BMS

Family Health &
Wellness Centers

AFFORDABLE HEALTH CARE

SLIDING FEE
DISCOUNT PROGRAM

*Information Packet

*Enrollment Form

2025 SLIDING FEE DISCOUNT - AFFORDABLE MEDICAL and DENTAL SERVICES

Based Upon Income Guidelines as Published in the Federal Register on January 15, 2025

% of Income Poverty	A (0-100%)	B 101% - 133%	C 134% - 150%	D 151% - 170%	E 171% - 185%	F 186% - 200%	G (201%+)
FAMILY SIZE	**ANNUAL INCOME**						
1	$0 - $15,650	$15,651 - $20,815	$20,816 - $23,475	$23,476 - $26,605	$26,606 - $28,953	$28,954 - $31,300	$31,301 - OVER
2	$0 - $21,150	$21,151 - $28,130	$28,131 - $31,725	$31,726 - $35,955	$35,956 - $39,128	$39,129 - $42,300	$42,301 - OVER
3	$0 - $26,650	$26,651 - $35,445	$35,446 - $39,975	$39,976 - $45,305	$45,306 - $49,303	$49,304 - $53,300	$53,301 - OVER
4	$0 - $32,150	$32,151 - $42,760	$42,761 - $48,225	$48,226 - $54,655	$54,656 - $59,478	$59,479 - $64,300	$64,301 - OVER
5	$0 - $37,650	$37,651 - $50,075	$50,076 - $56,475	$56,476 - $64,005	$64,006 - $69,653	$69,654 - $75,300	$75,301 - OVER
6	$0 - $43,150	$43,151 - $57,390	$57,391 - $64,725	$64,726 - $73,355	$73,356 - $79,828	$79,829 - $86,300	$86,301 - OVER
7	$0 - $48,650	$48,651 - $64,705	$64,706 - $72,975	$72,976 - $82,705	$82,706 - $90,003	$90,004 - $97,300	$97,301 - OVER
8	$0 - $54,150	$54,151 - $72,020	$72,021 - $81,225	$81,226 - $92,055	$92,056 - $100,178	$100,179 - $108,300	$108,301 - OVER

Discount	100%	73%	66%	49%	29%	14%	0%
Office Visit	$0	$65	$82	$123	$172	$208	$242
Nutrition Visit	$0	$49	$61	$92	$128	$155	$180
* Dental							
Limited Oral Evaluation(D0140)	$0	$15	$19	$29	$40	$49	$57
Detailed Oral Evaluation(D0120 or D0150)	$0	$21	$27	$40	$55	$67	$78
Detailed and extensive oral evaluation (D0160)	$0	$37	$47	$70	$98	$119	$138
Comprehensive Periodontal Evaluation(D0180)	$0	$17	$21	$32	$45	$54	$63
Prophylaxis - Adult (D1110)	$0	$18	$22	$34	$47	$57	$66
Prophylaxis - Child (D1120)	$0	$14	$17	$26	$36	$44	$51
Topical Fluoride (D1206)	$0	$12	$15	$23	$32	$39	$45
Sealant - per tooth (D1351)	$0	$11	$13	$20	$28	$34	$39

**** Extensive Dental procedures will require deposits over and above the Sliding Fee Scale on an Individual basis.***

1. For family units with more than 8 members, add **$5,500** for each additional member pursuant to the scale.
2. All persons must show valid ID (example: Driver license, Passport, NY Resident ID, Valid Employment ID.)
3. All persons must show proof of income (example: pay stubs, SSI stub, prior year federal tax return, current letter from employer stating annual income). Patients without valid proof of income will be assessed and billed for the full fee until income is verified.
4. Persons with income above 200% of the Federal poverty level will be assessed and charged the full fee.
5. It is the policy of B.M.S. Family Health & Wellness Center to provide medically necessary services regardless of the patient's ability to pay.
6. The above cost does not include laboratory and other ancillary charges
7. Dental visits may cover more than one service

2025 SLIDING FEE DISCOUNT - URGENT CARE SERVICES

Based Upon Income Guidelines as Published in the Federal Register on January 15, 2025

% of Income Poverty	A (0-100%)	B 101% - 133%	C 134% - 150%	D 151% - 170%	E 171% - 185%	F 186% - 200%	G (201%+)
FAMILY SIZE	ANNUAL INCOME						
1	$0 - $15,650	$15,651 - $20,815	$20,816 - $23,475	$23,476 - $26,605	$26,606 - $28,953	$28,954 - $31,300	$31,301 - OVER
2	$0 - $21,150	$21,151 - $28,130	$28,131 - $31,725	$31,726 - $35,955	$35,956 - $39,128	$39,129 - $42,300	$42,301 - OVER
3	$0 - $26,650	$26,651 - $35,445	$35,446 - $39,975	$39,976 - $45,305	$45,306 - $49,303	$49,304 - $53,300	$53,301 - OVER
4	$0 - $32,150	$32,151 - $42,760	$42,761 - $48,225	$48,226 - $54,655	$54,656 - $59,478	$59,479 - $64,300	$64,301 - OVER
5	$0 - $37,650	$37,651 - $50,075	$50,076 - $56,475	$56,476 - $64,005	$64,006 - $69,653	$69,654 - $75,300	$75,301 - OVER
6	$0 - $43,150	$43,151 - $57,390	$57,391 - $64,725	$64,726 - $73,355	$73,356 - $79,828	$79,829 - $86,300	$86,301 - OVER
7	$0 - $48,650	$48,651 - $64,705	$64,706 - $72,975	$72,976 - $82,705	$82,706 - $90,003	$90,004 - $97,300	$97,301 - OVER
8	$0 - $54,150	$54,151 - $72,020	$72,021 - $81,225	$81,226 - $92,055	$92,056 - $100,178	$100,179 - $108,300	$108,301 - OVER

Discount	86%	73%	66%	49%	29%	14%	0%
Office Visit	$30	$65	$82	$123	$172	$208	$242
Discount	**75%**	**73%**	**66%**	**49%**	**29%**	**14%**	**0%**
Lab/Radiology Services	$25	$27	$34	$51	$71	$86	$100

1. For family units with more than 8 members, add **$5,500** for each additional member pursuant to the scale.
2. All persons must show valid ID (example: Driver license, Passport, NY Resident ID, Valid Employment ID.)
3. All persons must show proof of income (example: pay stubs, SSI stub, prior year federal tax return, current letter from employer stating annual income). Patients without valid proof of income will be assessed and billed for the full fee until income is verified.
4. Persons with income above 200% of the Federal poverty level will be assessed and charged the full fee.
5. It is the policy of B.M.S. Family Health & Wellness Center to provide medically necessary services regardless of the patient's ability to pay.
6. The above cost does not include other ancillary charges

The Sliding Fee Discount Program is a service extended to the patients of BMS Family Health and Wellness Centers (BMS) when receiving care at the center. It is designed to assist patients who fall within specific income levels and family size (at or below 200% of Federal poverty Guidelines). Through this program, we can help you to significantly reduce the cost of your medical visit. Individuals and families with incomes over 200% of Federal Poverty Guidelines may not receive a discount, therefore, the patient is responsible for the full cost of the services.

What are the benefits of enrolling in the program?
You may be eligible to receive medical, dental and mental health services at perspective rates.

How do you enroll?

1. Complete the **Sliding Fee Enrollment Form**.
2. Give the complete form to the Patient Service Representative and he or she will determine whether you might be eligible.
3. If you are eligible, you will be asked to bring in documentation of your income, at which time you will be asked to complete the **Income Verification Form**. BMS will extend only one visit at a sliding fee price without obtaining a copy of both income and family documentation.
4. After you complete the Income Verification Form, you will be considered enrolled for a period of six months. You are to let the Patient Service Representative know of any change in your family income or family size when you return for service.

All applicants must provide the following information within 30 days:

A. *Two pieces of identification (One must be a picture ID).*

Acceptable IDs

Driver's License	**or**	Social Security Card
Voter's Registration		Motor Vehicle ID
Marriage License		Employment ID
Birth Certificate		Student ID
Immigration Papers		Passport
Alien Registration		

B. Proof of Address (One of the following)

Gas or Electric Bill	**or**	Telephone Bill
Mortgage Statement		Rent Statement/ Receipt
Charge Account Statement		

C. Proof of Income (One of the following)

1. **Employed Applicants** Must provide a recent pay stub.
2. **Unemployed Applicants**-Must provide a statement from ***NYS Department of Labor Unemployment Division***, verifying the amount received.
3. **Self-Employed Applicants**-Must provide statement(s) from the source(s) of income (notarized, if source of income pays cash)
4. Statement from other source(s) of income (interests, dividends, etc.)
5. Other acceptable documentation could be:
    - W-2 form,
    - Federal Tax Return,
    - Any verifiable source of income

SLIDING FEE ENROLLMENT FORM

DATE: _____

NAME (PRINT): _____

PATIENTS' NAME (PRINT): _____

FAMILY INCOME: $_____ **(ANNUALLY)**

FAMILY SIZE (NUMBER OF PEOPLE): _____

I, _____, certify that the income and family size that I stated above is true, complete and correct to the best of my knowledge and belief. I also understand that I must provide written documents confirming the above stated amount within thirty (30) days in order to continue to utilize the Sliding Fee Discount pricing of the BMS Family Health and Wellness Centers. I understand that if I do not return within 30 days with my written documents, I will receive a bill.

PATIENTS'/GUARDIAN'S SIGNATURE: _____

PATIENTS' ID #: _____

DATE: _____

FOR OFFICIAL USE ONLY

PATIENT SERVICE REPRESENTATIVE'S SIGNATURE: _____

DATE: _____

INCOME SELF DECLARATION FORM

PATIENT NAME: _____

PATIENT ADDRESS: _____

TELEPHONE #: _____

CHART #: _____

MARITAL STATUS: _____

GROSS EARNINGS: $_____ **(ANNUALLY)**

PUBLIC ASSISTANCE:	☐YES	☐NO	$_____	PER_____
SOCIAL SECURITY:	☐YES	☐NO	$_____	PER_____
UNEMPLOYMENT:	☐YES	☐NO	$_____	PER_____
OTHER (*ex. Child Support, Retirement)*	☐YES	☐NO	$_____	PER_____

TOTAL SINGLE/FAMILY INCOME: $_____

NUMBER OF FAMILY MEMBERS: _____

I certify that all the statements made in this form are true, complete and correct to the best of my knowledge and belief; I also understand I must be rectified six (6) months from this date.

SIGNATURE: _____

DATE: _____

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IDENTIFY THE PROOF OF INCOME: _____

SOURCE OF IDENTIFICATION: _____

PROOF OF ADDRESS: _____

PROOF OF IDENTITY: _____

ELIGIBLE FOR DISCOUNT: ☐YES ☐NO

PROCESSED BY: _____

DATE: _____