Islands Community Medical Services, Inc.
15 Medical Center Loop, Vinalhaven, ME 04863
Phone: (207) 863-4341 Fax: (207) 863-2737

Sliding Fee Program Application

For Office Use Only:
Income: _____
SF Scale: _____
Date Received: _____
Initial: _____

Patient Name: _____

Sliding Fee Program Application Guidelines:

- Please be sure to fill in all the information on this application
- Please be sure to sign and date the completed application
- **PROOF OF INCOME MUST ACCOMPANY THIS APPLICATION**
  - Accepted forms of income verification include: current year's taxes by filing deadline, four most recent weeks of paystubs, unemployment payment documentation, and social security award letter.
  - Income receipts can be paychecks, check stubs, notice of electronic transfer, and ledgers from employers or letters from employers with proper documentation regarding employment.
  - If you have been currently laid off or your job has been terminated since your last tax return proof from your previous employer stating your last day of employment must be attached.
  - If you are self-employed your Schedule C or Schedule F must be attached.

WE CANNOT PROCESS YOUR APPLICATION WITH INCOME VERIFICATION

If you qualify for the Sliding Fee Program, payment is required as time of service unless otherwise specified.

If you have any questions or concerns please call Annie Debow at (207) 863-4341 x1122.

Islands Community Medical Services, Inc.
Sliding Fee Program Application

I, hereby, request Islands Community Medical Services make a written determination of my eligibility for the Sliding Fee Program.

Date of request: _____
Are you requesting assistance with your bills 30 days prior to application date? ☐ YES ☐ NO

Full Name: _____ _____ _____
First Name M.I. Last Name

Date of Birth: _____ Social Security Number: _____

Are you a U.S. Citizen: ☐ YES ☐ NO

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Address:

_____

_____

City: _____ State: _____ Zip Code: _____

Employment Information:

Current Employer: _____ Occupation: _____

Employer Address: _____

_____

Household Information: Please list all members of your household.
Household is defined as:

- Unmarried couples living under the same roof and sharing financial responsibilities
- Anyone who is not contributing 50% or more to the household income is being support by another person is viewed as a dependent and the supporting person's income will be counted as household income
- Anyone who was claimed on the current year's tax return will be considered a member of the household
- A person of age 65 or older, who is not being claimed as a dependent and only receives social security as income, will not be included as a member of the household.

Household Size: _____

Name:	Relationship:	Date of Birth:

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Name:	Relationship:	Date of Birth:

Income Information: Please list the total income for the year for entire household. If you have ZERO income a no income form must be completed and attached with your application.

Type of Income	Total of 4 Most Recent Weeks	Total for Year
Wages		
Fishing or Self Employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Child Support or Alimony		
Other:		

Payment of a nominal fee (co-pay) is required at time of service, if this is an extreme financial burden to you, please contact Annie Debow at (207) 863-4341 x1122.

Insurance Coverage Information:

Has anyone in the household applied for Medicaid (Mainecare)? ☐ YES ☐ NO

Has anyone in the household been approved for Medicaid (Mainecare)? ☐ YES ☐ NO
If so, who? _____

Does anyone in the household have any other insurance? ☐ YES ☐ NO
Who: _____ Insurance Company: _____

Under penalties of perjury, I agree that the information provided on this application is accurate to the best of my 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 or household.

_____ _____

Signature **Date**

_____

Name (Print)

FOR OFFICE USE ONLY:

Date Received: _____ **Sliding Fee Program Scale:** ☐ **A** ☐ **B** ☐ **C** ☐ **D**

Authorized by: _____ Date: _____

Mainecare Application Sent? ☐ **YES** ☐ **NO**

COMMENTS OR EXCEPTIONS:

_____

_____

_____

_____

_____