NorthLakes
COMMUNITY CLINIC

715-685-1243
www.nlccwi.org

SLIDING FEE SCALE APPLICATION INSTRUCTION SHEET

The Sliding Fee Scale may give you a discount on services at NorthLakes Community Clinic.

- Completed sliding fee scale application and proof of income is required to determine your eligibility for the Sliding Fee Scale Program.
- All information provided will be kept confidential.
- If you have private insurance, your normal co-pays still apply.

STEP 1: Complete Sliding Fee Scale Application

STEP 2: Sign the bottom of the Sliding Fee Scale Application

STEP 3: Submit proof of ALL income for ALL household members over the age of 18. Applications may be denied if not received by the return date on the application.

Accepted documents for proof of income:

- Most current 1040 tax form *(preferred)*
- W-2's (include 1099 tax form if applicable)
- 3 months of most recent **pay stubs**
- Award letters from Social Security or Pensions, Annuities, Trust funds
- Most current 3 months' paycheck stubs
- Most current unemployment statements or check stubs
- DHS Medicaid Enrollment Form

If you cannot provide any of the above, please include:

- Payroll & Earnings Verification Statement (NL-Form 617)
- For Social Security only: Last month's bank statements showing income deposits

If you have no income:

- Self-Declaration of No Income Form (NL-Form 613)

STEP 4: Include your proofs of income with your Sliding Fee Scale Application and mail or drop off at any one of our NorthLakes locations.

Within 30 days, you will receive notice of your Sliding Fee eligibility.

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Sliding Fee Scale

The Sliding Fee Discount Program is a Federal program that allows NorthLakes Community Clinic to discount our normal charges for health care services at our locations.

Are my medications covered under the Sliding Fee Discount Program?

Prescriptions written by our providers for our patients without health insurance that have been approved for the Sliding Fee Discount Program, may be able to receive a subsidy for prescription drugs through NorthLakes Community Clinic's pharmacy.

How do I get an application for the Sliding Fee Discount Program?

Ask for a Sliding Fee Scale packet at the front desk or anytime during your appointment.

How is eligibility for the Sliding Fee Discount Program determined?

Eligibility is determined on the household size, annual gross income (net income for self-employment) for the household, completed application, and proof of income.

Who is considered "household member"?

Household members are related by blood, marriage or adoption, and legally financially responsible to each other.

How much will I pay if I am approved for the Sliding Fee Discount Program?

The charge for your visit depends on your income, household size, and the type of service you received. When you are approved for the Sliding Fee Discount Program you will receive a letter that details your financial responsibility for services received. Payments are due at the time of service.

2025 Income Guidelines

Household Size	Annual Gross Household Income
1	Up to $31,300
2	Up to $42,300
3	Up to $53,300
4	Up to $64,300
5	Up to $75,300
6	Up to $86,300

For each additional person, add $11,000/year for families at 200% of poverty.

Patient Financial Advocates are available to answer questions or help with filling out the Sliding Fee Scale Application.

Please call 715-685-1243 or Toll Free at 888.834.4551

NorthLakes
COMMUNITY CLINIC

OFFICE USE ONLY

Return Application by: ____________________________
Date Application Rec'd: ____________________________
Clinic Location: __________________________________
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:	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**		