Easterseals MORC
Sliding Fee Scale

Sliding Fee Scale (SFS) for qualified persons who are uninsured or under-insured, receiving non-covered behavioral health services:

The Sliding Fee Scale daily visit amount (Daily Visit Amount) is based on your ability to pay as laid out by the Chart below. Annual Income Limits in the chart are based on the 2026 Federal Poverty Level guidelines and are updated annually. Your daily visit amount will be updated at least annually or whenever your financial situation changes. Documentation of your Annual Income and Family Size are required before a final daily visit amount is approved. Your MI State tax return (MI 1040) will be used as documentation.

Category Determination Chart for Sliding Fee Scale

Family Size	Annual Income Limit				
Poverty Level	A <=100%	B <=150%	C <=200%	D <=300%	E <=400%
1	$15,960	$23,940	$31,920	$47,880	$63,840
2	$21,640	$32,460	$43,280	$64,920	$86,560
3	$27,320	$40,980	$54,640	$81,960	$109,280
4	$33,000	$49,500	$66,000	$99,000	$132,000
5	$38,680	$58,020	$77,360	$116,040	$154,720
6	$44,360	$66,540	$88,720	$133,080	$177,440
7	$50,040	$75,060	$100,080	$150,120	$200,160
8	$55,720	$83,580	$111,440	$167,160	$222,880
For each additional family member add:	$5,800	$8,520	$11,360	$17,040	$22,720

> 400% of poverty level - Full cost of services will be charged.

Sliding Fee Scale (*Based on annual state income and family size provided to EM and applied to the daily visit amount chart above.)*

Category	A	B	C	D	E
Daily Visit Amount*	$0	$5	$20	$50	$90

** Total monthly payments will not exceed your monthly ability to pay amount.*

I understand that I am responsible for fees for services rendered, during any day of service, up to my daily visit amount.

My category: _____ My Daily Visit Amount: $_____ Max. Monthly Amount: $_____

I attest that the information provided to determine my Daily Visit Amount is true and accurate to the best of my knowledge.

Individual Served Name: _____ Case #: _____

Name of Responsible Person: (Print) _____

_____ _____

Signature of Responsible Person Date

_____ _____

Case Holder Signature Date

No person will be denied medically necessary services based on a lack of ability to pay.