ASHER
COMMUNITY HEALTH CENTER

Sliding Fee Discount Program

It is Asher Community Health Center's mission to provide primary medical and dental care to all patients regardless of their ability to pay. Asher offers a Sliding Fee discount to all patients regardless if they are insured, uninsured, or under-insured patients.

What Does the Sliding Fee Discount program cover?

Our Sliding Fee discount program applies to all services at Asher Community Health Center. Patients who are eligible for the Sliding Fee Discount program will pay fees for services based on their eligibility category. Different programs may have different fee schedules. Once a patient is determined qualified for the Sliding Fee Discount program their eligibility remains in place for one year. Please Note: **IF APPROVED we require that you report any changes of income, address, and/or contact information within 10 days of the change to the Outreach Worker at Asher Community Health Center (541-763-2725).**

ATTENTION: The Dental Sliding Fee Discount Program is currently only available to Wheeler County Residents.

What is required to apply for the Sliding Fee Discount Program?

- Provide current proof of household gross income (for all household members over the age of 18 years old.) *NOTE: A household is all persons regularly living at the household.*
- Complete, sign, and date application
- Return application

Where do I send my completed applications?

- Return in person to Asher Community Health Center at 712 Jay Street, Fossil, OR
- MAILED TO: Asher Community Health Center, P.O. Box 307, Fossil, OR 97830
- Faxed to: 541-763-2850

By returning this application you have provided Asher Community Health Center consent to verify all information you have provided. If your application is complete and supporting documents are not needed your eligibility will be determined and you will be notified within 14 calendar days of receipt.

Can I get assistance with the application?

If you need assistance completing the Sliding Fee Scale Discount program application or if you have any questions or concerns, please contact the Outreach Worker at 541-763-2725.

Proof of Income Documentation

All applicants are requested to provide their most recent tax returns. If you do not file a tax return you must provide a written explanation why you do not.

** * If you declare no income you must attach a statement explaining how you sustain yourself. * **

Listed Below is accepted documentation to support income declaration	
Accepted Tax Returns • 1040 • 1040 NR • 1040A • 1040EZ **Supporting Tax documentation** • W-2 • SSA-1099	You can obtain a copy of your most recent return by calling the IRS at **(800)829-1040** or online at **http://www.irs.gov/individuals/Get-Transcript**.
Salalry and Wages	Three (3) consecutive months of paycheck stubs are requested. If less than three months can be provided the check stubs must include a letter from the employer stating your full/part time status and your wage/salary.
Social Security Retirement **Social Security Disability** **Supplemental Security Income**	An Award letter can be obtained from the Social Security Administration by calling **1-800-772-1213** - OR - go to the Social Security Office and request a copy.
Student Financial Aid	Go to FAFSA.gov and log into your Student Aid Report (SAR) to print a copy
Food Stamps / SNAP / TANF	An award letter can be otained from the local Department of Human Resources Fossil (541)763-2142 Condon (541)384-5088 Prineville (541)447-3851 Madras (541)475-6131
Alimony / Child Support	Copy of three (3) monthly checks **OR** Court award letter indicating dollar amount and time period **OR** Letter from the Child Support Enforcement Agency **OR** Letter from Attorney stating amount and time period
Housing Assistance	**Contact Public Housing Authority (PHA) in Redmond (541)923-1018**
Worker's Compensation	As Award letter or benefit statement can be obtained from the Workers Compensation Agency handling your cliam. You will need documentation that indicates the dollar amount and time period this income is receiced
Self-Employment Income	The most recent 1040
Other	Any award letter or benefit statement; copy of 3 months of check(s), written explation, and/or a judgement letter, strike benefits, income from investments or savings, dividend income, rental income, milatary pay stubs and family allotments, cash income or allowance from any resources that are readily available to the household.

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Sliding Fee Discount Program - Patient Rights and Responsibilities

1) All patients may apply for the program even if you have insurance
2) If you are less than or equal to 100% of the Federal Poverty Level you are required to apply for OHP coverage as you may be eligible for the Oregon Health Plan (OHP). Assistance in applying for OHP is available by contacting the Outreach Worker at Asher Community Health Center
3) The household size is everyone living in the house. Anyone residing in the household over the age of 18 is required to provide a copy of the most recent tax return, current proof of income, or a signed statement regarding no income.
4) Acceptance into the program is not guaranteed. You will be notified of your status 14 days after submission. If approved for the program payment for services is due at the time of the visit.
5) Patients in emergency situations needing immediate care will be given 30 days to complete and submit the paperwork to the Asher Outreach Worker. Failure to meet this deadline will result in the patient being responsible for the services at full charge.
6) Not all services provided in the clinic are covered under this program. Examples include: 1) Physicals for Commercial Driver's license; 2) Drug Screens requested by employers; 3) Insurance physicals; 4) some dental provisions
7) The guarantor of the account is responsible for payments due for anyone listed on this application. If the account is sent to a collection agency the guarantor is responsible for all collection agency account balances and fees.
8) Please do not provide originals for documentation. Copies of documents are to be included with application submission.
9) ANY CHANGES to a patient's income, living arrangement, or insurance status must be submitted to Asher Community Health Center within 10 days. If ACHC is not notified of changes the patient(s) may no longer be eligible for the program
10) Falsification of documentation, if discovered, will disqualify an applicant from eligibility.

By signing below I authorize Asher Community Health Center to verify the information on the application and I confirm that I have read and understand the Patient Rights and Responsibilities. I also acknowledge that this document was given to me in a language that I understand either in writing or as read to me in its entirety.

Signature:_____ Date:_____

Printed Name of Applicant:_____

Sliding Fee Eligibility Declaration

Today's Date: ____/____/____		Office Only: (Date Received)	
First Name:	Middle Name:		Last Name:
Physical Address	City	State	Zip
Mailing Address (If different than above)	City	State	Zip
Primary Phone #	Other Phone #		Email:

List ALL household members. All household members over the age of 18 MUST disclose their annual income.

#	Name of Household Member	Relationship	Date of Birth	Total Gross Income
1			____/____/____	
2			____/____/____	
3			____/____/____	
4			____/____/____	
5			____/____/____	
6			____/____/____	
7			____/____/____	
8			____/____/____	

** Please add additional family members on back of this form*

Comments: _____

_____

By singing below, you attest that the information you disclosed is true and correct to the best of your knowledge. The household members listed on this application are aware that their name and information have been provided. Asher Community Health Center reserves the right to verify the information provided on this application and may obtain information from other sources to determine your household eligibility

Applicant Name (please print): _____

Applicant Signature: _____ **Date:** _____

****** OFFICE USE SECTION ONLY ******	
Employee Signature:	Date Give to ACHC: _____
	Response Due Date: _____
Total Annual Earnings: _____	Effective Date: _____
Approved for Class: A A1 B C D E = Not Qualified	

2023 Federal Poverty Guidelines

Guideline is applicable to the 48 Contiguous states and D.C.

Person in Household	A 100%	A1 101 - 125 %	B 126 - 150 %	C 151 - 175 %	D 176 - 200 %
1	0 - 14,580	14,581 - 18,225	18,226 - 21,870	21,871 - 25,515	25,516 - 29,160
2	0 - 19,720	19,721 - 24,650	24,651 - 29,580	29,581 - 34,510	34,511 - 39,440
3	0 - 24,860	24,861 - 31,075	31,076 - 37,290	37,291 - 43,505	43,506 - 49,720
4	0 - 30,000	30,001 - 37,500	37,501 - 45,000	45,001 - 52,500	52,501 - 60,000
5	0 - 35,140	35,141 - 43,925	43,926 - 52,710	52,711 - 61,495	61,496 - 70,280
6	0 - 40,280	40,281 - 50,350	50,351 - 60,420	60,421 - 70,490	70,491 - 80,560
7	0 - 45,420	45,421 - 56,775	56,776 - 68,130	68,131 - 79,485	79,486 - 90,840
8	0 - 50,560	50,561 - 63,163	63,164 - 75,840	75,841 - 88,480	88,481 - 101,120
9	0 - 55,700	55,701 - 69,625	69,626 - 83,550	83,551 - 97,475	97,476 - 111,400
10	0 - 60,840	60,841 - 76,050	76,051 - 91,260	91,261 - 106,470	106,471 - 121,680

For families/households with more than 10 persons, add $5,140 for each additional person in Category A

MEDICAL – SFS RATES (X-rays and laboratory work not performed at this clinic are the patient's responsibility.)

1) Category A: $20.00 per visit and 00% of in-clinic laboratory work & X-rays
2) Category A1: $25.00 per visit. and 10% of in-clinic laboratory work & X-rays
3) Category B: $30.00 per visit. and 15% of in-clinic laboratory work & X-rays
4) Category C: $35.00 per visit and 25% of in-clinic laboratory work & X-rays
5) Category D: $40.00 per visit. and 50% of in-clinic laboratory work & X-rays

DENTAL – SFS RATES

1) Category A: $30.00 for the initial visits and 5% for additional services.
2) CategoryA1: $35.00 for the initial visits and 15% for additional services.
3) Category B: $40.00 for the initial visits and 25% for additional services.
4) Category C: $45.00 for the initial visits and 40% for additional services.
5) Category D: $50.00 for the initial visits and 50% for additional services.
6) Additional fees for outside lab expense