OPSAM HEALTH
Caring for the Community Since 1973

SLIDING FEE DISCOUNT APPLICATION

PATIENT INFORMATION

Name: _____ Date: _____

(First) (Middle) (Last)

Social Security Number: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow

Spouse's Name: _____

Patient Name: _____ Applicant Relationship to Patient_____

HOUSEHOLD INFORMATION

Please list everyone living in your home (**including yourself**). Include anyone at least 18 years of age or older who lives in the household and contributes to the basic living expenses of the household (**including yourself**).

Name (First and Last)	Age	Relationship	Monthly Income
			$
			$
			$
			$
			$
			$
			$

Total Number of Household Size: _____ **Total Household Income: $_____**

Please include income documentation for each ADULT listed below.

Proof of income can be any of the following:

√ Current paycheck

√ Documentation of Benefits (unemployment, social security, retirement, military, etc.)

√ Current year filed Federal Tax Returns

√ Self-Attestation (duly signed)

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HOUSEHOLD INFORMATION

Household Earnings Information:

I do hereby swear or affirm that the information provided in this application is true and correct to the best of my knowledge and belief. I agree that any misleading or false information and/or omissions may disqualify me from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws, including fines and imprisonment. I further agree to inform Opsam Health if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will follow all rules and regulations of Opsam Health. I hereby acknowledge that I read the foregoing disclosure and understand it.

I consent to the release of any and all of my financial records, including but not limited to sliding fee scale application and supporting documentation, patient information, insurance information, and any other types of information contained within my electronic health and/or dental records that may be deemed necessary for reviewed by any auditor, for participating in any assistance programs including but not limited to sliding fee scale, grant-funded programs for which I may be eligible.

Date: _____

Name (Print): _____

Signature: _____

Email Address: _____

Witnessed by Opsam Health staff: _____