

Ambulance Service Financial Assistance Application

Spouse Name						
Address				Phone #		
П	Yes 🛛	No	Are vou a resid	ent of Michigan?		
	I Yes I No Are you a college student?					
	Yes 🛛	No	Do you have health insurance? Policy number			
		No Are you the policyholder? If not who is?				
		No	Are you a Medi			
	Yes 🛛	No	Have you applie	ed for Medicaid?		
Please explain reaso	n why you are re	questing ass	sistance:			
			Income Info	ormation		
Monthly family incom	ne at time of serv	vice: Num	ber of people in fam	nily		
Patient or pa	arent monthly wa	age:	\$	Spouse monthly wage	: \$	
Monthly per	ision:	-	\$	Monthly social securit	y: \$	
	employment:		\$	Monthly workers com	p: \$	
	nony/child suppo	ort:	\$	Monthly interest incon		
Monthly div	idend income:		\$	Other public assistanc	e: \$	
	т	otal Monthly	Income ¢			
		otal Monthly				
Coj	ng documents M	IUST be incl y filed Federa <i>nd</i> paycheck stub r	uded, or reason wh Il income tax return** b.	y they are not included MUST be Return completed applic Emergent Health Partne 1200 State Circle Ann Arbor, MI 48108-16	cation to: rs	
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