Sliding Fee Discount Program **Original Effective Date: April 11, 2012**
Policy Number: 5.2 **Reviewed & approved: March 24, 2022**

Appendix C: JRCHC Application

Jericho Road Community Health Center

Sliding Fee Application

Please complete and return to: ☐ 184 Barton St Buffalo, NY 14213 ☐ 1690 Genesee St Buffalo, NY 14211

Our mission at Jericho Road Community Health Center (JRCHC) is to serve all patients regardless of the ability to pay for the services. We give discounts based on family/household size and annual income. Please complete the information below and give to the front desk team member so we can see if you or members of your family can get a discount. The discount will be for all services received at JRCHC, but may not those services which you get from outside, including lab testing, drugs, x-rays and other specialists.

Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____

Street Address: _____

City:_____ State:_____ Zip:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Sex: _____Female _____Male

Social Security #: _____-_____-_____ Marital Status: _____Single _____Married _____Divorced _____Widow

Are you a United States Citizen? _____ Yes _____ No* *If no, you must bring proof of immigration status.

Driver's License or State ID #: _____ State Issued: _____

My Annual household income is: _____ Number of related persons living in your household: _____

Please list spouse and dependents under age 18

First Name	Last Name	Date of Birth	Social Security Number (REQUIRED)	Relationship

Sliding Fee Discount Program **Original Effective Date: April 11, 2012**
Policy Number: 5.2 **Reviewed & approved: March 24, 2022**

Jericho Road Community Health Center

Sliding Fee Application

Page 2

Annual Household Income:

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Social Security, pension, annuity, or veterans benefits				
Alimony, child support, military family allotments				
Income from self-employment, and dependents				
Rent, interest, dividends and other income				
Income from Disability and/or unemployment Insurance				
Totals				

Please provide proof of income for all household members. Below are acceptable forms of proof:

- Paystubs for Most Recent Full Month
- Income Tax Return
- Pension Statement
- Social Services Letter
- Employer Statement

I give permission to Jericho Road Community Health Center (JRCHC) to see if I and/or my family qualify for the sliding fee discount program. I understand that the information about my family income and size will be required. I also understand that if information which I give is false, I will be expected to pay for all services at full charge. By signing this application I agree that the information given is true and correct to the best of my knowledge. I understand that it is my responsibility to tell JRCHC of any and all changes in my financial and insurance information.

Print Name _____ Signature_____ Date_____

For Office Use Only:

Patient Eligible for: Medicaid ☐

ACA Plan ☐

Sliding Fee Scale Discount ☐ Qualifies for Category _____ discount

Full Pay ☐

Further action required _____

_____

Application Reviewed by: _____ Approved/Disapproved By_____

Employee Signature_____ Date_____

JERICHO ROAD COMMUNITY HEALTH CENTER
Fiscal Policies and Procedures

Sliding Fee Discount Program **Original Effective Date: April 11, 2012**
Policy Number: 5.2 **Reviewed & approved: March 24, 2022**

For services provided by another organization via a formal contract or other written arrangement, JRCHC will ensure that the service provider offers a sliding fee discount program consistent with this policy (i.e. fees will be discounted for patients with income between 100% and 200% of the FPG, patients with income below 100% FPG will receive a full discount or assessed a nominal charge only, and patients with income above 200% FPG will receive no discount).