

SLIDING FEE DISCOUNT PROGRAM (SFDP) APPLICATION FORM

This program may help lower the cost of your care at Opsam Health. How much you pay is based on how many people live in your home and how much money your household makes. Please fill out this form if you want to apply for the discount.

1. Patient Information

Full Name: _____

Date of Birth: _____

2. Do You Want to Apply?

- ☐ YES, I want to apply for the discount program. *(Please fill out the rest of this form.)*
- ☐ NO, I do not want to apply. **(SKIP numbers 3 – 4 and GO TO number 5. Do NOT scan the QR code below and do NOT upload any documents.)**

3. Insurance Status

☐ I have insurance.

☐ I do **not** have insurance.

4. Proof of Income *(Recent pay stub, latest tax return, W2 or 1099 form, government benefits award letter, letter from employer)*

Are you able to provide proof of your income today?

- ☐ YES. ***(Please provide it to the staff.)***
- ☐ NO, I have proof of income but do not have it with me today. I will provide within 10 business days.

(Use the QR code to submit OR drop in any clinic location.)



- ☐ NO, I am not able to provide or obtain proof of income ***(If you select this, please answer below AND complete the Self-Declaration Form separately.)***

- ☐ My employer does not provide pay stubs or written verification.
- ☐ I am paid in cash.
- ☐ I am self-employed or do informal work.
- ☐ I cannot contact my employer/former employer.
- ☐ I am unemployed.

5. Agreement – Please Read and Sign

- I promise the information I give is true and correct.
- I allow Opsam Health to use this information to see if I qualify for a Sliding Fee Discount.
- I am responsible for paying my bill until I give proof of income.
- I will bring or send my income documents within **10 business days**.
- If I do **not** turn in my documents on time, I will be charged the **full fee**.
- I will tell Opsam Health if my income or insurance changes.
- My discount may change based on the new information, and if I overpaid, a refund may be given.

Signature:

Date:

Patient/Representative Name:

Relationship/Authority:

STAFF USE ONLY – PATIENT REFUSED TO FILL OUT & SIGN FORM

Date of refusal: ____ / ____ / ____ Staff name (print): _____

Staff signature: _____

Comments (optional): _____