If my financial situation changes in the upcoming year, I will report these changes to Bronx Community Health Network, Inc. immediately.

Print Patient Name: _____

Signature of Patient/Guardian:_____ Date signed:_____

Witness: _____ Printed Name: _____

For Finance & Accounting Use Only:

Approved ☐ Denied ☐

Date Reviewed:____/___/_____

Reviewed by:_____ Title: _____ Date: _____

Reason for Denial:_____

BCHN Percentage: % ____

Athena Health Slide: _____