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

DATE:_____

SLIDING FEE APPLICATION

PROOF OF INCOME MUST ACCOMPANY THIS APPICATION

Please attach your most recent tax return, W-2, Social Security statement or a months' worth of paystubs, as 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:_____

ADDRESS:_____City, State:_____Zip:_____

TELEPHONE NUMBER:_____

ALTERNATE CONTACT:_____

SOCIAL SECURTIY NUMBER:_____

***PLEASE LIST NAME AND DATE OF BIRTH FOR ALL MEMBERS OF YOUR HOUSEHOLD 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:_____**

Revised 4/27/2023