 Sliding Fee Discount Program Application

Options provides essential services regardless of an individual’s ability to pay. Options offers discounts based on family size and annual income.

Please complete the following information to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at Options, but not those services or equipment

purchased from outside, including reference laboratory testing, prescriptions, or other such services. You must complete this form every 12 months or more frequently if your financial situation changes.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NAME: | |  | | | | | | |
| STREET ADDRESS: | | | |  | | | | |
| CITY: |  | | | | STATE: |  | ZIP: |  |
| PHONE: | | |  | |

Please list all household members, including those under age 18.

|  |  |  |
| --- | --- | --- |
|  | NAME | DATE OF BIRTH |
| CLIENT: |  |  |
| PERSON #2: |  |  |
| PERSON #3: |  |  |
| PERSON #4: |  |  |
| PERSON #5: |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ANNUAL INCOME | SELF | OTHER | TOTAL |
| Gross wages, salaries, tips, etc. | $ | $ | $ |
| Income from business and self-employment | $ | $ | $ |
| Other sources of income | $ | $ | $ |
|  | TOTAL INCOME: | | $ |

I certify that the family size and income information shown above is correct.

|  |
| --- |
|  |
| NAME (PRINT) |

|  |  |  |
| --- | --- | --- |
|  |  |  |
| SIGNATURE |  | DATE |

--------------------------------------------------OFFICE USE ONLY --------------------------------------------------

|  |  |
| --- | --- |
| APPROVED DISCOUNT: |  |
| APPROVED BY: |  |
| DATE APPROVED: |  |