

Patient Name: _____ Date: _____

RYAN WHITE ANNUAL PAYMENT CAP

The HIV program at Wake County Human Services Inc. is partially funded through a grant from the Ryan White Care Act. As a recipient of Ryan White funds, WCHS will not charge you for services if your health care costs exceed an annual payment cap. This cap is a percentage of your annual income and follows the guidelines described in the Ryan White Care Act. The payment cap limits the amount you can be charged by us for out-of-pocket medical expenses.

Use the table below to determine your **Ryan White Annual Payment Cap**.

Annual Income	% Charge
<101% Federal Poverty Level	0
101% - 200% FPL	5%
201% - 300% FPL	7%
>300% FPL	10%

For example, someone whose annual household income is 150% of the Federal poverty level may only be charged a maximum of 5% of their annual income. Once that cap is met, they cannot be charged any additional medical expenses by the Ryan White Program for the rest of the year.

As a starting point, the 2016 Federal Poverty Breakdowns for a single person household are provided below (based upon your household size, your individual FPL calculation may vary).

Poverty Level	Maximum Income for a Household of 1
0-100%	\$11,770
101% - 200%	\$23,570
201% - 300%	\$35,310

Anything above \$35,310 is in excess of 300% FPL.

You may use the table on the back side of this form to track your out-of-pocket expenses. Qualifying expenses include charges from BOTH Wake County Human Services as well as external charges (including, but not limited to: physician office visits, mental health and substance abuse counseling, dental care, ophthalmology care, dermatology care, prescriptions, medical insurance premiums and co-pays, and over-the-counter medications). If you receive a medical bill from any other location, please present it to WCHS for calculation toward your maximum cap.

If you reach your Payment Cap, contact your clinic social worker. Wake County Human Services will not charge you for any additional services we provide for the rest of the year. If you have questions, please ask your provider for additional information.

Received by: _____ Date: _____
Patient Signature

