



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 #: _____	DOB: _____	Number of people in your household, including yourself: _____	
Insurance: Medicaid (MA/Badger Care) _____ Medicare _____ Other Insurance (include name) _____			
No Insurance _____			

Household Information

Please list all people in your household, related by blood, marriage or adoption, and financially legally responsible for each other. Eligible household members will be included in your application.

Last Name	First Name	DOB	Relationship to Applicant

Please use back of page for more household members. Check if you added information on the back of this form

Types of Income Received by Household

Please place a check (✓) in the columns below to indicate *all* sources of income:				
Source of Income	Applicant	Spouse/ Partner	Other	Additional Information
Salary/Wages				
Self-Employment				
Unemployment				
Social Security/Disability**				
Pension/Investment				
Alimony/Other				

**Please do not include Veterans Assistance benefits.

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 during the COVID-19 Outbreak, or in person if you have a scheduled appointment

*******For Office Use Only*******

Action	Notes	Staff Name and Date
Verified Household Income		
Verified Number in Household		
List POI Reviewed		
Medicaid Eligibility		
Level/Start Date/End Date	A B C D E	