

Satellite Family Child Care Request for Provider Fee Reduction

Provider Name: _____
(Please Print Name)

I am eligible for a fee reduction because our family's monthly gross income meets the following guidelines:

<u>Family Size</u>	<u>Income</u>	<u>Family Size</u>	<u>Income</u>
<input type="checkbox"/> 1 or 2	less than \$2,158	<input type="checkbox"/> 7	less than \$4,933
<input type="checkbox"/> 3	less than \$2,713	<input type="checkbox"/> 8	less than \$5,488
<input type="checkbox"/> 4	less than \$3,268	<input type="checkbox"/> 9	less than \$6,043
<input type="checkbox"/> 5	less than \$3,823	<input type="checkbox"/> 10	less than \$6,598
<input type="checkbox"/> 6	less than \$4,378		

I agree to pay a reduced fee of \$10 per quarter.

I agree to begin paying Satellite fees when I am no longer eligible for a fee reduction. I also understand that a new fee reduction form will need to be completed annually.

Signature

Date

APPROVED: Y N
CONSULTANT INITIALS: _____