



**Sliding Fee Application**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Last Name

First Name

M.I.

Household Member Name	Relationship to Patient	Date of Birth

Please document all sources of income for all members of the patient's household

Source of Income	Amount	Frequency (weekly, bi-weekly, monthly, or annually)
Earned Income	\$	
Unemployment Benefits	\$	
Supplemental Security Income (SSI)	\$	
Disability Benefits	\$	
Retirement Income	\$	
Child Support	\$	
Alimony or Spousal Support	\$	
Public Assistance	\$	
Other Unearned Income	\$	

I certify that the above information is correct to the best of my knowledge. I authorize the staff of Careteam+ to verify the information that I have provided. I will notify Careteam+ of any changes in my household income, or insurance status. I understand that annual reapplication for the Sliding Fee discount is required. I understand that I must provide proof of income in order to qualify for a Sliding Fee discount.

\_\_\_\_\_  
(Signature of patient/authorized representative)

\_\_\_\_\_  
(Date)

Source of Income	Total /Frequency	Total Annual
Earned Income		
Unearned Income		
<b>Total Annual Income from All Sources</b>		\$

Approved at SF Level: \_\_\_\_\_ Expiration Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Staff Use Only**