[Date]

[Patient Name]
[Patient Address]
[City, State, Zip Code]

Subject: Approval of Sliding Scale Fee Discount Application

Dear [Patient Name],

We are pleased to inform you that your application for the Sliding Scale Fee Discount Program has been approved. Based on the financial information provided, you have been placed in **[Discount Category/Pay Class]**.

Under this plan, your responsibility for covered services will be:

- Medical Office Visit: $[Amount]
- Behavioral Health Visit: $[Amount]
- Dental Visit: $[Amount]
- Lab/Diagnostics: [Percentage or Flat Fee]

Please note the following details regarding your approval:

- **Effective Date:** [Start Date]
- **Expiration Date:** [End Date]
- **Renewal:** You will need to re-apply and provide updated income documentation before the expiration date to maintain your discount.

This discount applies only to services provided directly by [Facility Name]. It does not cover outside referrals, certain elective procedures, or services provided by third-party laboratories.

Please present your identification and notify the front desk of your discount status at each visit. If your financial situation or household size changes significantly, please contact our billing office.

If you have any questions regarding your account or this program, please contact us at [Phone Number].

Sincerely,

[Staff Name/Signature]
[Title]
[Facility Name]