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

Members of EMERGENT HEALTH PARTNERS

Ambulance Service Financial Assistance Application

Emergent Health Partners
1200 State Circle
Ann Arbor, MI 48108
1-800-507-7847

Date: _____

Phone Number: _____

Patient Information

Patient Name:_____ Social Security #_____
Or parent/legal guardian, if patient is a minor

Spouse Name:_____ Social Security #_____

Address: _____

Are you a Michigan resident? ☐ Yes ☐ No
Are you a college student? ☐ Yes ☐ No
Do you have health insurance? ☐ Yes ☐ No
If yes, policy number:_____
Are you the policyholder? ☐ Yes ☐ No
If not, who is?:_____
Are you a Medicaid recipient? ☐ Yes ☐ No
Have you applied for Medicaid? ☐ Yes ☐ No

Please explain why you are requesting financial assistance: _____

_____

Income Information

Number of people in household: _____
Household is defined by who is included on a single tax return.

Monthly Family Income at Time of Medical Service

Monthly Income Source	Patient/Parent/Legal Guardian	Spouse
Employment	$_____	$_____
Pension	$_____	$_____
Unemployment	$_____	$_____
Alimony/Child Support	$_____	$_____
Dividends	$_____	$_____
Social Security	$_____	$_____
Workers Comp	$_____	$_____
Interest Income	$_____	$_____
Public Assistance	$_____	$_____
Total Monthly Family Income	$_____	

Required Documentation

You must include the following documents in your application, or give a reason why they are not included.

- If you are married, include the documentation for yourself **and** your spouse.
- If you are a student, and your parents claim you on their tax return, include documents for your parents instead.
- Indicate if you have attached the document, or give a reason why it was not included in the table below.

Required Documentation

Documentation	Patient/Parent/Legal Guardian	Spouse
Copy of most recently filed tax return		
Copy of most recent paycheck stub or Social Security/pension check stub.		
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: _____

Submit the completed application and documentation by email or mail to:

Email: billinginfo@emergenthealth.org

Mail:
Emergent Health Partners
1200 State Circle
Ann Arbor, MI 48108

This application will be used by Emergent Health staff to determine eligibility for resolving your financial obligation. All information in the application will be kept confidential.

Office Use Only

Patient Account #:_____ Call(s) #:_____

Approved *(Initial)* _____ W/O Dollar Amount $ _____ Amt Pt Responsible $ _____

Denied *(Initial)* _____ Reviewed by: _____
(Signature)

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