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]

● Medical Disclaimer: CAMED provides complementary wellness and pain relief support. Our programs do not replace formal medical/hospital care. Please maintain your regular doctor consultations. ● Privacy (HIPAA): All data is strictly confidential under HIPAA, used solely for Sliding Fee Scale screening, and never shared without authorization. ● Requirements: Applications must be fully completed with valid proof of income. Missing documents will result in denial. Changes & Validity: Approved discounts last 12 months. You must report any changes in income or household size within 30 days. ● Non-Discrimination: Services are provided equally to all patients without regard to race, color, sex, national origin, religion, age, disability, or sexual orientation. ● Honesty Policy: Providing false information leads to immediate disqualification and full liability for all service costs.

Signature : _____ **Date** : _____

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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 :** _____/_____/_____