



Sliding Fee Scale Discount Application For CY 2026

Note: Your answers will be kept on file and in strict confidence. You must verify your income at least every year. Copies of following documentation is required: Most recent income tax return, W-2 forms, prior month's paycheck stubs, social security benefit letter, proof of child support or alimony, and any other income verification with in the last 30 days of household member.

First name:	Middle:	Last:	Other names:
Address:	City:	State:	Zip:
Phone #:		Social Security#: Optional	
Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed (optional)		
Have you applied for medical assistance before?			

Household Members	Name	Date of Birth	Social Security # (Optional)	Relationship	Health insurance?	Patient at Clinics?	
Income	Monthly/Annual Income	For YOU	For SPOUSE	For Children	For Other	Subtotal	
	Household Member is unemployed						
	Gross wages, salaries and tips						
	Social security and pensions						
	Child support & alimony						
	Self-employment & other						
	Total						

- Verification of income is mandatory. By signing below, I agree that NRMC Clinics may contact each employer of all persons working in the above mentioned household and/or may contact various agencies to verify any source of income. Within 30 days, I will provide NRMC with a copy of all requested information, as listed, for all persons in the above mentioned household.
- I will be asked to reapply for the SFS at least once a year so NRMC can maintain an updated SFS application on file. I am obligated to inform NRMC of any change in household size, income, and/or insurance. I am also obligated to provide NRMC with any income information that is requested. Applications lacking required information will be denied without notice after 30 days.
- I understand that I am responsible for making payments prior to the visit if I am approved for the Sliding Fee Scale Program. If at any time I am not able to make a payment, I will be required to make a different appointment and will not be seen.
- I verify that all information provided on this form is true and correct. Fraudulent self-reporting on any portion of this application may jeopardize your status at NRMC Clinics.

Signature: _____ Date: _____

Printed Name: _____