Baptist Community Health Services

SLIDING SCALE FEE APPLICATION

Our Mission:

Demonstrating the love of Christ by providing high quality primary medical and behavioral healthcare to medically underserved communities.

Sliding Fee Discount Scale –Annual Gross Income

Medical	$25 Nominal Fee	Pays $50	Pays $75	Pays $100	Pays 100% of Charges
Behavioral Health	$20 Nominal Fee	Pays $30	Pays $40	Pays $50	Pays 100% of Charges
Poverty Level	0%	Over 100%	Over 150%	Over 175%	Over 200%	and higher
Family Size	100%	150%	175%	200%	
	Level A	Level B	Level C	Level D	Level E
1	$ 0	$ 13,590	$ 13,591	$ 20,385	$ 20,386	$ 23,783	$ 23,784	$ 27,180	$ 27,181	and higher
2	$ 0	$ 18,310	$ 18,311	$ 27,465	$ 27,466	$ 32,043	$ 32,044	$ 36,620	$ 36,621	and higher
3	$ 0	$ 23,030	$ 23,031	$ 34,545	$ 34,546	$ 40,303	$ 40,304	$ 46,060	$ 46,061	and higher
4	$ 0	$ 27,750	$ 27,751	$ 41,625	$ 41,626	$ 48,563	$ 48,564	$ 55,500	$ 55,501	and higher
5	$ 0	$ 32,470	$ 32,471	$ 48,705	$ 48,706	$ 56,823	$ 56,824	$ 64,940	$ 64,941	and higher
6	$ 0	$ 37,190	$ 37,191	$ 55,785	$ 55,786	$ 65,083	$ 65,084	$ 74,380	$ 74,381	and higher
7	$ 0	$ 41,910	$ 41,911	$ 62,865	$ 62,866	$ 73,343	$ 73,344	$ 83,820	$ 83,821	and higher
8	$ 0	$ 46,630	$ 46,631	$ 69,945	$ 69,946	$ 81,603	$ 81,604	$ 93,260	$ 93,261	and higher
Each add'l member	$ 0	$ 4,720	$ 4,721	$ 7,080	$ 7,081	$ 8,260	$ 8,261	$ 9,440	$ 9,441	and higher

Sliding Fee Discount Scale –Weekly Gross Income

Medical	$25 Nominal Fee	Pays $50	Pays $75	Pays $100	Pays 100% of Charges
Behavioral Health	$20 Nominal Fee	Pays $30	Pays $40	Pays $50	Pays 100% of Charges
Poverty Level	0%	Over 100%	Over 150%	Over 175%	Over 200%	and higher
Family Size	100%	150%	175%	200%	
	Level A	Level B	Level C	Level D	Level E
1	$ 0.00	$ 260.63	$ 260.64	$ 390.95	$ 390.96	$ 390.97	$ 390.98	$ 390.99	$ 391.00	and higher
2	$ 0.00	$ 351.15	$ 351.16	$ 526.73	$ 526.74	$ 526.75	$ 526.76	$ 526.77	$ 526.78	and higher
3	$ 0.00	$ 441.67	$ 441.68	$ 662.51	$ 662.52	$ 662.53	$ 662.54	$ 662.55	$ 662.56	and higher
4	$ 0.00	$ 532.19	$ 532.20	$ 798.29	$ 798.30	$ 798.31	$ 798.32	$ 798.33	$ 798.34	and higher
5	$ 0.00	$ 622.71	$ 622.72	$ 934.07	$ 934.08	$ 934.09	$ 934.10	$ 934.11	$ 934.12	and higher
6	$ 0.00	$ 713.23	$ 713.24	$ 1,069.85	$ 1,069.86	$ 1,069.87	$ 1,069.88	$ 1,069.89	$ 1,069.90	and higher
7	$ 0.00	$ 803.75	$ 803.76	$ 1,205.63	$ 1,205.64	$ 1,205.65	$ 1,205.66	$ 1,205.67	$ 1,205.68	and higher
8	$ 0.00	$ 894.27	$ 894.28	$ 1,341.41	$ 1,341.42	$ 1,341.43	$ 1,341.44	$ 1,341.45	$ 1,341.46	and higher
Each add'l member	$ 0.00	$ 90.52	$ 90.53	$ 135.78	$ 135.79	$ 135.80	$ 135.81	$ 135.82	$ 135.83	and higher

BCHS's sliding fee scale is based uponthe 2022Federal Poverty Guidelines (FPG)

https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Effective Date: March 1, 2022

DETERMINING ELIGIBILITY

Baptist Community Health Services is able to offer a discount on all services provided by BCHS based on a household's income and size. Sliding fee calculations are determined by using Federal Income Tax forms, W-2's, or last two consecutive pay stubs. The staff at BCHS then uses the table on the inside of this brochure to determine your eligibility.

Your household discount will be assessed annually.

If you have any questions, please contact our office at 504-533-4999 or email us at info@bchsnola.org.

Return completed application to:
4960 St. Claude Avenue
New Orleans, LA 70117

TO BE COMPLETED BY BCHS STAFF

Annual Gross Income $_____

Patient is eligible for sliding fee discount in Category _____

☐ Proof of Income
☐ Patient refused to comply
☐ Patient does not qualify for sliding fee

_____ _____
Verified By Date

SLIDING FEE DISCOUNT APPLICATION

If you wish to qualify for the sliding fee, you MUST show proof of income for all family members/individuals for whom you are financially responsible. If you do not have any source of income, please speak with a staff member. Applicants should provide a copy of either:

- Two consecutive pay stubs for each employed adult age 18 and over living in the household, or living outside the household but for whom the household is financially responsible.
- Previous year's tax return of W-2 for each adult living in the household or for whom the household is financially responsible (income will come from Adjusted Gross Income line on respective tax return).

Name: _____ Date of Birth: _____ Family size: _____
(Number of family members living in your household)
List the name ***and*** date of birth of ***each*** family member/individual living in your household or each individual for whom you are financially responsible.

_____
_____
_____
_____

Address:_____

Disclaimer:
I hereby certify that the above information is, to the best of my knowledge, true and correct. I further agree to notify Baptist Community Health Services of any changes in this information within ten (10) days of such change.

I understand that I must re-qualify annually to maintain my eligibility.

I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government.

Sliding Fee payment is due and payable at the time of service. To maintain discount, fees must be paid promptly. If you are unable to make payment at time of service, please speak to the receptionist to make other arrangements.

_____
Signature of patient or responsible party