OLE HEALTH

Place Patient/Client Label Here

SLIDING FEE SCALE APPLICATION (ENGLISH)

Need Help Paying for Your Visit?

You may be eligible for our Sliding Fee Program, which adjusts the cost of your services based on your income. The less money you make, the less you pay for services. If you earn more, you'll pay more.

To apply for this voluntary confidential program, please provide your information and sign below.

Please list all dependents living in your household (include yourself/spouse, children, and any dependent relatives):

				Staff Use Only	
Name	Relationship	Date of Birth	Income	Frequency Paid Check how often patient is paid	Total Monthly Income
1. (Self)	(Self)			☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐Annually x 0.08333	
2.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
3.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
4.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
5.				☐Weekly x 4.330 ☐2x month x 2.00 ☐Biweekly x 2.167 ☐Monthly x 1.0 ☐ Annually x 0.08333	
				Total Gross Monthly Income for Household	
				Total Household Size	
				Applicable Scale	

Important: ATTACH PROOF OF INCOME TO THIS FORM

By signing this form, I certify that all the information I am providing is accurate and understand that any false statements about income or household size may result in payment in full being required. I understand that my eligibility is dependent on meeting certain income requirements. I acknowledge that it is my responsibility to provide proof of my income and report any changes in income or number of people in my household to OLE Health, and that those changes may affect my eligibility for the Sliding Fee Program. I understand that self-reported income is only valid for 30 days from the signature date below and if proof of income is not provided, I will be responsible for the full cost of the services provided after that date.

*** Sliding fee documents are valid for 1 year from signature.* ***If patient is unable to provide proof of income, see Self-Attestation.*

Applicant/Guardian Signature **Date**

COMPLETE THIS SECTION IF YOU CHOOSE NOT TO APPLY FOR SLIDING FEE SCALE

I acknowledge that I have been given the opportunity to apply for the OLE Health sliding fee scale schedule. At this time, I do not wish to apply for the sliding fee schedule. I also acknowledge that I will not be allowed to receive a retroactive discount for any medical charges if a future sliding fee scale application is completed.

I understand that I can revoke this consent at any time by providing written notification to OLE Health. I understand that I have the right to ask questions about this consent and my financial responsibilities before signing.

Patient/Guardian Signature **Date**