Trans-Care Ambulance
Patient Questionnaire for Financial Hardship Determinations

Instructions to Patient:

Please complete this form in its entirety and return it to Trans-Care Ambulance, 1299 Voorhees Street, Terre Haute, IN 47802. **Please include all documents that give the income amounts you list in the Financial Information section.** See the Information section for a list of those documents.

Personal Information:

Patient Name: _____
Address: _____
City/State/Zip: _____
Telephone Number(s): Home: _____ **Other:** _____

Responsible Party (if different from patient): _____
Address of Responsible Party: _____
City/State/Zip of Responsible Party: _____

Health Insurance Information:

Medical Insurance? Yes _____ No_____
If "yes" print name of Insurance Company:_____
Policy Number:_____ Group Number: _____
Other Coverage? Yes _____ No _____ Please identify other coverage: _____
Medicare _____ Medicaid _____
Is the medical treatment because of a car accident or other third party injury? Yes ____ No ____
Is the medical treatment because of an on-the-job injury or accident? Yes ____ No ____

Financial Information

List below **all** residents in your household even if they do not have an income. Financial assistance is based on the size of your household as well as income. Please list the dollar amount of the total monthly income that supports the household. Include money that is earned

(paychecks, profits, interest, savings) as well as income that is not earned (welfare, unemployment, child support, gifts, grants).

	Name	Birth Date	Relationship	Monthly Income
1				
2				
3				
4				
5				
6				
7				
8				

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three months?
Yes _____ No _____ **If yes, please describe**:
_____
_____

Do the documents that you are including with this application show your current financial situation correctly?
Yes _____ No _____ **If no, why not**? _____
_____

I am applying for a Hardship Determination in order that you will consider waiving all or a portion of my co-pay/co-insurance/deductible (or up to total charges if uninsured) for service and care provided to me on _____ (date of service).

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 current employment/unemployment status (paystubs or unemployment notices) and a copy of my federal tax return or W-2 form for the previous year.

Statement of Agreement: "I am supplying this information to request that Trans-Care Ambulance waive collection of all or part of the Medicare or other deductible/co-insurance amounts in my case due to financial hardship. I also understand that Trans-Care can and will begin to attempt to collect charges should my financial situation improve. I agree to be responsible for any balance remaining after the application of any waiver by Trans-Care, if any."

Patient/Guardian signature:_____ Date:_____

INFROMATION

Please provide one from each section:

- Proof of employment/unemployment
    - If employed, last paystub
    - If unemployed, wage summary from unemployment office or Social Security Letter showing monthly benefit amount
- Proof of income
    - Last year W-2
    - Last year tax return
    - Social Security Letter showing monthly benefit amount

Financial assistance is secondary to ALL other financial resources available to the patient. This may include:

- Group or individual medical plans
- Worker's compensation
- Medicare
- Medicaid
- Other state, federal or military programs
- Third party liability situations (auto accidents or personal injuries)

Financial assistance is limited to "medically necessary, emergency and hospital to hospital ambulance" transportation. Financial assistance will not be provided for:

- Wheelchair or ambulatory transportation
- Non-emergency ambulance transportation
- Non-medically necessary transportation

If you have any questions regarding this application, please contact our Client Services Department at (812) 462-2848.

Mail the application with all documentation to:

Trans-Care Ambulance
1299 E Voorhees St
Terre Haute, IN 47802