

SLIDING FEE DISCOUNT PROGRAM

We're Here for You

At Finger Lakes Community Health, we care for everyone. You will never be turned away if you are unable to pay.

We offer a Sliding Fee Discount Program to help lower the cost of your care. The discount is based on how many people live in your home and how much money your household makes (not counting any overtime).

The Sliding Fee Program is available to everyone — even if you have insurance.

If your household income is within 200% of the Federal Poverty Guidelines, you may qualify for a discount.

Everyone is welcome to apply. You'll need to renew your application once a year or anytime your income or family size changes.

If you have questions or need help with the form, just ask. We're happy to help!

**Finger Lakes Community Health Sliding Fee Discount Program
Effective March 2, 2026 – March 1, 2027**

Family Size	Annual Income	
	Nominal Fee =< 100%	Sliding Fee 101% - 200%
1	\$0 - \$15,960	\$15,961 - \$31,920
2	\$0 - \$21,640	\$21,641 - \$43,280
3	\$0 - \$27,320	\$27,321 - \$54,640
4	\$0 - \$33,000	\$33,001 - \$66,000
5	\$0 - \$38,680	\$38,681 - \$77,360
6	\$0 - \$44,360	\$44,361 - \$88,720
7	\$0 - \$50,040	\$50,041 - \$100,080
8	\$0 - \$55,720	\$55,721 - \$111,440
9	\$0 - \$61,400	\$61,401 - \$122,800
10	\$0 - \$67,080	\$67,081 - \$134,160

Medical Services	Nominal Fee =< 100%	Sliding Fee 101% - 200%
Medical Visit	As low as \$20	\$40-\$80
Family Planning Funded Visit	As low as \$0	\$40-\$80
Behavioral Health Counseling	As low as \$10	\$20-\$40
Dental Services	Nominal Fee =< 100%	Sliding Fee 101% - 200%
Preventive Care Exam, Prophy/Fluoride/Varnish, X-Ray (Bitewing/PA, Panorex), Sealants and Silver Diamine, Periodontics	As low as \$25	\$40-\$60
Restorative Filling, Extractions	As low as \$40	\$60-\$100
Minor Prostodontic Prosthetic Repair, Flippers, Nightguard/Space Maintainer	As low as \$20 + Lab Cost	\$30-\$50 + Lab Cost

Major Prosthodontic Other Surgical Procedures, Denture - Complete – Upper, Denture - Complete – Lower, Partial - Acrylic -Upper Partial - Acrylic - Lower Partial - Metal - Upper Partial - Metal - Lower Partial - DuraFlex - Upper Partial - DuraFlex - Lower Crown Major Prosthetic Repair Root Canal	As low as \$50 + Lab Cost	\$70-\$110 + Lab Cost
Pharmacy Services	Nominal Fee =< 100%	Sliding Fee 101% - 200%
340B Drugs	As low as \$9.60 + Drug Cost	\$10.90-\$13.50 + Drug Cost

How to Apply for the Sliding Fee Discount Program

To apply, please complete the **Sliding Fee Discount Application** included with this packet. The information you provide will help determine your eligibility and discount level.

What You'll Need to Complete:

✓ Household Information

List everyone who lives in your home and is supported by your household income. These are usually the same people you list as dependents when you file your taxes.

✓ Income Information

List all income for everyone in your household. This includes both taxable and non-taxable income, such as:

- Wages and tips
- Pensions and annuities
- Veterans' benefits
- Social Security benefits
- Alimony or child support
- Workers' compensation
- Unemployment benefits
- Self-employment income
- Rental income

Please include the number of hours worked per week and months worked per year for each person. We do not include overtime in our calculations.

✓ Proof of Income

You must provide one of the following to verify your income:

- Pay stubs for one full month (must be in order and dated within the last 45 days)
- Social Security annual benefit letter
- Unemployment benefit letter
- Workers' compensation or disability documents
- A signed letter from your employer with your current monthly gross income and hours worked
- Self Attestations or Bank statements (*only accepted if other documents are not available*)

Additional Information About the Sliding Fee Discount Program

- **Minors (ages 12–18):** If you're getting family planning funded health services, we only count your income—or you can say you have no income. We look at your whole household's income for all other services (like medical, dental, or mental health).
- **Do you have no income or job?** We'll connect you with a Financial Advocate to see if you qualify for insurance or other help.
- **Can't afford care?:** You may qualify for a hardship discount—possibly up to 100% off—after filling out a short form.
- **Keep your information up to date:** If your income or household size changes, please fill out a new application—even if it's before your yearly update.

If you have any questions or need help filling out the application, our team is here to help—please don't hesitate to reach out!

Sliding Fee Discount Program Application

First Name		MI	Last Name		DOB (MM/DD/YY)	Today's Date
Current Age		<input type="checkbox"/> Married	<input type="checkbox"/> Not Married	<input type="checkbox"/> Minor (12 to 18 years of age) applying for Family Planning Funded Discount only		

List below all household members and household income (including yourself):

Name	DOB (MM/DD/YY)	Relationship	Monthly Income
		<i>Self</i>	

If you are reporting no income, you must describe your current means of support and/or living situation:

DECLINED (by initialing and dating, I understand that I am not eligible for any sliding fee discounts.) _____
Initials Date

I authorize Finger Lakes Community Health Staff to discuss my patient account balance in my absence with _____
 whose phone number is _____.

I declare, under penalty of perjury, that the information I have given on this form is true, correct and complete. I understand that the giving of false information may make me ineligible for discounted services.

Applicant Signature: _____ **Date:** _____

Office Use Only		
Total Household Members: _____	Total Monthly Household Income: _____	Total Monthly Family Planning Funded Income: _____
Did you assign the General Slide to the patient account? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you note the Family Planning Funded in the Income Section? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
POI Provided:		
<input type="checkbox"/> Yes (Expires 365 days) Termination Date: _____		
<input type="checkbox"/> No Termination Date: _____		
<input type="checkbox"/> No (Expires in 365 days) The patient has barriers that do not allow them to obtain the necessary proof income and doing so would place barriers to care and/or financial hardship. I have, as best as possible determined that the stated income is correct, and that the number of people listed as household members is true to the best of my knowledge. Termination Date: _____		
Staff Signature: _____		Date: _____