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