Careteam+®

FAMILY HEALTH & SPECIALTY CARE

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		
Total Annual Income from All Sources		$

Approved at SF Level: _____   Expiration Date: _____/_____/_____

Staff Use Only