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Abbeville Area Medical Center

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 if they meet the criteria below. 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, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

NOTE: Copies of last year's tax returns or W-2, 2 most recent pay stubs, and copy of the last 2 months banking 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 _____



Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent 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%	
Family Size	Nominal Fee (\$10)		80% discount		60% discount		40% discount		20% discount	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
1	0	\$16,988	\$16,988	\$20,385	\$20,385	\$23,783	\$23,783	\$27,180	\$27,180	\$ 30,578.00
2	0	\$22,888	\$22,888	\$27,465	\$27,465	\$32,043	\$32,043	\$36,620	\$36,620	\$ 41,198.00
3	0	\$28,788	\$28,788	\$34,545	\$34,545	\$40,303	\$40,303	\$46,060	\$46,060	\$ 51,818.00
4	0	\$34,688	\$34,688	\$41,625	\$41,625	\$48,563	\$48,563	\$55,500	\$55,500	\$ 62,438.00
5	0	\$40,588	\$40,588	\$48,705	\$48,705	\$56,823	\$56,823	\$64,940	\$64,940	\$ 73,058.00
6	0	\$46,488	\$46,488	\$55,785	\$55,785	\$65,083	\$65,083	\$74,380	\$74,380	\$ 83,678.00
7	0	\$52,388	\$52,388	\$62,865	\$62,865	\$73,343	\$73,343	\$83,820	\$83,820	\$ 94,298.00
8	0	\$58,288	\$58,288	\$69,945	\$69,945	\$81,603	\$81,603	\$93,260	\$93,260	\$ 104,918.00
Self Pay payments with no prior Commercial Insurance discount qualify for 30% off on bills if balance is being paid in full.										
* Based on the 2022 Federal Poverty Guidelines.										

Adopted 1/1/2022