Special Consideration Application

Personal Information

Patient Name: _____ Run#: _____ Form Initiated By: _____

Application Due by:_____ Original Balance: $_____ Balance Due: $____

Section 1: Applicant

Relationship to Patient: _____

Last Name: _____ First Name: _____ SSN: _____DOB_____

Home Phone #: (____)_____ Cell Phone #: (____)_____

Address: _____ City: _____ State: _____ Zip: _____

Name of Applicant's Employer: _____ Position: _____

Employer Phone: (____)_____Length of Employment: _____

Section 2: Co-applicant (Parent, Spouse, or Partner)

Relationship to Patient: _____

Last Name: _____ First Name: _____ SSN: _____DOB_____

Home Phone #: (____)_____ Cell Phone # (____)_____

Name of Co-applicant's Employer: _____ Position: _____

Employer Phone: (____)_____ Length of Employment:____

Section 3: Please list everyone living with patient in home:

Household Members: Name	Relationship	Age	Employment Status

Section 4: Medicaid

Have you filed for Medicaid? ☐ No ☐ Yes Policy number: _____ If Denied, denial date: _____

Reason for denial:_____

Section 5: Incident Information

Was transport due to auto accident? ☐ No ☐ Yes If yes, what is name of auto insurance? _____

Claim number: _____ Adjuster: _____ Phone #: (____)_____

Have you received a settlement from any insurance? ☐ No ☐ Yes If yes, how much? $_____

Do you have an Attorney? Name: _____ Phone#: (____)_____

Were you a victim of a crime? ☐ No ☐ Yes If yes, did you apply for Victims of Crime? ☐ No ☐ Yes

If yes, claim number: _____ Adjuster: _____ Phone#: (____)_____

Were you injured at work? ☐ No ☐ Yes If yes, please provide carrier name: _____

If yes, claim number: _____ Adjuster: _____ Phone#: (____)_____

Were you injured at a business or home (other than your own)? ☐ No ☐ Yes

If yes, claim number: _____ Adjuster: _____ Phone#: (____)_____

Section 6: Monthly Expenses

Rent/Mortgage (Circle one)	$	Credit Card Payment	$
Groceries:	$	Loan Payments	$
Auto Loan	$	Other:	$
Cable / internet	$	Other:	$
Cell phone / home phone	$	Other:	$
Utilities (gas, water, electric, trash)	$	**Total Expenses**	$

Section 7: Income		*Section 7: Assets*	
Applicant's Income:	$	Real Estate/Rental Property Equity:	$
Co-Applicant's Income:	$	All Checking Accounts Balance's: $ Account Number: Bank Name:	
Child Support:	$	All Savings Account Balance's: $ Account Number: Bank Name:	
Alimony:	$	IRA's, Retirement Accounts, Stocks Bonds, CD's, 401k's **Total Value:**	$
SSI:	$	Cash Value of Life Insurance:	$
Food Stamps:	$	Available balance on all Credit Cards:	$
Family Support:	$	Investments:	$
Retirement Pension:	$	Personal Property Value:	$
Other Income:	$	Other Assets	$
Other Income:	$		$
Total Income:	**$**	**Total Assets:**	**$**

Check List:

To ensure the most complete and timely review - please enclose ALL applicable items from the following list: Note: Applications received with missing, invalid, or incomplete information will not be considered for review.

- **Completed application with all appropriate signatures: Enclosed ☐ No ☐ Yes**
- **Written description of how you (the patient) are supported by another party. Enclosed ☐ No ☐ Yes**
- **Copies of two (2) bills and cancelled check copies (showing expenses paid by another party) Enclosed ☐ No ☐ Yes**
- **Most recent Federal Income Tax Return: (all pages) Enclosed ☐ No ☐ Yes**
  1. **If you did not file taxes last year, attach: a notarized statement explaining why you did not file**
- **Three months most recent paycheck stubs. Enclosed ☐ No ☐ Yes**
- **Last three months bank statements for <u>all</u> checking and savings accounts and other applicable accounts, e.g.: Trust Accounts, Settlement Accounts, money market, CD's, 401k Enclosed ☐ No ☐ Yes**

Important Information: Mail Application to Air Ambulance Services, PO Box 2532, Fontana CA 92334-9938

Applications received with missing, invalid or incomplete information will not be considered for review and will be denied. The patient will be notified if the submitted application contains missing, invalid or incomplete information. The application will also be denied with an offer to reconsider if the requested information is received within ten (10) business days. Reconsideration applications not received within ten (10) business days may be accepted or rejected at the company's sole discretion. The application will be denied if it is not received by the above mentioned due date. A credit report will be obtained for all applicants. This is a request for special consideration of a currently due and owing balance, and does not apply to any future charges which may be incurred by the undersigned applicant. The acceptance of the information contained herein does not in any way imply a guaranteed reduction of balances owing. The information provided will be used for evaluation purposes only. Final decisions and determinations are made at the sole discretion of the Company's special consideration committee.

Print Applicants Name: _____

Applicant Signature: _____ **Date:** _____

Print Co-Applicants Name: _____

Co- Applicant Signature: _____ **Date:** _____

Administrative Use Only: (Patients please do not write in this box)

Run Number: _____ Adjustment Amount Approved: $_____ Denied: _____

Remarks: _____

Authorized Signature: _____ Date: _____