St. Thomas East End Medical Center Corporation
4605 Tutu Park Mall, Suite 207
P.O. Box 503177
St. Thomas, VI 00805-3177

Tel: (340)775-3700
Fax: (340)777-7927

"Your Health is our First Priority"

SLIDING FEE APPLICATION

☐ **First Time Application** ☐ **Renewal**

Application Name:_____ Date:_____

Date of Birth:_____/_____/_____ Social Security Number:_____

Home Phone:_____ Mobile (Cell) Phone:_____

Physical Address: _____ City/State:_____

Mailing Address:_____ City/State:_____

Employer:_____ Address:_____

☐ Annual ☐ Bi- Weekly ☐ Monthly ☐ Daily ☐ Twice Monthly ☐ Weekly Amount: $_____

Child Support $_____ Insurance:_____

Affidavit- *If I provide STEEMCC with proof of my family income and my income is within the Sliding Fee Scale guidelines, fees for services will be reduced. I understand that I will be charged 100% of the cost if I do not provide required documents. I understand that I am not eligible for sliding scale fees if I have MAP.*

Applicant's Signature:_____ Date:_____

☐ Spouse ☐ Significant Other Name: _____

Date of Birth:_____/_____/_____ Social Security Number:_____

☐ Annual ☐ Bi- Weekly ☐ Monthly ☐ Daily ☐ Twice Monthly ☐ Weekly Amount: $_____

Child Support $_____ Insurance:_____

Spouse's Signature:_____ Date:_____

**Four consecutive check stubs for proof of income must be provided to STEEMCC within 30 days from effective date of temporary coverage. Discounts are good for 12 months (1 year) and must be renewed after that period to maintain discount level.*

Additional Household Members: List Family Members

Name	Social Security #	Relationship	Date of Birth	Age of 18 or younger
				☐ Yes ☐ No
				☐ Yes ☐ No
				Insured
				☐ Yes ☐ No
				☐ Yes ☐ No

Please list any special circumstances we need to be aware of:

Official Use Only

☐ Most recent tax form ☐ Self- Employed (schedule C) ☐ Last/ Previous paystubs (4) Gross Income

☐ Benefits check (Unemployment/ Disability/SSI/ Alimony/Child Support) ☐ Self-Declaration Income (None/ Limited Income)

☐ Notarized Letter (Personal Assistance) ☐ No. of children in household Total Household Gross Income $

Application Received By:_____ _____Approved Date From_____/_____To _____/_____

Date Initials

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SELF-DECLARATION OF INCOME
(NOT CURRENTLY EMPLOYED)

I, _____ certify that my total gross income is $_____

☐ Per Week ☐ Month ☐ Year Household/ Family Size: _____
(Household= Applicant = Spouse/ Significant Other = Legal Tax Dep)

I am currently:

☐ Unemployed- Seeking employment ☐ Unemployed- Appling for disability
☐ Disabled- Receiving disability income ☐ Retired
☐ Other: _____

I certify that all statements made herein are true and correct and subject to verification. I also authorize the release of employment records and other financial information from the sliding scale application to an agent of St. Thomas East End Medical Center Corporation for sliding fee determine purposes.

Instructions: If you have NO or limited income and are receiving assistance from friends/ family, the following must be completed, signed and dated by your benefactors.

STATEMENT OF PERSONAL ASSISTANCE

I, _____, assist _____ (patient) by providing basic living needs listed below:

Shelter: ☐ Yes ☐ No Food: ☐ Yes ☐ No Money: ☐ Yes ☐ No Amount: $_____
Relationship to Applicant:_____ Date: _____

Name (Please Print): _____

Address:

Home Phone_____ Mobile (cell) phone:_____

Signature:_____ Date:_____

Please list any special circumstances:

NOTARY OF PUBLIC

Subscribed and sworn before me this _____ day of _____, 20_____ in St. Thomas, US Virgin Islands.

_____
Notary Public