NorthLakes
COMMUNITY CLINIC

OFFICE USE ONLY

Return Application by: _____
Date Application Rec'd: _____
Clinic Location: _____
Services: _____
Staff (initial): _____

SLIDING FEE SCALE APPLICATION

APPLICANT INFORMATION

Last Name:	First Name:		Middle Initial:
Mailing/Street Address:	City:	State:	Zip Code:
Phone #:	Date of Birth:		# in Household:

Insurance: ☐Medicaid (MA/BadgerCare) ☐Medicare ☐None ☐Other- Insurance Name:

HOUSEHOLD INFORMATION

Please list all people in your household, related by blood, marriage or adoption, and financially legally responsible for each other.

Last Name	First Name	Date of Birth	Relationship to Applicant	Also Applying
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

(Please use back of page for more household members) ☐ Check if you added on back

TYPE OF INCOME RECEIVED BY HOUSEHOLD

Source of Income	Applicant	Spouse/Partner	Other	Additional Information:
SALARY/WAGES	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
SELF-EMPLOYMENT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
UNEMPLOYMENT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
SOCIAL SECURITY/DISABILITY	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
PENISION/INVESTMENT	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
ALIMONY/OTHER	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

I hereby certify that the information provided on this application is accurate and I authorize NorthLakes Community Clinic to verify any of the information above.

***(REQUIRED)* Signature of Applicant:** _____ Date: _____

RETURN COMPLETED APPLICATION TO : NORTHLAKES COMMUNITY CLINIC

Please return via mail only in the stamped envelope provided during the COVID-19 Outbreak

OFFICE USE ONLY

Action	Comments	Initial & Date
Verified Household Income		
Verified Number in Household		
Verification Documents Viewed		
Medicaid Eligibility		
Level/Start Date/End Date	A B C D E	