



NORTHEAST MISSOURI
HEALTH COUNCIL
"Partners for a *Lifetime* of health"

Northeast Missouri Health Council
1416 Crown Drive
P.O. Box 1027
Kirksville, MO 63501
Phone: 660-627-5757

Fax: 660-627-6285 (Billing Office)
Fax: 660-627-5802 (Administrative Office)

LETTER OF PROOF OF UNEMPLOYMENT FOR SLIDING FEE SCALE APPLICANT

I have known _____
Print full name of applicant

for approximately _____
Period of time you have known the applicant

I am confirming to my knowledge this person is currently not employed.

I am neither related to this applicant or live in the same residence.

Please print full name of person confirming unemployment of applicant.

Signature of person confirming unemployment of applicant:

Date signed ____/____/____

Two letters must be returned with Sliding Fee Scale application.



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