Patient Request for Financial Hardship Determination

Instructions to Patient:

Please complete this form in its entirety and return to:

Adair County Ambulance District
606 W Potter Ave
Kirksville, MO 63501

Patient Name ______________________________
Address ______________________________
City, State, Zip ______________________________
Date of Service ______________________________
Run Number ______________________________
Balance Owed ______________________________

Responsible party (If different than patient):______________________________
Address of Responsible Party: ______________________________
City/State/Zip of Responsible Party: ______________________________

I am applying for a Hardship Determination in order that you will consider waiving my co-pay/co-insurance/deductible (or total charges if uninsured) for services and care provided to me on _________________________ (Date of Service).

I am supplying the following information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources, including Social Security Benefits, pensions, annuities, dividends, etc. Attached you will find verification of my employment/unemployment status (current paycheck stub, etc) and copies of my federal tax returns for the previous two (2) years**If you have not filed a tax return in the last two years and/or do not have proof of income please attach a letter stating your current situation.**

My insurance information is:
Insurer Name: ______________________________

Insurance Policy/ID Numbers: ______________________________

Contact Phone Number: ______________________________

Monthly Income:	**Self:**		**Spouse:**	
Wage/salary	$____________		$____________	
Social Security	$____________		$____________	
Pension	$____________		$____________	
Interest Income	$____________		$____________	
Other	$____________		$____________	
Totals:	$ ____________	+	$ ____________	= $ ____________

Size of Household (Please include yourself) ____________________

Statement of Agreement: "I am supplying this information to request that Adair County Ambulance District waive collection of all or part of the Medicare or other deductible/co-insurance amounts, in my case, due to financial hardship. I also understand that Adair County Ambulance District can and will begin to attempt to collect charges should my financial situation improve. I agree to be responsible for any balance remaining after the application of any waiver by Adair County Ambulance District, if any."

Patient Signature: ______________________________ Date: __________________

Adair County Ambulance District
606 W Potter Ave
Kirksville, MO 63501
Phone 660.665.0000 Fax 660.665.6311 Email billing@academs.us