AFFIDAVIT OF ELIGIBILITY
Sliding Fee Scale
Annual Gross Income

Date______________ Household Size:________

MONTHLY Gross Income for all persons living in the household: ______________

Names and dates of birth for all persons living in the household

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 all my income to establish my eligibility for the sliding fee scale.

Proof of income eligibility:
Most recent tax return with schedules is a required document for all applicants. (W-2's or 1099's for applicants who are under the filing threshold and don't file taxes) Applicants whose only income is social security are required to provide a copy of their annual increase letter or, if new to SSA, a copy of their award letter.

Incomes per household include ALL individual's income living within one house.

Changes in income listed on this application, up or down, during the next 12 months, need to be reported.

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Patient's Signature Date

Revised 4/30/2019

2019 Sliding Fee Scale
Annual Gross income

Person in Household	A	A1	B	C	D
	100%	101-125%	126-150%	151-175%	176-200%
1	12,490	15,613	18,735	21,858	24,980
2	16,910	21,138	25,365	29,593	33,820
3	21,330	26,663	31,995	37,328	42,660
4	25,750	32,188	38,625	45,063	51,500
5	30,170	37,713	45,255	52,798	60,340
6	34,590	43,238	51,885	60,533	69,180
7	39,010	48,763	58,515	68,268	78,020
8	43,430	54,288	65,145	76,003	86,860
9	47,750	59,688	71,625	83,563	95,500
10	52,070	65,088	78,105	91,123	104,140

Add: $4,320.00 for each person over 8

Sliding Fee Scale Rates:

ASHER **MEDICAL** FEES

1. Category A: If you are at 100% or below the Federal Poverty Level, we require a fee of $25.00 per visit. This fee includes any x-rays and laboratory work provided at this clinic. X-rays and laboratory work not performed at this clinic are your responsibility.

2. Category A1: If you are between 101% and 125% of the Federal Poverty Level, the fee is $25.00 per visit. You pay 10% of the cost of all x-rays and laboratory work provided at this clinic. X-rays and laboratory work not performed at this clinic are your responsibility.

3. Category B: If you are between 126% and 150% of the Federal Poverty Level, the fee is $25.00 per visit. You pay 15% of the cost of all x-rays and laboratory work provided at this clinic. X-rays and laboratory work not performed at this clinic are your responsibility.

4. Category C: If you are between 151% and 175% of the Federal Poverty Level, the fee is $30.00 per visit. You pay 25% of the cost of all x-rays and laboratory work provided at this clinic. X-rays and laboratory work not performed at this clinic are your responsibility.

5. Category D: If you are between 176% and 200% of the Federal Poverty Level, the fee is $35.00 per visit. You pay 50% of the cost of all x-rays and laboratory work provided at this clinic. X-rays and laboratory work not performed at this clinic are your responsibility.