



70 Main Street, Porter, Maine  
 P. O. Box 777, Parsonsfield, ME 04047  
 Telephone: (207) 625-8126  
 (TTY: 1-800-437-1220)  
[www.svhc.org](http://www.svhc.org)

<b>Office Use Only</b>	Code _____
	Date given to applicant: _____
	Date received: _____
	Date letter sent requesting further documentation: _____
	Effective date: _____
	Expiration date: _____
	Total income: _____

## Sliding Fee Program Application

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
PO Box or Street                      Town                      State                      Zip Code

**Town of residence if different than mailing address:** \_\_\_\_\_

Have you been enrolled in the Sliding Fee Program before?     Yes     No

### HOUSEHOLD INFORMATION

Please list ALL MEMBERS of your household (include yourself). Include those who contribute to the household income and all persons for whom you are financially responsible or those you can claim on your taxes. **If child is over 18, indicate if student.**

Name	Birth Date	Social Security Number	Relationship to Applicant
			self

- I have no health insurance coverage.  
 I have health insurance coverage through \_\_\_\_\_.  
 If you have insurance, we will bill your insurance first and then apply the discount to any balances due.

Please fill out the income information section on the next page for ALL members of family. If you have no source of income, please go to zero income section on next page.

## INCOME INFORMATION

Sources of Income	Name of Source	Gross Annual Income
Wages		
Self-employed (net receipts after deductions)**		
Social Security Benefits (SSI, Survivor's, Disability)		
Child Support/Alimony		
Unemployment Benefits, Workers' Compensation		
Stocks, Dividends, Rental Property		
Interest Income		
Other (Pensions, Veteran's Benefits, etc.)		

**\*\*If you are self-employed, you must fill out a self-employment form. In addition, you must submit a copy of your most recent Federal Income Tax Return.**

**YOU MUST INCLUDE PROOF OF INCOME SUCH AS PAYCHECK STUBS, COPIES OF UNEMPLOYMENT CHECKS AND/OR SOCIAL SECURITY CHECKS.**

Without proof of income your application will not be processed and your enrollment into the program will be delayed. If you have difficulty getting proof of income, speak to the Health Center's Social Services Coordinator. If there are special issues you feel should be considered when we review your application, please include on a separate piece of paper.

## ZERO INCOME

**PLEASE FILL OUT ONLY IF YOU HAVE NO SOURCE OF INCOME**

Name of last employer: \_\_\_\_\_ Date of last employment: \_\_\_\_\_

Please explain how your basic needs have been met:

Food: \_\_\_\_\_ Utilities: \_\_\_\_\_

Shelter: \_\_\_\_\_ Non-food items (clothing, etc.): \_\_\_\_\_

I, \_\_\_\_\_, certify that I have had no source of income since \_\_\_\_\_.

**All Applicants: PLEASE READ THE FOLLOWING STATEMENT AND SIGN BELOW.**

- I agree to be responsible for my Health Center bills.
- I also agree to tell the Health Center if I become eligible for any other form of coverage.
- I understand that if I provide false or incomplete information, I may no longer qualify for a fee discount.
- I certify that the information I have given on this application is complete and true.

**Signature** \_\_\_\_\_ Date: \_\_\_\_\_

*Help is available for referral to financial assistance outside of the Health Center.  
Please call our Social Services Coordinator at (207) 625-8126.*