SLIDING FEE DETERMINATION WORKSHEET

Client Name: _____ **Client Date of Birth:** _____

care resource
Your Community's Source for Healthcare

FAMILY SIZE INFORMATION

List All Family Member Names and Relationships: A family is a group of two or more persons related by birth, marriage, domestic partnership, or adoption who live together; all such related persons are considered as members of one family.

Family Size	*Name of family member*	*Relationship (i.e. spouse, child, etc..)*
1		Self
2		
3		
4		
5		
6		

GROSS INCOME INFORMATION

Income includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

Income Source: ☐ **Weekly** ☐ **Bi-Weekly** ☐ **Monthly** ☐ **Annually**			
Gross Wages 1:		Unemployment:	
Gross Wages 2:		Third Party Support:	
Gross Wages 3:		Self Declaration:	
Alimony:		Shelter Letter:	
Child Support:		Retirement:	
Disability:		Other:	
Rental Income:		Other:	
		Total Gross Income:	

CERTIFICATION

By my initials and signature and after reviewing my income with Care Resource registration staff, I agree to the fee established utilizing the Sliding Fee Discount Program (SFDS) for each service received as a patient of the Health Center.

Please initial each line acknowledging the following statements *(if applicable)*:
_____I agree that payment is due at the point of service.
_____I certify family size and income information provided above is true and accurate.
_____I agree to notify Care Resource of any changes to my financial status.
_____I have received a copy of this agreement, or; _____ ☐ I refused a copy of this agreement.

By my signature, I agree to the above financial arrangement for my treatment as a patient of Care Resource.

_____ _____ _____
Printed Name Signature Date

ELECTION NOT TO PARTICIPATE

By my signature below and after having the Sliding Fee Discount Program explained by Care Resource registration staff, I elect not to participate in the Sliding Fee Discount Program (SFDS) and understand that no discounts based on income will be available to me.

_____ _____ _____
Printed Name Signature Date

**Note: approved supporting documentation must be attached to this form per policy 3021.009.

Revised 2019.10.31