



NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE

Mary T. Bassett, MD, MPH

Commissioner

Dear Patient:

This letter is to notify you that the New York City Health Department may ask for health insurance information or a fee for immunization services given to adults (age 19 and over). The Health Department must ask for insurance or payment for services to meet Medicaid standards and other legal requirements.

- If you have health insurance, see **Section A**.
- If you do not have health insurance, see **Section B**.

If you do not have insurance or cannot pay the fee, you will still get services. Everyone will receive 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,

A handwritten signature in black ink that reads 'Mary T. Bassett'.

Mary T. Bassett, MD, MPH
Commissioner

A. If you have health insurance, but did not bring your insurance card: Please fill out this form at home and submit it to the mailing address below.

Please bill the health insurance listed below for my visit:

Health Insurance Name: _____

Health Insurance Address: _____

Health Insurance Telephone Number: _____

Insurance ID: _____ Group Number: _____

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

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Insured: () Spouse () Parent () Other

Signature: _____ Date: _____

B. If you do not have health insurance: 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 name, date of visit, and patient's ID number** (found on the front of this letter) on the check or money order. The address to send payment is below.

Sliding Scale

Family Size	Yearly Income					
	Under \$17,235	\$17,236 to \$22,980	\$22,981 to \$28,725	\$28,726 to \$34,470	\$34,471 to \$40,215	Over \$40,216
1	Under \$23,265	\$23,266 to \$31,020	\$31,021 to \$38,775	\$38,776 to \$46,530	\$46,531 to \$54,285	Over \$54,286
2	Under \$29,295	\$29,296 to \$39,060	\$39,061 to \$48,825	\$48,826 to \$58,590	\$58,591 to \$68,355	Over \$68,356
3	Under \$35,325	\$35,326 to \$47,100	\$47,101 to \$58,875	\$58,876 to \$70,650	\$70,651 to \$82,425	Over \$82,426
4	Under \$41,355	\$41,356 to \$55,140	\$55,141 to \$68,925	\$68,926 to \$82,710	\$82,711 to \$96,495	Over \$96,496
5	Under \$47,385	\$47,386 to \$63,180	\$63,181 to \$78,975	\$78,976 to \$94,770	\$94,771 to \$110,565	Over \$110,566
6	Under \$53,415	\$53,416 to \$71,220	\$71,221 to \$89,025	\$89,026 to \$106,830	\$106,831 to \$124,635	Over \$124,636
Fees	\$0	\$3.57	\$7.14	\$10.71	\$14.28	\$17.85

Fee Scale Examples:

- A single person (family size of 1) with a yearly income of \$28,000: \$7.14 due.
- A person living with 3 children, a spouse and a parent (family size of 6), with a yearly income of \$85,000: \$10.71 due.

Based on the sliding scale, enclosed is a payment of \$_____.

Please mail the completed form (A) or payment (B) to:

NYC Department of Health and Mental Hygiene
 Attn: Division of Finance
 42-09 28th Street, CN 32W
 Long Island City, NY 11101