**NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE**
Ashwin Vasan, MD, PhD
*Commissioner*

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**Gotham Center**
**42-09 28th St.**
**Long Island City, NY 11101**

February 21, 2024

Dear Patient,

This letter is to notify you that the New York City Department of Health and Mental Hygiene (NYC Health Department) asks for health insurance information or a fee for certain clinic services given to adults (age 19 and older). The NYC Health Department must ask for insurance or payment for services to meet Medicaid standards and other legal requirements.

- If you do not have health insurance or do not want your insurance billed for this visit, see **Section A.**
- If you want to use your health insurance to pay for this visit, see **Section B.**

**If you do not have insurance or cannot pay the fee, you can still get services.**

For more billing information, visit nyc.gov/health and search for **clinic billing FAQ** or call **311** and ask about "health department clinic billing." If you have any questions, please ask clinic staff.

Sincerely,

Ashwin Vasan, MD, PhD
Commissioner
New York City Department of Health and Mental Hygiene

**A. If you do not have health insurance or do not want your insurance billed:**

**Please use the sliding scale.**

1. In the "Family Size" column, find the number of family members who live in your house, including yourself.
2. Read ACROSS and locate your yearly income. You will not be asked for proof of family size or yearly income.
3. Look DOWN to the bottom of that column to see how much you owe.
4. Complete a check or money order (not cash) payable to **NYC Department of Health and Mental Hygiene.**
5. Include **patient's full name, date of visit, and patient's electronic medical record identification (EMR ID) number** (found on the label on the front of this letter) on the check or money order. The address to send payment to is below.

**Instructions**

| **Step 1.** | **Step 2** | **Step 3** |
|---|---|---|
| Find your family size (include all adults and children living with you). | Find the amount that you get paid in one year in the columns listed (from left to right). | Follow the columns down the bottom of the chart to find out how much you will be asked to pay for your clinic visits. |

**Sliding Scale**

| **Family Size** | **Yearly Income** | | | | | |
|---|---|---|---|---|---|---|
| 1 | Under $14,580 | $14,581 to $18,225 | $18,226 to $21,870 | $21,871 to $29,160 | $29,161 to $36,450 | Over $36,451 |
| 2 | Under $19,720 | $19,721 to $24,650 | $24,651 to $29,580 | $29,581 to $39,440 | $39,441 to $49,300 | Over $39,301 |
| 3 | Under $24,860 | $24,861 to $31,075 | $31,076 to $37,290 | $37,291 to $49,720 | $49,271 to $62,150 | Over $62,151 |
| 4 | Under $30,000 | $30,001 to $37,500 | $37,501 to $45,000 | $45,001 to $60,000 | $60,001 to $75,000 | Over $75,001 |
| 5 | Under $35,140 | $35,141 to $43,925 | $43,926 to $52,710 | $52,711 to $70,280 | $70,281 to $87,850 | Over $87,851 |
| 6 | Under $40,200 | $40,281 to $50,350 | $50,351 to $60,420 | $60,421 to $80,560 | $80,561 to $105,420 | Over $105,421 |
| 7 | Under $45,420 | $45,421 to $56,775 | $56,776 to $68,130 | $68,131 to $90,840 | $90,841 to $113,550 | Over $113,551 |
| **Fees** | **$0** | **$2** | **$3** | **$20** | **$30** | **$40** |

**Fee Scale Examples:**

- A single person (Family Size of 1) with a yearly income of $19,000 will pay a fee of $3.
- A person living with three children, a spouse and a parent (Family Size of 6) with a yearly income of $60,421 will pay a fee of $20.

**B. Using your health insurance to pay for the visit**:

**If you did not bring your insurance card today,** please fill out the bottom of this page and submit it to the mailing address below.

**If you gave your insurance information at the clinic or are submitting it by mail,** you or the policyholder may receive an Explanation of Benefits (EOB) from your insurance provider. The EOB will list the services you received and show if a copayment is required. If you owe a copayment, please mail a check or money order (not cash) payable to **NYC Department of Health and Mental Hygiene** to the address listed below. The check or money order should include the **patient's full name, date of visit and patient's EMR ID number** (found on the label on the front of this letter).

**Mailing address:**

NYC Department of Health and Mental Hygiene
Attn: Division of Finance
42-09 28th St., CN48
Long Island City, NY 11101

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**Please bill the health insurance listed below for my visit:**

Health Insurance Name (required): _____

Health Insurance Address: _____

Health Insurance Telephone Number: _____

Insurance ID (required): _____ Group Number: _____

**If insurance coverage is through a spouse, parent or other:**

Policyholder's Name: _____ Policyholder's Date of Birth: _____

Relationship to Insured (if not patient or self): ☐ Spouse ☐ Parent ☐ Other

**Signature: _____** **Date: _____**