TANEY COUNTY AMBULANCE DISTRICT
Send to our contracted billing service: EMS Billing Services Inc.
P.O. Box 641880, Omaha NE 68164-7880
Phone: 1-800-367-9111

Application for Financial Hardship

Date of Request: _____/_____/_____

Patient Name: _____

Mailing Address: _____

Home Phone: _____

Other Phone: _____

Social Security#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth: _____/_____/_____

PROOF OF INCOME MUST BE PROVIDED WITH YOUR COMPLETED APPLICATION. A copy of your most recent W-2(s) is(are) preferred. ALL household income must be reported, including but not limited to; unemployment, food stamps, welfare assistance, rental income, business income, alimony, child support, interest or dividends, social security and pension or retirement benefits.

How many people reside in household? _____ Adults _____ Dependent children you legally claim

Patient Gross Income: $_____
annual earnings

Spouse Gross Income: $_____
annual earnings

Other Gross Income: $_____
annual earnings

TOTAL Gross Income: $ _____
annual earnings

I, _____ am requesting assistance with my bill for medically necessary ambulance services rendered on _____ (date or dates) in the amount of $_____.

I understand that this application is made so Taney County Ambulance District can determine my eligibility for uncompensated services based on the financial information provided with this application. I have no other insurance or assistance to file a claim on the balance due. If any information I have given proves to be untrue, I understand that the ambulance service may re-evaluate my financial status and take whatever action is deemed appropriate.

I certify that all the information given is true and accurate. Further, I will make application for any assistance, including Medicare, Medicaid, etc., which may be available for payment of my ambulance service charges. I will assign insurance benefits to Taney County Ambulance District and pay Taney County Ambulance District any amount recovered toward the ambulance bill. I understand the information submitted is subject to verification by Taney County Ambulance District and subject to review by other agencies as required for verification purposes.

_____
Patient signature or authorized representative

_____
Print name & relationship to patient if signed by representative