CAMED CARE FOUNDATION

IRS Department of the Treasury Internal Revenue Service

CERTIFIED 501(c)(3) NONPROFIT

Integrative Manual Therapy & Rehabilitation / Pain Management

4282 Wilshire Blvd. #103B Los Angeles, CA 90010

SLIDING FEE SCALE (SFS) APPLICATION

1. Applicant Information

Full Name : _____ Date of Birth : _____

Address : _____

Phone : _____ Email : _____

2. Household Composition

.

(Name): _____ (Relationship): Self_____(DOB): _____

(Name): _____ (Relationship): _____ (DOB): _____

(Name): _____ (Relationship): _____ (DOB): _____

(Name): _____ (Relationship): _____ (DOB): _____

Total Number of Household Members : _____

3. Income Verification

Gross Monthly Income : $ _____ Annual Household Income : $ _____

Attached Proof :

[ ] Pay Stubs [ ] Benefit Letter [ ] Tax Return

[ ] No Income Declaration

4. Attestation and Consent

I hereby certify that the information provided is true and accurate to the best of my knowledge.

Signature : _____ **Date** : _____

[Important Disclosures & Notes]

Confidentiality & Privacy (HIPAA): All information provided in this application is strictly confidential and protected under HIPAA (Health Insurance Portability and Accountability Act) regulations. This data will be used exclusively to determine eligibility for the Sliding Fee Scale program and will not be shared with unauthorized third parties.Documentation Requirements: Applications must be completed in full to be processed. Applicants are responsible for providing valid proof of income. Failure to provide required documentation may result in the denial of the application.Validity Period & Reporting Changes: Approved sliding fee discounts are valid for 12 months from the date of approval. Applicants must notify CAMED Care Foundation within 30 days of any significant changes in household size or gross income. Non-Discrimination Policy: CAMED Care Foundation provides services to all patients regardless of race, color, sex, national origin, religion, age, disability, or sexual orientation.Truthfulness of Information: Any person who knowingly provides false information to obtain financial assistance may be disqualified from the program and held responsible for the full cost of services rendered.

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FPL Category: [ ] A: ≤ 100% (90% Disc.) [ ] B: 101% - 150% [ ] C: 151% - 200% [ ] D: > 200% (Full Fee)

Doctor's Note: _____

Approved By (Dr.): _____ **Date :** _____/_____/_____