Patient Financial Hardship / Sliding Fee Discount Application

Purpose: This form allows you to request a temporary reduction in self-pay or out-of-network fees under the Financial Hardship Discount Policy. All information is confidential and used only to verify income for determining eligibility. Discounts apply only to direct clinical services.

Section 1 – Patient Information: **Date of Application:** _____

Patient Full Name: _____ Date of Birth: _____

Address: _____ City / State / ZIP:_____

Phone: _____ Email: _____

Section 2 – Household and Income Information:

Number of Household Members (including yourself): _____ Total Gross Annual Household Income: $_____

Employment Status:

☐ Employed ☐ Self-Employed ☐ Unemployed ☐ Retired ☐ Other: _____

Sources of Income:

☐ Wages ☐ Self-Employment ☐ Unemployment ☐ Disability/SSI ☐ Public Assistance ☐ Other: _____

Proof of Income Provided:

☐ Pay Stubs ☐ Tax Return ☐ W-2 ☐ Benefit Letter ☐ Employer Letter ☐ Self-Declaration of Income

If unable to provide documentation, please explain:

_____

Section 3 – Financial Situation (Optional Narrative)

Describe any special financial circumstances (job loss, medical bills, dependent care, etc.):

_____

Section 4 – Patient Certification

I certify that the information provided above is true and complete. I understand that discounts are based on verified income and household size, apply only to self-pay or out-of-network services, and remain valid for 12 months unless my financial situation changes. I agree to notify Orange Coast Psychiatry of any changes in income or household size.

Patient Signature: _____ Date: _____

Section 5 – Authorized Representative (Clinic Use Only)

Household Income: $_____

Household Size: _____

100% FPL for Household Size: $_____

Calculated FPL%: _____ %

Hardship Category: ☐ Severe (0–100%) ☐ Moderate (101–200%) ☐ Limited (201–300%) ☐ Ineligible (>300%)

Discount Approved – Initial Evaluation: ☐ $75 ☐ $50 ☐ $25 ☐ None

Discount Approved – Follow-Up Visit: ☐ $50 ☐ $25 ☐ None

Discount Approved – Therapy Session: ☐ $50 ☐ $25 ☐ None

Effective Dates: From _____ To _____ (max 12 months)

Approved By (Print Name): _____ Title: _____

Signature: _____ Date: _____

Notes / Comments: _____

Good Faith Estimate Acknowledgment: Patient has received and reviewed a Good Faith Estimate of expected charges for requested services in compliance with the No Surprises Act.

Confidentiality and Retention Notice: This completed form and supporting documents are confidential and stored securely in billing files, in compliance with HIPAA and California privacy law. Records are retained for seven (7) years under the Orange Coast Psychiatry Financial Hardship Discount Policy (2025).