Advanced Medical Transport

1718 N Sterling Ave

Peoria, IL 61604-3831

(309) 494-6203 or (855) 268-2455 (855-AMT-BILL)

http://www.amtci.org/

Financial Assistance Program Application Process

Advanced Medical Transport 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.

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 (if you are receiving or have received within the year reported)
- 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 to the address listed above. For assistance with your questions, please contact our Customer Service Department at ***(309) 494-6203 or (855) 268-2455 (855-AMT-BILL)***

Advanced Medical Transport 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	$

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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.