OFFICE USE ONLY

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

NorthLakes COMMUNITY CLINIC

Sliding Fee Scale Application

Applicant Information

Last Name, First Name, Middle Initial:			
Mailing/Street Address:	City:	State:	Zip Code:
Phone #:	Date of Birth:	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	Date of Birth	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-(Proof of Income required with completed application)

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

**********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**		