



**Sliding Fee Discount Application**

It is the policy of the Abbeville Area Medical Center and its owned practices to provide primary care services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income (see schedule attached). Please complete the following information and return to the front desk within 2 weeks to determine if you or members of your family are eligible for a discount.

The discount will apply to all medically necessary services received at Abbeville Area Medical Center and its affiliated clinics, but not those services or equipment that are purchased from outside entities, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

NAME OF HEAD OF HOUSEHOLD			PLACE OF EMPLOYMENT	
STREET	CITY	STATE	ZIP	PHONE

**Please list spouse and dependents under age 18.**

Name	Date of Birth	Name	Date of Birth
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	



**Annual Household Income**

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
<b>Total Income</b>				

**NOTE:** Copies of tax returns, pay stubs, or other information verifying income will be required before a discount is approved.

**All information should be returned within 2 weeks.**

I certify that the family size and income information shown above is correct.

Name (Print) \_\_\_\_\_

Signature Date \_\_\_\_\_



**Smaller. Smarter. Safer.**

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent of Poverty											
Poverty Level	At or Below 125%		over 125% up to 150%		over 150% up to 175%		over 175% up to 200%		over 200% up to 225%		over 225%
Family Size	Nominal Fee (\$10)		20% pay 80% Discount		40% pay 60% Discount		60% Pay 40% Discount		80% pay 20% Discount		100% Pay No Discount
	Min.	Max.	Min.	Max.	Min.	Max.	Min.	Max.	Min.	Max.	
1	0	\$16,100	\$ 16,101	\$ 19,320	\$ 19,321	\$ 22,540	\$ 22,541	\$ 25,760	\$ 25,761	\$ 28,980	<b>\$28981 plus</b>
2	0	\$21,775	\$ 21,776	\$ 26,130	\$ 26,131	\$ 30,485	\$ 30,486	\$ 34,840	\$ 34,841	\$ 39,195	<b>\$39196 plus</b>
3	0	\$27,450	\$ 27,451	\$ 32,940	\$ 32,941	\$ 38,430	\$ 38,431	\$ 43,920	\$ 43,921	\$ 49,410	<b>\$49411 plus</b>
4	0	\$33,125	\$ 33,126	\$ 39,750	\$ 39,751	\$ 46,375	\$ 46,376	\$ 53,000	\$ 53,001	\$ 59,625	<b>\$59626 plus</b>
5	0	\$38,800	\$ 38,801	\$ 46,560	\$ 46,561	\$ 54,320	\$ 54,321	\$ 62,080	\$ 62,081	\$ 69,840	<b>\$69841 plus</b>
6	0	\$44,475	\$ 44,476	\$ 53,370	\$ 53,371	\$ 62,265	\$ 62,266	\$ 71,160	\$ 71,161	\$ 80,055	<b>\$80056 plus</b>
7	0	\$50,150	\$ 50,151	\$ 60,180	\$ 60,181	\$ 70,210	\$ 70,211	\$ 80,240	\$ 80,241	\$ 90,270	<b>\$90271 plus</b>
8	0	\$55,825	\$ 55,826	\$ 66,990	\$ 66,991	\$ 78,155	\$ 78,156	\$ 89,320	\$ 89,321	\$100,485	<b>\$100486 plus</b>
For Each Additional Person, add		\$4,540		\$ 6,810		\$ 7,945		\$ 9,080		\$ 10,215	
<b>Self Pay payments with no prior Commerical Insurance discount qualify for 30% off on bills if balance is being paid in full.</b>											

*Adopted: 2/22/2021*