# OSPHL Reduced Fees Request Template

## Instructions:

Organizations requesting a reduction or waiver of fees for tests performed by the Oregon State Public Health Laboratory (OSPHL) under OAR 333-024-0240(1)(b) may use the following letter as a template to request waived or reduced fees. The OSPHL reduced fee will be similar to the fees prior to March 1, 2014 while the OSPHL is assessing the actual financial impact of the changes. *The numbered information in the template below is required for your request to be considered.*

Please note that the availability of fee waivers or reduced fees does not apply for testing that is already provided free of charge to the submitting organizations. Examples may include testing paid for by grants, rabies tests, outbreak investigations, and isolates required by law.

Complete each section of the template below. You may provide supplemental information that you think may help the OSPHL make a determination about your request. The table provided under Testing Information (#5) is a list of the tests for which the OSPHL offers a reduced rate. Please check the appropriate box for your request (Reduced Rate Requested or Fee Waiver Requested) and provide the estimated number of samples you expect to send per year.

If you have questions about this process, please contact Sarah Humphrey King, OSPHL Client Services Coordinator by phone at 503-693-4124 or by e-mail at sarah.m.humphrey@dhsoha.state.or.us.

## Template:

*[Copy and paste the template below to your letterhead.]*

Oregon State Public Health Laboratory
Attn: Director, OSPHL
7202 NE Evergreen Pkwy., Suite 100
Hillsboro, Oregon 97124

I am writing to request a fee waiver or reduced fee for laboratory testing provided by the Oregon State Public Health Laboratory (OSPHL). By submitting this request, I understand that the decision to allow fee waivers or reduced fees is both subject to OAR 333-024-0240(1)(b) and discretionary with the OSPHL. I further understand that all, a portion of, or none of this request may be approved.

I am providing the following information for your consideration:

1. Organization Name: _____
2. Responsible Official *(this is the person to whom we will respond to the request)*:

_____ _____
(Print Name) (Phone)

_____

2-21-2014

(E-Mail Address)

3. Type of Submitter/Organization: ☐ Public ☐ Private non-profit
4. I have included proof of non-profit status. ☐ Yes ☐ No ☐ Not applicable
5. Testing Information:

| **Test Name** | **OSPHL <u>Full</u> Rate** | **Requesting Reduced Rate** | **Requesting Fee Waiver** | **Number of Samples Per Year** |
|---|---|---|---|---|
| Chlamydia / Gonorrhea (CT/GC) | $67.54 | ☐ | ☐ | |
| HIV-1/HIV-2 Antibody Screen or Confirmation | $23.18 | ☐ | ☐ | |
| QuantiFERON (QFT) | $59.64 | ☐ | ☐ | |

Sincerely,

[Name]
[Position/Title]
[Contact information]

2-21-2014