northlakes COMMUNITY CLINIC

**Return Application by:** _____

**Date Application Rec'd:** _____

**Staff (initial):** _____

OFFICE USE ONLY

# SLIDING FEE SCALE APPLICATION

| APPLICANT INFORMATION | | | |
|---|---|---|---|
| Last Name: | First Name: | | Middle Initial: |
| Mailing/Street Address: | City: | State: | Zip Code: |
| Phone #: | Social Security: | | Date of Birth: |
| County you live in: | | | # 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 responsible for each other.)

| Last Name | First Name | Social Security # | 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 | |
| CHILD SUPPORT/ALIMONY | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| SOCIAL SECURITY/DISABILITY | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| PENSIONS/ANNUITIES/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 (SEE SFS FLYER FOR ADDRESSES)

**OFFICE USE ONLY**

| Action | Comments | Initial & Date |
|---|---|---|
| Verified Household Income | | |
| Verified Number in Household | | |
| Verification Documents Viewed | | |
| Medicaid Eligibility | | |
| Level/Start Date/End Date | | |