Asher Community Health Center
Sliding Fee Scale
Annual Net Income

2018 Federal Poverty Guidelines					
Guideline applicable to the 48 Contiguous States and the District of Columbia					
Family Size	A 100%	A1 101-125%	B 126-150%	C 151-175%	D 176-200%
1	$12,140	$15,175	$18,210	$21,245	$24,280
2	$16,460	$20,575	$24,690	$28,805	$32,920
3	$20,780	$25,975	$31,170	$36,365	$41,560
4	$25,100	$31,375	$37,650	$43,925	$50,200
5	$29,420	$36,775	$44,130	$51,485	$58,840
6	$33,740	$42,175	$50,610	$59,045	$67,480
7	$38,060	$47,575	$57,090	$66,605	$76,120
8	$42,380	$52,975	$63,570	$74,165	$84,760
9	$46,700	$58,375	$70,050	$81,725	$93,400
10	$51,020	$63,775	$76,530	$89,285	$102,040
Add $4,320 for each additional person over 10					

Medical services:

Category A: 100% FPL -- $25 per visit which includes any lab and/or x-rays provided in-house. X-rays and laboratory work not performed at this clinic are your responsibility.
Category A1: 101% -125% -- $25 per visit and pay 10% of any lab and/or x-rays. X-rays and laboratory work not performed at this clinic are your responsibility
Category B: 126% - 150% --$25 per visit and pay 15% of any lab and/or x-rays. X-rays and laboratory work not performed at this clinic are your responsibility.
Category C: 151% - 175% --$30 per visit and pay 25% of any lab and/or x-rays. X-rays and laboratory work not performed at this clinic are your responsibility.
Category D: 176% - 200% -- $35 per visit and pay 50% of any lab and/or x-rays.
X-rays and laboratory work not performed at this clinic are your responsibility

Dental services:

Category : A - 100% FPL -- $30 for initial visit and $0 per additional procedure
Category A1: 101% - 125% -- $45 for initial visit and $15 per additional procedure
Category B: 126% - 150% -- $45 minimum fee or 25% of total visit whichever is greater
Category C: 151% - 175% -- $45 minimum fee or 40% of total visit whichever is greater
Category D: 176% - 200% -- $45 minimum fee or 50% of total visit whichever is greater

Root canals and procedures processed at outside labs (crowns, dentures, bridges, partials, night guards, etc.) are at additional cost to the patient.

Asher Community Health Center

Asher Clinic: P.O Box 307, Fossil OR 97830

Spray Clinic: 106 2nd St., Spray OR 97874

Mitchell School-Based Health Center: 340 SE High St., Mitchell, OR 97750

Telephone: (541) 763-2725 ◆ Fax: (541) 763-2850 ◆ TTY: 1 (800) 735-2900

AFFIDAVIT OF ELIGIBILITY
Sliding Fee Scale

Date_______________ Family Size________

MONTHLY Net Income ____________________

Names and dates of birth for family members, including yourself, applying for or to be covered by ACHC/SFS:

Last name:	First name:	DOB:

Please initial

1. ___I certify that I have reviewed the sliding fee scale (SFS) that determines my eligibility.

2. ___I have provided to ACHC proof of income to establish my eligibility for the sliding fee scale.
Acceptable proof of income may include: **3 MONTHS OF PAY STUBS , YOUR MOST RECENT TAX RETURN, A COPY OF YOUR BANK STATEMENT SHOWING DIRECT DEPOSIT, A COPY OF YOUR SOCIAL SECURITY BENEFITS, A COPY OF YOUR UNEMPLOYMENT BENEFITS, RETIREMENT PAYMENTS, AND/OR DIVIDENDS.**

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Patient signature Date