

NorthLakes COMMUNITY CLINIC

Self-Declaration of No Income

Please complete this form and submit it with your Sliding Fee Scale Application. If you stated no income on the Sliding Fee Scale Application.

Applicant Information

Last Name:	First Name:	Middle Initial:	DOB:
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Are you enrolled in Forward Health? _____ Yes _____ No

If you are enrolled in Forward Health/Medicaid/BadgerCare you may submit a copy of your *Income Declaration Page* with this form.

Budget Information

Your Monthly Expenses	Approximate cost each month	How do you pay for this expense? Please include government assistance programs.
Rent/ Mortgage		
Groceries		
Electricity		
Heating		
Water/ Sewage/ Trash		
Internet		
Cell Phone		
Child Care		

I affirm this information is true to the best of my knowledge and I hereby give NorthLakes Community Clinic permission to verify any of the information above.

Applicant Signature: _____ Date: _____

For assistance with this form, please contact a Patient Financial Advocate at (715) 685-1243.