Islands Community Medical Services, Inc.

15 Medical Center Loop, Vinalhaven, Maine 04863

Telephone: (207) 863-4341 Fax: (207) 863-2737

SLIDING FEE APPLICATION

Patient Name:____

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For Office Use Only:

Income:______________________

SF Scale:_____________________

Date Processed:_______________

Initial:___________

Date Scanned:_________________

Initial:___________

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<u>Application Guidelines:</u>

- You must complete all information on this application.
- Be sure to include all income for the household.
- Please sign and date the application.
- PROOF of income must accompany this application in order for it to be processed. This includes a current tax return. If you did not file a tax return, we will require four pay stubs, unemployment information, or Social Security income.
- If you qualify for the sliding fee, payment is expected at the time of service.

Please return this application with the proper forms to the address above. Thank you.

WE CANNOT PROCESS YOUR APPLICATION WITHOUT INCOME VERIFICATION

Thank you for applying for the Sliding Fee Scale. If you have any questions, please call Leslie Dyer or Dinah Moyer at (207) 863-4341.

May 29, 2019

Islands Community Medical Services, Inc.

Application for Sliding Fee Scale

Date of Request:________________________________

I hereby request that ICMS make a written determination of my eligibility for Sliding Fee Scale.

Name:____

(First) (Middle Initial) (Last)

Telephone Number:____

Address:____

City:____ **Zip Code:**__________________________

Are you a U.S. Citizen? (Circle One) Yes / No

Social Security Number:________________________________ **Date of Birth:**______________________

Occupation:____

Employer Name and Address:____

____

Income: List ALL Income for the Household		
	Total for 3 Months	**Total for Year**
Wages	$	$
Fishing or Self-Employment	$	$
Public Assistance	$	$
Social Security	$	$
Unemployment Compensation	$	$
Workman's Compensation	$	$
Child Support, Alimony	$	$
Military Family Allotments	$	$
Pensions	$	$
Dividends, Interest, or Rent (Income)	$	$
Other	$	$

Household Size:________________________________

List All Household Members			
Name	**Relationship**	**Date of Birth**	**Social Security Number**

*If more than 1 household member, scan application into all family member charts.

Has anyone in the household applied for Medicaid (MaineCare)? Yes / No

Is anyone in the household on the Medicaid (MaineCare) program? Yes / No

If so, who?:____

Does anyone in the household have any other health insurance? Yes / No

If so, what?:____

I am requesting assistance with my bills 30 days prior to the application date: Yes / No

Under penalties of perjury, I agree that the information provided on this application is accurate to the best of me knowledge and understand that misrepresentation is a clear violation of ICMS policies. I understand that if the information, which I submit, is determined to be false, I will be liable for all charges for services provided. I agree to pay at the time of service. I also agree to immediately notify ICMS of any change in my income.

Signature:____

Printed Name:____ **Date:**_________________

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OFFICE USE ONLY

Date Received:_____/_____/_____ **MaineCare Application (sent)**_________________

Authorized By:____ **Date:**_________________