HVA·JCA·MCA·LCA·ACA·LIFECARE AMBULANCE

Ambulance Service
Financial Assistance Application

Patient (Parent if minor) Name ______________________________ Social Security #____________________
Spouse Name ______________________________ Social Security #____________________
Address ______________________________ Phone # ____________________

☐ Yes	☐ No	Are you a resident of Michigan?
☐ Yes	☐ No	Are you a college student?
☐ Yes	☐ No	Do you have health insurance? Policy number ____________________
☐ Yes	☐ No	Are you the policyholder? If not who is? ____________________
☐ Yes	☐ No	Are you a Medicaid recipient?
☐ Yes	☐ No	Have you applied for Medicaid?

Please explain reason why you are requesting assistance: ____
____

Income Information

Monthly family income at time of service: Number of people in family ____________

Patient or parent monthly wage:	$__________	Spouse monthly wage:	$__________
Monthly pension:	$__________	Monthly social security:	$__________
Monthly unemployment:	$__________	Monthly workers comp:	$__________
Monthly alimony/child support:	$__________	Monthly interest income:	$__________
Monthly dividend income:	$__________	Other public assistance:	$__________

Total Monthly Income $____________________

The following documents MUST be included, or reason why they are not included MUST be reported on this form.

Copy of most recently filed Federal income tax return**
And
Copy of most recent paycheck stub.
Or
Copy of Social Security/pension check stub.

Return completed application to:
Emergent Health Partners
1200 State Circle
Ann Arbor, MI 48108-1691

****STUDENTS: if your parents claim you on their tax return, please include a copy of their financial information instead.**

FAILURE TO PROVIDE THE ABOVE DOCUMENTATION WILL RESULT IN YOUR APPLICATION BEING DENIED.

I certify that the information on this application is complete, true, and correct.

Signature ____ Date ____________________

Office Use Only

Patient Account #____________________ Call(s) # ______________________________

Approved __________ W/O Dollar Amount $ __________ Amt Pt Responsible $ __________
(Initial)
Denied __________ Reviewed by: ______________________________
(Initial) (Signature)

EMERGENT HEALTH PARTNERS