The Chautauqua Center

Our Family Caring For Your Family

The Chautauqua Center's policy is to provide essential clinical services regardless of the patient's ability to pay. We assure that families and individuals have access to healthcare services at cost based on a person's ability to pay.

The Sliding Fee Scale Program applies to all patients who qualify as uninsured and under-insured regardless of the type of insurance, except where the insurance contract terms state otherwise.

Discounts are based on income and family size and no other factors apply to any and all patients.

Please Complete the attached Application.

Submit Proof of Income.

Payment is expected at each and every visit unless you make other accommodations with the Billing Department.

Family Planning also has its own scale and eligibility if you do not fall under TCC's policy. Please ask for additional information.

Without proof of income, your application is considered incomplete and you will owe 100% of the cost of services.

The Chautauqua Center Sliding Fee Program Application For all Services

New App ____________
Renewal ____________

Patient Name: ____

Address: ______________________________ Date of Birth ______________

Guarantor Name: ____
(If different)

Current phone ________________ ____________________

Health Insurance ? __________ Insurance ________________________

Seasonal Worker ?__________ How many months of year do you work ? ________

Please return documents&application to 75 E Third Street,Dunkirk NY 14048 Attn: Billing

Application Not approved until Proof Of Income provided from all sources within 14 days from today and reviewed.

if zero income, You must enter a zero by person.

Family Member(s)	relationship	Date of Birth	**Income**	week	monthly	annual	Pt:	misc.
	self							
	spouse							
	child							
	child							
	other							

** If additional members,please advise so we can give you additonal form.*

Examples of Acceptable proof of income:Current Pay stubs,W2s, Tax return from prior year, Letters from sources or attestation. **** Total Income Greater than 200% Current Federal Poverty Guidelines are not eligible for Discount.**

Once Application reviewed, you will be notified of any type of discount by letter. If approved, it will be good for one year from date of signature. You are required to notify TCC of any change in Family size and/or income during this time. An updated application will be required. ________

(initial proof of reading)

I do hereby affirm that the information provided 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 sliding fee program and may subject me to penalties under Federal or State laws. I further agree to inform The Chautauqua Center if there is a change in my income or family size. If acceptance to the Sliding Fee Program is obtained under the application, I will comply with all rules and regulations of The Chautauqua Center. I acknowledge that I have read the foregoing disclosure and understand it. Payments tobe made at every visit.

______________________________ ____________________
(Signature) Date

____
(Printed Name)

REGISTRATION USE ONLY: DATE REC'D __________ INITIALS__________

07/2022 PT. ACCT NO.________

The Chautauqua Center Sliding Fee Self-Declaration Form

To Be filled out by The Patient

Para ser llenado por el paciente

Date (*Fecha*)**: __________________**

Patient Name (*Nombre del paciente*)**: ______________________________________**

To Whom It may Concern (*A quien corresponda*)**:**

I declare that my household monthly income is_______________ and/or my family size is________.

Declaro que mi ingreso en mi hogar mensual es _______________ y/o el tamaño de mi familia es________.

Please use this in determining my Sliding Fee eligibility.

Por favor use esto para determinar mi elegibilidad.

Yours truly (*Sinceramente*),

____

Patient Signature (*firma del Paciente*)