Light of Life

RECOVERY & WELLNESS SERVICES

Sliding Fee Discount Program (SFDP) Patient Application

It is the policy of Light of Life Recovery & Wellness Services to provide compassionate, trauma-informed care to all individuals regardless of ability to pay. We offer a Sliding Fee Discount Program based **solely** on family size and annual household income using the current Federal Poverty Guidelines. No one will be denied services due to inability to pay.

This application must be completed every 12 months or whenever your income or family size changes significantly.

Patient Information

- **Patient Name (Last, First, MI):** _____
- **Date of Birth:** _____ **Phone:** _____
- **Address:** _____
- **City/State/ZIP:** _____

Household / Family Information

List **all** people living in your household (including yourself).

Name (Last, First)	**Relationship to Patient**	**Age**	**Gross Annual Income**
_____	_____	___	$_____
_____	_____	___	$_____

(add rows as needed)

Total Family Size: _____

Total Gross Annual Household Income:
$_____

Note: Non-cash benefits (e.g., SNAP/food stamps, housing subsidies) are not counted as income.

Income Verification

Staff are available to assist you with this application. Please provide one or more of the following (attach copies):

- Prior year tax return (Form 1040) or W-2
- Two most recent pay stubs
- Employer letter
- Self-employment income/expense statement (last 3 months)
- Other: _____

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Self-Declaration (only if unable to provide documents):

I am unable to provide documentation because: _____ I declare under penalty of perjury that the income above is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Certification & Authorization

I certify that the information provided is true and complete. I authorize Light of Life Recovery & Wellness Services to verify this information as needed. I understand:

- Eligibility is based only on family size and income.
- The discount applies to all services provided at this clinic (it does not apply to services purchased from outside providers, labs, pharmacies, etc.).
- Approved discounts cover balances up to 6 months prior and 12 months forward (or until a significant change).
- Services will never be denied due to inability to pay.
- Providing false information may result in loss of eligibility and full charges.

Patient / Responsible Party Signature: _____ Date: _____

For Office Use Only

- Total Household Income: $_____ Family Size: _____ % of FPG: _____%
- Discount Level: _____ Nominal Fee (if applicable): $20
- Staff Initials & Date: _____ Approval: _____

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