COLE CAMP COMMUNITY AMBULANCE DISTRICT
DISCOUNT POLICY

Hardship Discount
Accounts for ambulance service can be discounted a percentage approved by the Board of Directors if the account qualifies. If the household income is within 200% of the national poverty level, based on the number of family members, the family's income and total expenses, the account may qualify for a discount.

For an account to be considered for discounting:

1. It must be for an un-insured or under-insured patient.
2. Under-insured meaning the insurance company has paid less than 50% of the total charges.

Qualifying requirements:

1. The patient must complete and return the application for Hardship Discount.
2. Documentation may be required to support the information on the application.
3. It may be necessary for our office to call and verify the information submitted.
4. The patient must have applied for state Medicaid medical assistance or show reasons Medicaid will not cover the service.
5. If the account had been discounted at less than 100%, a minimal payment must be made at the time of discounting.
6. Payment arrangements must be made and a payment must be received on the account each and every month until paid in full.

If your income is less than the amount stated in the table below, depending on your household expenses, your account may qualify for a hardship discount.

The table represents 200% of 2015 Federal Poverty Guidelines for the 48 contiguous states according to the U.S. Census Bureau.

If your annual income is less than the amount listed for the number of family members that live in your house, please complete the Discount Application.

Persons in family/household	Poverty guideline
For families/households with more than 8 persons, add $4,160 for each additional person.	
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890

COLE CAMP COMMUNITY AMBULANCE DISTRICT
Application for Hardship Relief

NAME: _____ Date: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: _____

DEPENDENT INFORMATION

Please name all dependents that reside with you and require your financial support.

SPOUSE: _____ AGE: _____ NAME: _____ AGE: _____
NAME: _____ AGE: _____ NAME: _____ AGE: _____
NAME: _____ AGE: _____ NAME: _____ AGE: _____

GROSS MONTHLY INCOME

Please provide us with information concerning your income. Attach copies of most recent pay stubs. If you are receiving alimony, child support or Social Security benefits, attach a copy of divorce decree or letter verifying Social Security income.

EMPLOYMENT: $_____ SOCIAL SECURITY: $_____
UNEMPLOYMENT: $_____ OTHER INCOME: $_____
ALIMONY/CHILD SUPPORT: $_____ Describe:_____

MONTHLY EXPENSES

MORTGAGE:$_____ Mortgage Co. Name:_____
Address:_____
City,State,Zip:_____

RENT:$_____ Mortgage Co. Name:_____
Address:_____
City,State,Zip:_____

LOAN:$_____ Mortgage Co. Name:_____
Address:_____
City,State,Zip:_____

LOAN:$_____ Mortgage Co. Name:_____
Address:_____
City,State,Zip:_____

Gas: $_____ Trash: $_____

(Attach copies of last 2 mos. Statements for following :)

Electric: $_____ Water: $_____ Credit Cards: $_____

Telephone: $_____ Sewer: $_____ Medical: $_____

Food: $_____ Insurance: $_____ Other: $_____

BANK ACCOUNTS

BANK NAME: _____ ACCT. NO.: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

BANK NAME: _____ ACCT. NO: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

BANK NAME: _____ ACCT. NO: _____
ADDRESS; _____
CITY, STATE, ZIP: _____

ATTACH COPIES OF LAST TWO YEARS OF FEDERAL INCOME TAX RETURNS INCLUDING W-2's.

NOTE: NO APPLICATION WILL BE ACCEPTED IF IT IS INCOMPLETE OR ANY REQUESTED DOCUMENTS ARE MISSING.

The undersigned certifies that all statements made in this application are for the purpose of obtaining hardship relief and are correct to the applicant's knowledge. The undersigned authorizes Cole Camp Community Ambulance District, Cole Camp, Missouri, to investigate the references listed pertaining to applicant's financial responsibilities.

_____ _____
Signature Date

PRIVACY ACT NOTICE STATEMENT

This information is to be used by the agency collecting it in determining whether you qualify as a prospective hardship case under the agency program. It will not be disclosed outside the agency without your consent except to financial institutions for verification of your deposits and as required and permitted by law.

You do not have to give us this information, but if you do not your application for consideration as a prospective hardship case may be delayed or rejected.

COLE CAMP COMMUNITY AMBULANCE DISTRICT

AUTHORIZATION

To my employer, bank, landlord, Social Security Office and my creditors:

This is your authorization to furnish any and all of the following:

- Benefit records
- Medicare records
- Employment and earnings records
- Bank account information
- Residency information
- Credit account information

to Cole Camp Community Ambulance District.

All materials and facts collected from said investigation for the purpose of this transaction will become property of Cole Camp Community Ambulance District.

_____
Printed Name

_____
Signature

_____
Date

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