



Dear Patient:

On the next page of this document is the CareFlite Charity Care Application. Completion of this application will enable us to present your account for consideration of financial assistance for your recent CareFlite transport.

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will only be shared within CareFlite (or its agents) on a need to know basis.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application.

Please provide copies of your pay stubs covering the last three months and/or proof of any other form of income for the household. If you do not receive check stubs, please provide copies of your bank statements showing your monthly deposits. If self-employed, please provide a copy of your most recent files personal income tax return and a current profit and loss statement. Failure to provide the documentation may result in a denial for charity consideration.

It is extremely important that you complete this application and return it as promptly as possible.

If you have difficulty completing this application or there is an area that is unclear, please call 972-339-4232.

Mail To:

CareFlite Charity Care
3110 South Great Southwest Parkway
Grand Prairie, TX 75052

CareFlite

Charity Care Application

Patient Name: Last _____ First _____ MI _____

Social Security # _____ Birth Date _____ CareFlite Account Number _____

Married _____ Single _____ Divorced _____ Widowed _____ Separated _____

Do you have children (under 18) _____ Yes _____ No
Is the Patient Employed: _____ Yes _____ No
Is the Spouse Employed: _____ Yes _____ No
Do you have medical insurance? _____ Yes _____ No
Are you on disability? _____ Yes _____ No How Long _____
Are you a veteran? _____ Yes _____ No

Family Members – (living in the home)

Spouse: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____
Child: _____ Age: _____

Employment Information

Name of Employer _____
Telephone # _____
Occupation _____
Spouse's Employer _____
Telephone # _____
Occupation _____

Income (Monthly Amount):

| | | | |
|-----------------------|----------|-----------------|----------|
| Patient | \$ _____ | Pensions | \$ _____ |
| Spouse | \$ _____ | Dependents | \$ _____ |
| Public Assistance | \$ _____ | Social Security | \$ _____ |
| Food Stamps | \$ _____ | Unemployment | \$ _____ |
| Worker's Compensation | \$ _____ | Child Support | \$ _____ |
| Alimony | \$ _____ | | |

Total \$ _____

I understand that CareFlite may verify the financial information contained in this application by requesting certain document such as tax returns and pay stubs, and authorize the hospital to contact my employer to certify the information provided and to request reports form credit reporting agencies. I also understand that any charity approval may be completely or partially reversed in the event of a recovery from a third-party or other source. Any reimbursement I receive relating to this transport must be sent to CareFlite immediately. This includes payments from an insurance company, government program, employer and legal settlements.

Signature of Person Making Request, If Patient

Date

Signature of Person Making Request, If Not Patient

Relationship

Patient's Address

Home Telephone Number