CareFlite®

Making precious minutes count since 1979

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 well 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 recently filed 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 upon receipt and return it as promptly as possible.

If you have difficulty completing this application or there is an area that is unclear, please call 972-339-4212.

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