Financial Assistance Application

This is a Financial Review Application to consider account adjustment for services rendered by Apollo MedFlight. **We want to help.**

- Please submit your application promptly. You may receive bills until we receive your information.
- Please complete this application as accurately as possible and attach all requested documentation.
- For help filling out the form, you can contact us at:

1-844-838-7994 **Fax:** 1-888-978-5029

PatientFinancialServices@apollomedflight.com

ATTN: Patient Financial Services
Apollo MedFlight, LLC
5600 Bell St. Ste. 105-144
Amarillo, TX 79109

Section 1: PLEASE NOTE

- We cannot guarantee that you will qualify for account adjustment, even if you apply.
- Once you send in your application, we may verify all information provided and may ask for additional information or proof of income.
- Within 14 calendar days after we receive your completed application and documentation, we will notify you of our decision and your options.
- Any personal financial information request is for the purpose of determining your financial situation and will not be shared with outsides parties.

Section 2: PATIENT AND ACCOUNT INFORMATION

Please return by:		**Guarantor Name:**	
Patient Name:		**Account No.:**	
Date of Service:		**Balance Due:**	

Section 3: HOUSEHOLD INFORMATION

Is a parent or other person completing this application for the patient? **YES** ☐ **NO** ☐

If "yes," please provide the name and relationship to patient below and answer all remaining questions in this application for that individual instead of for the patient:

Name/Relationship: _____ **SSN:** _____ **Date of Birth:** _____

Spouse (*or check if N/A* ☐ **):**	**SSN:** _____	**Date of Birth:**

Total number of persons in household (including patient):

Section 4: SIGNIFICANT LIFE EVENTS

In the past 12 months, have you experienced any of the following? *Only answer if you would like us to consider these events in deciding if you are eligible for assistance. Please attach proof of each event, such as a notice of foreclosure/eviction, death certificate, etc.*

Lost your job? ☐	Filed for bankruptcy? ☐	Been evicted? ☐	Death in immediate family? ☐
Filed for divorce? ☐	Foreclosure on house? ☐	Became disabled? ☐	Any other life even we should consider? ☐

If you checked any of the above, please provide the date(s) of the event(s):

Section 5: WAGES OR SALARY INFORMATION

Are you employed? **YES** ☐ **NO** ☐	Is your spouse employed? **YES** ☐ **NO** ☐
Your Employer:	Spouse's Employer:
Your Position/Title	Spouse's Position/Title:
Wage/Salary:	Wage/Salary:
If hourly, average hours worked: ____per WEEK ☐ MONTH ☐	If hourly, average hours worked:____per WEEK ☐ MONTH ☐

If anyone in the household (including you or your spouse) has additional sources of income, please list each such source of income below. Include disability payments, unemployment compensation, rental income, investment returns, or any other income.

Source:	Who received the income?	Amount: $	Frequency:
Source:	Who received the income?	Amount: $	Frequency:

****Applications submitted without requested documentation will not be considered. Please see Page 2, Section 7.****

Financial Assistance Application

Patient Name:	Acct. No.:	Date of Service:

Section 6: ASSETS

- **Please provide the total amount of any other resources and liquid assets available to you.**
- *Please include all savings accounts, checking accounts, stocks, bonds, etc., but do not include retirement accounts (401(k)s or IRAs) or other resources that you cannot access without penalty.*

Financial Institution	Account Type	Current Balance
		$
		$
		$
		$
		$
		$
		$
		$
		$

TOTAL ASSETS: _____

Section 7: INCOME VERIFICATION AND APPLICATION ATTESTATION

Please provide the following types of documentation for each adult member of your household.

- Tax Return (Form 1040 or 1040EZ and all schedules) or Proof of Extension - **REQUIRED**
- 3 Months Bank Statements - **REQUIRED**
- IRS Form W-2, 1099 or Employer Verification - **REQUIRED**
- Copy of Paycheck or Stub / Remittance
- Spousal/Child Support – **REQUIRED IF APPLICABLE**
- Social Security, Workers' Compensation or Unemployment Compensation Determination Letter – **REQUIRED IF APPLICABLE**
- Proof of Participation in Governmental Assistance programs (WIC, food stamps, housing assistance, etc.) – **REQUIRED IF APPLICABLE**
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance – **REQUIRED IF APPLICABLE**

If you cannot provide documentation of your income, you must explain why you are unable to at the bottom of this form.

Section 8: MONTHLY EXPENSES/LIABILITIES

Rent/Mortgage	**$**	**Credit Card Payments:**	**$**
Groceries:	**$**	**Student Loan Payments:**	**$**
Auto Loans:	**$**	**Other:**	**$**
Cable/Internet:	**$**	**Other:**	**$**
Cell Phone/Home Phone	**$**	**Other:**	**$**
Utilities (GAS, WATER, TRASH, ELECTRIC)	**$**	**Other:**	**$**

TOTAL EXPENSES/LIABILITIES: _____

Section 9: CURRENT MEDICAL EXPENSES

*Please only include amounts **not paid for by insurance** that you would like to be considered.*

Hospital Name:	**$**
Physician Name:	**$**
Surgeon Name:	**$**
Lab/X-ray Name:	**$**
Clinic Name	**$**
PT/Rehab:	**$**
Other Name:	**$**
Other Name:	**$**
Other Name:	**$**
Other Name:	**$**
Other Name:	**$**

TOTAL MEDICAL EXPENSES: _____

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Financial Assistance Application

Patient Name:	Acct. No.:	Date of Service:

Section 10: PATIENT QUESTIONARE			
How many dependents will you file on this year's tax return?		If not a dependent, are you financially responsible for anyone else in your household? Explain:	
Have you applied for Medicaid?	YES ☐ NO ☐	Was your Medicaid approved?	YES ☐ NO ☐
If YES, when were you approved?		If NO, when was it denied?	
Have you applied for Medicare?	YES ☐ NO ☐	Are you currently on disability?	YES ☐ NO ☐
In the past, were you ever approved for free hospital care?	YES ☐ NO ☐	If YES, name and date of institution (documentation required):	
Were you approved for Charity Care?	YES ☐ NO ☐	If YES, name and date of institution (documentation required):	
Was your medical transport the result of an accident?	YES ☐ NO ☐	If YES, what kind of accident?	AUTO ☐ WORK ☐ HOME ☐ OTHER: _____
Have you filed any insurance claims for this accident?	YES ☐ NO ☐	If YES, insurance name:	
Claim Number:		Adjuster Name:	
Adjuster Phone:		Any other insurance?	
Have you hired an attorney to represent you?	YES ☐ NO ☐	Law Office Name:	
Attorney Name:		Attorney Phone Number:	

Section 11: ADDITIONAL INFORMATION OR EXPLANATION FOR MISSING DOCUMENTATION

Attach any documentation requested and/or additional documents to be considered to this application.
Account numbers on financial statements may be redacted for confidentiality.

Section 12: PATIENT AGREEMENT

I understand Apollo MedFlight may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance and/or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

SIGNATURE: _____	**DATE**: _____

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