HARRINGTON FAMILY HEALTH CENTER
50 East Main St.
Harrington Me 04643
TEL: 483-4502 ~ FAX: 483-2750

SLIDING FEE APPLICATION DATE:_____

PROOF OF INCOME MUST ACCOMPANY THIS APPICATION

Please attach a proof of all income for everyone in your household. In the event that you are unemployed and someone else is providing food and shelter, we require a letter stating responsibility for you.

Income includes but is not limited to wages, business income, dividends, social security, annuities, retirement funds, disability compensation, SSI, SSDI, worker's compensation, alimony, child support, and foster care payments.

NAME:_____

MAILING ADDRESS:_____

TELEPHONE NUMBER:_____

ALTERNATE CONTACT:_____

SOCIAL SECURTIY NUMBER:_____

***PLEASE LIST ALL NAMES AND DATES OF BIRTH FOR ALL DEPENDENTS, INCLUDING YOURSELF.**

NAME:	**DATE OF BIRTH:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pending your eligibility and documentation received for the sliding scale application, the discounted rate may apply towards past balances, up to 3 months prior.

By signing below, you agree and testify that all of the information provided, is true and accurate, to the best of your knowledge. You also agree to notify Harrington Family Health Center, within a timely manner, of any changes in household size and/or income so we can best serve you.

Signature: _____ **Date:** _____

Application Reviewed By:_____ **Date:**_____

Level of Slide Approved:_____ **Slide Dates:**_____

Finalized By:_____ **Date:**_____