HIGHLY CONFIDENTIAL

APPLICATION FOR SLIDING FEE SCALE
NORTH HAVEN MEDICAL CLINIC

Date of Request: ______________________________

I hereby request the Treasurer or Town Administrator to make a written determination of my eligibility for the Sliding Fee Scale.

Name: ____
First *Middle* *Last*

Telephone: ____

Address: ____

Date of Birth: ___________________________Occupation: _______________________

Employer & Address: ____

Income: ***PLEASE LIST ALL INCOME FOR HOUSEHOLD***

	TOTAL FOR YEAR
Wages	
Fishing or Self-employment	
Public assistance	
Social Security	
Unemployment Compensation	
Workman's Compensation	
Child Support, Alimony	
Military Family Allotments	
Pensions	
Dividends, interest and rental income	
Other Income	
TOTALS	

Household: ***PLEASE LIST ALL MEMBERS OF THE HOUSEHOLD***

NAME	**RELATIONSHIP**	**DATE OF BIRTH**	**SOCIAL SECURITY**

Has anyone in the household applied for Medicaid? ____________Yes ____________No

Is anyone in the household on the Medicaid Program? ____________Yes ____________No

If so, who? ____

Does anyone have any other insurance? If so, what? __________________________________

Under penalties of perjury, I agree that the information provided on this application is accurate to the best of my knowledge and understand that misrepresentation is a violation of clinic policies. I understand that if the information which I submit is determined to be false I will be liable for all clinic charges at current, unadjusted rates. I agree to notify the Town Treasurer immediately of any change in my income.

Date: ____________________________________Signed: _____________________________________

Office use only:

Date Received: _______________________________________

Authorized by: ____ *Date:* _________________________