Attachment A

Application for Financial Hardship

Date of Request: _____/_____/_____ Social Security#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Patient Name: ____________________________________ Contact Phone:_____________________________

Street Address: ____

City: ___________________________State: ______________ Zip Code: ___________________

Date of Birth: _____/_____/_____ Contact Email: ____

PROOF OF INCOME MUST BE PROVIDED WITH YOUR COMPLETED APPLICATION. A copy of your most recent W-2(s) is (are) preferred. ALL household income must be reported, including but not limited to; work income, unemployment, food stamps, welfare assistance, rental income, business income, alimony, child support, interest or dividends, social security, disability, pension and or retirement benefits.

How many people reside in household? Adults: _________ Dependent children you legally claim on Taxes: __________

Patient Annual Gross Income: $ _____________________ Spouse Annual Gross Income: $ _____________________

Other Annual Gross Income: $ _____________________ **TOTAL** Annual Gross Income: $ [ ]

I, __________________________________ am requesting financial assistance with my bill for medically necessary pre-hospital emergency care rendered on _______________________ (date or dates) in the amount of $_______________.

I understand that this application is made so Cole County Emergency Medical Services (CCEMS) can determine my eligibility for uncompensated services based on the financial information provided with this application. I have no other insurance or assistance to file a claim on the balance due. If any information I have given proves to be untrue, I understand that Cole County may re-evaluate my financial status and take whatever action is deemed appropriate.

I certify that all the information given is true and accurate. Further, I will make application for any assistance, including Medicare, Medicaid, etc., which may be available for payment of my ambulance service charges. I will assign insurance benefits to CCEMS and pay CCEMS any amount recovered toward the ambulance bill. I understand the information submitted is subject to verification by CCEMS and subject to review by other agencies as required for verification purposes.

____ ____

Patient signature or authorized representative Print name & relationship to patient