CALLAWAY COUNTY AMBULANCE DISRICT
PO BOX 246
FULTON, MO 65251

FINANCIAL HARDSHIP REQUEST FORM

PRINT PATIENT'S FULL NAME			
PATIENT'S SOCIAL SECURITY NO.			
PRINT PATIENT'S DATE OF BIRTH		PATIENT'S PHONE NO.	
PRINT STREET ADDRESS			
PRINT CITY - STATE - ZIP			

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 service and care provided to me.

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 and copies of my federal tax returns or W-2 forms for the previous 2 years.

I WOULD LIKE TO HAVE YOU CONSIDER WAIVING MY ☐ CO-INS ☐ CO-PAY ☐ DED ☐ TOTAL BILL

MY INSURANCE CO IS _____

MONTHLY INCOME	SELF	SPOUSE		
WAGE/SALARY				
SOCIAL SECURITY				
PENSION				
INTEREST INCOME				
OTHER INCOME				
TOTALS			=	
TOTAL SIZE OF HOUSEHOLD				

I CERTIFY THE INFORMATION CONTAINED IN THIS APPLICATION FOR CONSIDERATION OF FINANCIAL HARDSHIP IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND AND AGREE THAT PROVIDING FALSE OR INACCURATE INFORMATION MAY RESULT IN MY APPLICATION FOR CONSIDERATION OF FINANCIAL HARDSHIP BEING DENIED.

PATIENT SIGNATURE _____ DATE _____

For Office Use Only

Application Approved ☐ Application Denied ☐

Comments _____