NorthEast Wisconsin Community Clinic

Sliding Fee Application

Name:	Social Security #:	Date of Birth:
Current Address:		Phone:
City:	State:	Zip Code:

EMPLOYMENT INFORMATION			***Provide Proof of Income***
Current employer:			How long?
Phone:	Rate of Pay:		Frequency of Pay:
How many people are supported by this income (including you)?		How many hours per week do you work?	
SPOUSE/SIGNIFICANT OTHER/OTHER EMPLOYMENT INFORMATION			***Provide Proof of Income***
Current employer:			How long?
Phone:	Rate of Pay:		Frequency of Pay:

LIST ALL HOUSEHOLD MEMBERS

PLEASE INDICATE WHICH MEMBER IS A DEPENDENT **PROVIDE SEPARATE SHEET IF MORE ROOM IS NEEDED**

SFDP Applicant?	Name:	Relationship:	Date of birth:	Annual Income:
Yes/No				
Yes/No				
Yes/No				
Yes/No				
Yes/No				
Yes/No				
Yes/No				
Yes/No				
Yes/No				
Yes/No				

I use services: Medical, Dental, Behavioral Health, Physical Therapy, WIC (Please list all):	
What type of insurance do you have Medicare, Medicaid, Commercial, or Other?	

I swear and affirm under penalty of perjury, that all the information listed dis accurate to the best of my knowledge. I understand my responsibility as a sliding fee participant. Your financial information is not forward to any agency. Your payment is due at the time of visit.

Patient/Parent/Legal Guardian Signature:	Date:

Continued on reverse side

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TYPES OF INCOME ARE AS FOLLOWS	*Provide Proof of Income*
Employed	Check stubs from the 4 weekly or 2 biweekly pay periods preceding the application
Paid Cash	N.E.W. Community Clinic Income Verification Form
Self-Employment	Most recent year tax return with schedule C
Unemployment / Workman's Compensation	Official benefit letter stating amount
Disability/ Social Security	Most recent official benefit letter for current year
Child Support/Alimony	Official letter or court order
Government Assistance	Official benefit letter
Pensions	Official benefit letter
If claimed on someone else's tax return	Most recent year tax return required
Homelessness	Housing Document or Case Manager referral
No Income	Completed N.E.W Community Clinic Hardship waiver

TO BE COMPLETED BY N.E.W. COMMUITY CLINIC FINANCIAL SERVICES REPRESENTIATIVE

Household Size:	Annual Income:	MRN:
Approved By:	Date:	Expiration Date:
Discount Plan A, B, C, D, or Does not Qualify:		

Name:	Enumber

Contact with Questions or Concerns the Health Benefits team

Call: (920) 863-9376

Email: HBS@newcc.health