PATTONVILLE FIRE PROTECTION DISTRICT

13900 St. Charles Rock Road, Bridgeton, MO 63044
Phone: (314) 739-3118 • Fax: (314) 739-5477 • www.pattonvillefd.com

Ambulance Billing Financial Hardship Application

Patient Information

Date of Service: _____ Contact Phone Number: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Method: ☐ US Mail, ☐ Phone, ☐ Email: _____

Was your ambulance treatment or transport bills related to:

☐ Workplace Injury, ☐ Automobile Accident, ☐ Crime, ☐ Other: _____

Have you, or will you file a lawsuit related to your injury or illness? ☐ Yes ☐ No

Attorney's Name: _____ Phone Number: _____

I live ☐ alone, ☐ with a spouse, ☐ with others- describe: _____

Total yearly income from ALL sources: $ _____

Are you currently employed? ☐ Yes, ☐ No

Have you applied for Medicaid? ☐ No, ☐ Yes, awaiting approval, ☐ Yes, not eligible.

Please provide the following documents so we may complete your application:

- ☐ A copy of your most recent IRS tax return (must be signed).
- ☐ A copy of your most recent W-2.
- ☐ A copy of employment checks for the past 30 days for all living in the home.
- ☐ A copy of unemployment check stubs for the past 30 days.
- ☐ A copy of any health insurance cards (Medicaid, Medicare, HMO)
- ☐ A copy of your driver's license or identification card.

Please Check all of the below items that apply to you:

- ☐ You are an emancipated minor.
- ☐ You are 65 years or older.
- ☐ You have children under age 19 living with you
- ☐ You are pregnant.
- ☐ You are blind.
- ☐ You are disabled as determined by the Social Security Administration.
- ☐ You take medication to control diabetes, high blood pressure or seizures.
- ☐ Other; Briefly Explain _____

_____

I understand that this application for financial assistance is for medical treatment and transport services provided by the Pattonville Fire Protection District. I understand and agree that intentionally providing incorrect information or refusal to cooperate with the Pattonville Fire Protection District to assess my eligibility(including not providing requested documentation) will result in a denial for assistance.

The information provided in this application is true and correct and I believethat I have declared all assets and sources of income as requested. By signing below, I authorize the Pattonville Fire Protection District to investigate the above claims by contacting employers, debtors, credit bureaus and other agencies necessary for income verification or service eligibility.

Patient Signature:_____Date: _____

Spouse Signature: (If Applicable)_____Date: _____

If someone other than the patient is completing this application, please provide your name and phone number below.

_____

The Pattonville Fire Protection District will keep all privileged Financial and Medical Documentation confidential. All Documentation will be destroyed upon resolution of the hardship application.