Valle Ambulance District

12363 State Route 21 De Soto, MO 63020
(636) 586-2132 * Fax (636) 586-4436
www.valleambulance.com

Valle Ambulance District offers financial assistance to make healthcare affordable and accessible to members of the community. If payment of your healthcare expenses could create a financial hardship for you, you ***may*** qualify for financial assistance.

The information is being collected, so we may present it to the Valle Ambulance District Board of Directors for consideration of a reduction or write-off of the patient's account. Submitting the fully completed Financial Assistance Application does not guarantee and/or constitute a reduction or write-off of the patient's account.

The account must be a current, non-collection referred account

How do I apply?

Complete the enclosed financial assistance application. Along with the application, you must submit **all** of the following documents that apply to you and your household;

- Copies of prior year Federal Income Tax Return for each household member(s)
- Copies of prior year W-2's for each household member(s)
- Copies of the 3 most recent paycheck stubs or a statement of earnings from each household member(s) employer
- Copies of 3 most recent bank statements for each household member(s). This includes checking, savings, money market, IRA, 401k, or any account held by a household member(s)
- Copies of unemployment and/or disability compensation statements for each household member(s)
- Copies of Social Security or pension income for each household member(s)
- Copy of food stamp allocation for each household member(s)
- Copies of government assistance notices, such as Social Security Disability and Medicaid Programs for each household member(s)
- Copies of **all** monthly bills
- If applicable, a certified copy of death certificate. (Originals will be returned within 30 days upon request)

Your application and documentation may be sent back to Valle the following ways:

- Mail:

  Valle Ambulance District
  12363 State Route 21
  De Soto, MO 63020

- Secured Fax

  (636) 586-4436

What is the process?

- After the fully completed Financial Assistance Application is submitted in writing, the application and account will be presented to Valle Ambulance Board of Directors at the next regular scheduled Board meeting scheduled on the fourth Wednesday of every month.
- You will be contacted with the Board of Directors' decision within 10 days after it is presented to the Board of Directors.

If you have any other question, feel free to contact us at (636) 586-2132.

Thank you,

Valle Ambulance District

"We're Here For Life"

Valle Ambulance District

Financial Assistance Application

1. Patient's Information:

Last Name *First Name* *Middle Initial* *Social Security Number* *Date of Birth*

Street Address *City* *State* *Zip code*

Mailing Address *City* *State* *Zip code*

Home Phone Number *Work Phone Number*

check one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

2. Person Responsible for Paying the Bill

Last Name *First Name* *Middle Initial* *Relationship to Patient* *Social Security Number*

Address if Different From Patient's *Home Phone Number* *Work Phone Number*

Name of Insurance Company *Effective Date*

3. **Please indicate ALL people living in the household, including applicant: Use additional sheet of paper if needed

	NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOC. SECURITY#	DOCTOR'S NAME
1		**Self**			
2					
3					
4					
5					
6					

4. Is this application for future or past services? ☐ Future ☐ Past Date(s) of Services:_____

5. Has anyone in your household applied for NH Healthy Kids or Medicaid? ☐ Yes ☐ No Who:_____

When?_____ What is the status? ☐ Pending ☐ Denied Reason:_____

6. Is anyone in your household pregnant? ☐ Yes ☐ No

7. Has anyone in your household served in the military? ☐ Yes ☐ No Who:_____

8. Have you recently filed a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No Date:_____

9. Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No Who:_____

10. Is anyone in your household covered by health insurance or a health savings account (HSA)?

☐ Yes ☐ No Who:_____

11. Does anyone else claim you on their income tax return? ☐ Yes ☐ No Who:_____

12. HOUSEHOLD INFORMATION

	PERSON 1	PERSON 2	PERSON 3
*NAME of each household member:			
Name of employer:			
Monthly Income From:			
Employment:	$	$	$
Self-Employment:	$	$	$
Investment Accounts:	$	$	$
Real Estate rentals:	$	$	$
Unemployment: (since (__/__/__)	$	$	$
Retirement: (Soc. Security, Pension, Annuity)	$	$	$
Alimony/Child Support:	$	$	$
Public Assistance, Food Stamps:	$	$	$
Other Income:	$	$	$
Savings and Investments:			
Checking Account Balances	$	$	$
Savings & CD Account Balances	$	$	$
IRAs, 403B, 401K:			
Specify:	$	$	$
Other savings and investments:			
Specify:	$	$	$
Other:			
Value of Automobile:	$	$	$
What is the Year, Make, Model?			
Value of Recreation Vehicle:			
What is the Year, Make, Model?			

13. HOUSEHOLD EXPENSES

Monthly Rent Payment: $_____ or Mortgage Payment: $_____ Mortgage Loan Balance $_____

Property Tax Amount Not Included in Payment Amount Above: $_____ Value of Home: $_____

Do You Own Property Other Than Primary Residence? ☐ Yes ☐ No If Yes, What is the Value? $_____

Monthly Loan Payment: $_____ Paid to: _____ For: _____

Medicare Part D deducted from Social Security check: ☐ Yes ☐ No Amount:$ _____

Utilities	$	Insurance (Auto/Life/Property)	$	Other:	$
Alimony/Child Support	$	Health Insurance	$	Other:	$
Child Care	$	Healthcare Bills	$	Other:	$
Living (gas, food, clothes)	$	Medications	$	Other:	$

14. ASSIGNMENT OF RIGHTS *Read Carefully*

By signing below I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures may not be considered for assistance.

I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.

If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

_____ _____ _____ _____

Applicant Signature *Date* *CO-Applicant Signature* *Date*