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,

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					
1	Under $16,643	$16,643 - $18,093	$18,094 - $30,150	$30,151 - $36,180	$36,181 - $48,240	Over $48,240
2	Under $22,411	$22,411- $24,360	$24,361 - $40,600	$40,601 - $48,720	$48,721 - $64,960	Over $64,960
3	Under $28,180	$28,180- $30,630	$30,631 - $51,050	$51,051 - $61,260	$61,261 - $81,680	Over $81,680
4	Under $33,948	$33,948 - $36,900	$36,901 - $61,500	$61,501 - $73,800	$73,801 - $98,400	Over $98,400
5	Under $39,716	$39,716 - $43,170	$43,171 - $71,950	$71,951 - $86,340	$86,341 - $115,120	Over $115,120
6	Under $45,485	$45,485 - $49,440	$49,441 - $82,400	$82,401 - $98,880	$98,881 -$131,840	Over $131,840
7	Under $51,253	$51,253- $55,710	$55,711 - $92,850	$92,851 - $111,420	$111,421 - $148,560	Over $148,560
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