OPSAM HEALTH
Caring for the Community Since 1973

Financial Information Form/ Sliding Fee Application

The purpose of collecting the following information is to determine your federal poverty level. Your federal poverty level will determine if you may be eligible to any programs or benefits.

Patient Information

Full Name:	**Date of Birth:**

A **household** consists of all the people who occupy a house or apartment. Adult children living at home who are no longer dependent are considered a separate household. Roommates who share living arrangements but are not tied to one another through marriage, children or similar relationships are considered separate households. Those living with a friend or relative during a time of need are also considered a separate household.

Income includes any earnings, 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. Noncash benefits (such as food stamps and housing subsidies) do not count. Please complete the following information:

Total Number of Household Members: _____

Total Monthly Household Income: $_____

Select One:

☐ **I do not want to apply for financial assistance.**

☐ **I would like to apply for financial assistance**. If you choose to apply, this form also serves as the **Sliding Fee Discount Application** and proof of income is required.

> Proof of income must be provided in one of the following forms:
> - Current paycheck
> - Documentation of Benefits (unemployment, social security, retirement, military, etc.)
> - Current year filed Federal Tax Returns
> - Self-Attestation

Please Read and Sign

I certify that the information provided is true and authorize Opsam Health to use it to determine my poverty level. I understand I am responsible for all charges until I submit the required income documentation within 14 days. If I fail to do so, I will be charged the full fee. I will notify Opsam Health of any changes in my income or insurance status, and my fee scale will be reassessed accordingly.

Patient Signature: _____ **Date:** _____

Office Use Only

Slide Assigned: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

Income Provided and Verified: ☐ Yes ☐ No Staff: _____

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2025 SLIDING FEE SCALE
Federal Poverty Level
ANNUAL INCOME

Slide Scale:	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F
Gross Household Annual Income	**At or below 100% of FPL**	**At or below 125% of FPL**	**At or below 150% of FPL**	**At or below 175% of FPL**	**At or below 200% of FPL**	**Above 200% of FPL**
Family Size:						
1	$15,060	$18,825	$22,590	$26,355	$30,120	$30,271
2	$20,440	$25,550	$30,660	$35,770	$40,880	$41,084
3	$25,820	$32,275	$38,730	$45,185	$51,640	$51,898
4	$31,200	$39,000	$46,800	$54,600	$62,400	$62,712
5	$36,580	$45,725	$54,870	$64,015	$73,160	$73,526
6	$41,960	$52,450	$62,940	$73,430	$83,920	$84,340
7	$47,340	$59,175	$71,010	$82,845	$94,680	$95,153
8	$52,720	$65,900	$79,080	$92,260	$105,440	$105,967
Each additional family member	$5,380	$6,725	$8,070	$8,995	$10,760	$10,814

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COST OF PROCEDURE MEDICAL/PSCHYOTHERAPHY/DENTAL/CHIROPRACTIC						
Slide Scale:	**Plan A**	**Plan B**	**Plan C**	**Plan D**	**Plan E**	**Plan F**
Medical Visit (exclude procedures) Medical Fee includes provider evaluation only. Procedures, non-state supplied vaccinations, point-of-care lab, and other supplies excluded. Applies to primary care, cardiology, endocrinology, psychiatry, and OB-GYN.	$35	$40	$45	$50	$55	Full Charge
Medical Procedures Medical procedures include but are not limited to colposcopy, pap smear, ear irrigation, sutures, EKG, Echocardiogram, vascular ultrasound, etc.	**40%**	**50%**	**60%**	**70%**	**80%**	**Full Charge**
Psychotherapy Visit Applies to services provided by psychologists, licensed social workers, and licensed marriage and family therapists.	$35	$40	$45	$50	$55	Full Charge
Dental Visit Basic emergency preventive and restorative evaluations only Excludes supplies and lab fees. Dental nominal fee includes basic services – Emergency, preventive, and restorative evaluation, and X-ray. Supplies and lab fees are provided at cost to the patient.	$45	$50	$55	$60	$65	Full Charge
Dental Procedures Dental procedures (i.e., root canals, dental prophylactics, bridges, partials, dentures, etc.) will be charged a percentage of the full charge. Supplies and lab fees are provided at cost to the patient.	**40%**	**50%**	**60%**	**70%**	**80%**	**Full Charge**
Chiropractic Visit	$35	$40	$45	$50	$55	Full Charge