SACOPEE VALLEY
HEALTH CENTER
70 Main Street, Porter ME 04068
Phone (207) 625-8126 ● *Fax* (207) 625-7820 ● (TTY: 1-800-437-1220)
www.svhc.org

Code: _____

Date Received: _____

Effective Date: _____

Expiration Date: _____

Total Income: _____

Applicant Information

Names	**DOB**
Mailing Address	**City/State/Zip**
Marital Status	**Employer**
Home Phone	**Cell Phone**

Spouse/Co-Applicant (Married, Legal Parent, or Registered Partner)

Names	**DOB**
Mailing Address	**City/State/Zip**
Marital Status	**Employer**

Tax Dependents Under the Age of 18 (Dependents who are above the age of 18 must fill out separate application)

Name	DOB	Relationship

Sources of income and proof of income:
Check all that apply for you, your spouse and other dependents and **include proof of income** which includes one month's worth of most recent paycheck stubs, social security award letter, unemployment checks, pension, etc. with application.

If you are self-employed and/or receive rental income please complete a self-employment form. Tax returns are not required but are helpful if provided.
We discourage giving bank statements as documentation of income proof.

☐ **Wages -When did you start this job? _____**
Is it seasonal? ☐Yes ☐No
If yes, how many months? _____

☐ **Social Security** ☐ **Unemployment**

☐ **Worker's Comp** ☐ **Disability** ☐ **Alimony**

☐ **Child Support** ☐ **Pensions** ☐ **Rental Income**

☐ **Other _____**

☐ **No Income:** Please provide a written statement, or have the person providing you with support describe how you meet basic needs like food, shelter.

I agree to be responsible for my Health Center bills. I also agree to let the Health Center know of any changes in income or family size. 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: _____

Sacopee Valley Health Center is an Equal Opportunity Provider and Employer Organization. 1/9/18