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REQUIRED Information About Your Household Income

Because we are a federally-qualified community health center, we are required to report data about the basic financial information of our patients. Please fill out this form to the best of your ability. If you have any questions, please ask someone at the front desk.

Patient Name _____ **Date of Birth** _____ **Phone Number** _____ **Person has income?**
 Yes No

Please list all the people in your household, related by blood, marriage or adoption, and financially responsible for each other. If you have more than you can fit here, there are additional spaces on the back.

Name	Date of Birth	Relationship to Patient	Person has income?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

More spaces available on back →

Total Annual Household Income

Please estimate your gross income (before anything is deducted). Include any wages, child support, alimony, disability, social security, retirement, unemployment etc.

\$0-14,000 \$14,000-18,000 \$18,000-21,000 \$21,000-25,000 \$25,000-29,000 \$29,000 +

OPTIONAL Sliding Fee Scale

The Sliding Fee Scale is based on your ability to pay and can be applied to your bill at The Lakes Community Health Center. Copays cannot be adjusted. Please ask if you'd like more information about the Sliding Fee Scale.

- NO THANKS. I do not want to apply for the sliding fee scale.**
- YES! I do want to apply for the sliding fee scale.**

IF YOU CHECKED YES, PLEASE NOTE:

- You will need to provide proof of income for the previous 3 months (wages, child support, alimony, social security, disability, retirement, unemployment etc.)
- If you do not have income, you need to provide proof of no income.
- The sliding fee scale does not apply until we receive proof of income and your application is approved.
- You have 2 weeks from the date of your appointment at The Lakes to provide proof of income.

ACTION	COMMENT	INITIALS
Verified Household Income		
Verified Number in Household		
Verification Documents Viewed		
Date of Verification		
Date Application Expires		

OFFICE USE ONLY

Additional Household Members

Name	Date of Birth	Relationship to Patient	Person has income?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No