

Harrington Family Health Center

50 East Main Street
Harrington, ME 04643
Tel: 483-4502 ~ Fax 483-4778

SLIDING FEE APPLICATION

DATE: _____

Proof of income must accompany this application.

Please attach a copy of your current 1040 Tax return to this application and return.

If you are unemployed with no income, please provide a statement from the person(s) who provides you with food and shelter on your application. They will be considered as an applicant and we will need proof of income from that person(s). If only you are applying, please do not list them on the application.

Name _____

Mailing Address _____

Telephone Number _____

Contact Number _____

Social Security Number _____

PLEASE list the Names and Date of Birth for all dependants, including yourself:

NAME

DATE OF BIRTH

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Use reverse side for additional Name and Dates of Birth)

OFFICE USE ONLY:

Approved by: _____ Date: _____

Office Manager

An Equal Opportunity Employer & Provider