**AREA AMBULANCE SERVICE**
2730 12th Street SW
Cedar Rapids, IA 52404
Telephone: (800) 291-2606

www.area-ambulance.org

## Financial Assistance Program Application Process

Area Ambulance Service is a not-for-profit organization that provides both emergency and non-emergency transportation. As part of our commitment to provide chartable services to patients in our community, a Financial Assistance Program has been developed. This program provides discounts on transportation charges for patients that meet pre-determined household income and family size requirements. Discounts range from 10 to 100 percent based on applicant eligibility. If you are under 21 years of age and a full time student, this application needs to be completed by your family. Please note that the application is a two sided document.

The following documentation should be included with your application:

- Bank statements for the past 2 months
- Pay stubs for the last 3 pay periods
- W-2 forms for the most recent tax year
- Federal tax forms for the most recent year if filed
- Self-employed applicants should submit tax forms for the past 3 yrs
- Pension benefits
- Unemployment benefits
- Social Security or Social Security Disability benefits
- Please provide a letter if none of the above apply indicating how you support yourself if you have special circumstances and/or cannot complete the application in its entirety

Please return your completed application along with the required documentation in the enclosed envelope. For assistance with your questions, please contact our Customer Service Department at 1-800-291-2606.

# Area Ambulance Financial Assistance Program Application

| Patient Information | | | | |
|---|---|---|---|---|
| Patient Name | Social Security # | Birth Date | Age | Marital Status |
| | | | | |
| Patient Address (Street, City, State and Zip code) | | | | |
| | | | | |
| Responsible Party's Name | Social Security # | Birth Date | Relationship to Patient | |
| | | | | |
| Dependent Name(s) | Age(s) | Dependent Name(s) | Age(s) | |
| | | | | |
| | | | | |
| | | | | |

| **Patient's Employer Information** | | **Spouse's/Responsible Party's Employer Info.** | |
|---|---|---|---|
| Name: | | Name: | |
| Street: | | Street: | |
| City, State, Zip: | | City, State, Zip: | |
| Job Title: | | Job Title: | |
| # of Years Worked: | | # of Years Worked: | |
| Work Phone #: | | Work Phone #: | |

| Income | | |
|---|---|---|
| **Income Source - Employment** | **Hours Worked per Week** | **Hourly Wage or Salary** |
| Patient | | $ |
| Spouse/Responsible Party | | $ |
| **Income Source - Other** | **Gross Monthly Income** | |
| Patient | $ | |
| Spouse/Responsible Party | $ | |
| Working Children | $ | |
| Social Security | $ | |
| Pension(s) | $ | |
| Child Support | $ | |
| SSI/SSDI | $ | |
| Unemployment | $ | |
| Other Income (commissions, tips, rental property, farm or interest income) | $ | |
| **Total Monthly Gross Income** ➡ | $ | |
| **Annual Gross Income** (multiply Total Monthly Gross income by 12) ➡ | $ | |

I certify that my annual gross household income for last year was $______________ and that there are __________ people in my family.

| Banking Information | | | |
|---|---|---|---|
| **Name of Bank** | **Type of Account** | | **Acct Balance** |
| | ☐ Checking | ☐ Savings | $ |
| | ☐ Checking | ☐ Savings | $ |
| | ☐ Checking | ☐ Savings | $ |

## Area Ambulance Financial Assistance Program Application (pg2)

| Property Owned | | | |
|---|---|---|---|
| | Yes/No | Property Location | Approx Value $ |
| Home | | | $ |
| Rental Property | | | $ |
| Farm Land | | | $ |
| Other | | | $ |
| | Yes/No | Make/Model/Year | Approx Value $ |
| Vehicle #1 | | | $ |
| Vehicle #2 | | | $ |
| **Total Approx Value of Property Owned** | | ➡ | $ |

| Expenses | | | |
|---|---|---|---|
| | Monthly Payment | Payment Made To | Total Amount Due |
| Rent/Mortgage | $ | | $ |
| | $ | | $ |
| Car Loans | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| Hospital Bills | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| Doctor bills | $ | | $ |
| Health Insurance | $ | | $ |
| Medications | $ | | $ |
| Gas/Electric | $ | | $ |
| Telephone/Cell | $ | | $ |
| Cable/Satellite | $ | | $ |
| Groceries | $ | | $ |
| Credit Card | $ | | $ |
| **Total Monthly Expenses** | $ | **Total Amount Due** ➡ | $ |

| Have you applied for Medicaid and/or any other state/county assistance? ________Yes ________No | |
|---|---|
| Application Date | Program(s) Applied For: |
| | |
| | |
| | |

I acknowledge indebtedness to Area Ambulance Service for services received and billed to me. I have applied for Medicaid and/or any other third party benefits for which I am eligible. All Medicare, Medicaid, or insurance benefits due to me have been applied to this account(s). I am financially unable to pay the balance due and request financial assistance for the outstanding balance(s). I certify that the information submitted is true and accurate.

Patient or Responsible Party Signature:________________________________________ Date:___________

IMPORTANT: Income Verification must be submitted with Financial Assistance Program Application. These items include: Pay Stubs, W-2 Form, Social Security Information, Tax Forms, and Bank Statements.