CareFlite
a Texas 501(c)(3) non-profit air and ground ambulance service

Charity Care Application Packet

Instructions and application for CareFlite financial assistance

CareFlite understands that medical transportation expenses can create financial hardship. Charity care assistance may be available to eligible patient based on household income and other criteria. Please complete this application and submit the requested supporting documents so CareFlite can evaluate your eligibility.

Before you begin

CareFlite may reduce an eligible patient balance when a patient or household cannot afford to pay. This application is free and may be used for eligible medically necessary CareFlite ground, rotor-wing, or fixed-wing transport services.

Please print clearly, complete every section that applies, and use additional pages if you need more space.

What to include with your application

[ ]	This completed and signed application.
[ ]	Pay stubs covering the most recent three months for each employed household member. Gross pay before taxes and deductions will be used.
[ ]	Documentation for every other current household income source, such as benefit letters, retirement statements, tax documents, or other reliable records.
[ ]	A current profit-and-loss statement and supporting records for self-employment income.
[ ]	The sponsor hospital's decision letter if it approved charity care or financial assistance for the same incident.
[ ]	Available insurance, liability, workers' compensation, employer, or attorney claim information relating to the transport.

Important: CareFlite cannot make an eligibility decision until the application is complete and all required income-verification documents have been received. If information is missing, CareFlite will notify you of the specific documents or information needed to complete the review. An incomplete application is not an approval or denial of charity care.

How income is reported

Report wages and other employment income as gross income before taxes and deductions. Report self-employment income after ordinary and necessary business expenses. Report interest, dividends, rental income, and net realized investment gains actually received. Do not report unrealized investment gains or account balances as income.

Protect your information: Send copies, not originals. If bank statements are requested, you may black out full account numbers and unrelated transactions. Leave the account holder's name, statement dates, and relevant deposits visible.

Return the completed packet

Mail	CareFlite Charity Care 1630 Corporate Court Irving, TX 75038

SECTION 1

Patient and Account Information

Please complete the information for the CareFlite transport under review.

Patient and responsible party

Patient legal name		Date of birth	
Guarantor name, if different		Relationship to patient	
CareFlite account number(s)		Date(s) of service	
Transport type	[ ] Ground [ ] Rotor-wing [ ] Fixed-wing [ ] Unknown	Incident or pickup location	
Mailing address		City, state, ZIP	
Primary phone		Alternate phone	
Email address		Preferred contact	[ ] Mail [ ] Phone [ ] Email
Preferred language		Communication accommodation	

Insurance and other possible payment sources

Check every source that may apply to this transport, even if a claim was denied or remains pending.

Coverage or payment source	[ ] None [ ] Commercial insurance [ ] Medicare [ ] Medicaid [ ] VA/TRICARE [ ] Other
Policy, member, or claim number	
Accident or injury	[ ] Auto [ ] Work-related [ ] Premises or other liability [ ] Not applicable
Insurer, employer, or attorney	Name: _____ Phone: _____
Claim status	[ ] Paid [ ] Denied [ ] Pending [ ] Appeal pending [ ] Unknown
Payment received for this transport	$_____ Source: _____ Date: _____

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SECTIONS 2-3

Sponsor Hospital and Household

Household size is based on tax relationships, not everyone living at the same address.

2. Sponsor-hospital financial assistance

Complete this section if a hospital connected with the same incident reviewed or approved financial assistance. Attach the hospital's decision letter when available.

Sponsor hospital name		Hospital account number	
Hospital decision	[ ] Full charity [ ] Partial assistance [ ] Denied [ ] Pending [ ] Unknown	Decision date	
Same incident as CareFlite transport?	[ ] Yes [ ] No [ ] Unsure	Decision letter attached?	[ ] Yes [ ] No

3. Household members

For an adult patient, include the patient, spouse, and tax dependents. For a minor or tax-dependent patient, include the patient and the tax household of the financially responsible parent or guardian. Do not include unrelated roommates.

Full legal name	Relationship to patient	Age	Tax dependent?	Currently employed?
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No
			[ ] Yes [ ] No	[ ] Yes [ ] No

Household reminder: A person is not included solely because that person lives in the home. Use an additional page if more household-member rows are needed.

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SECTION 4

Household Income

List each current income source for every household member included in Section 3.

Gross versus net: Use gross pay before taxes and deductions for wages. Use net income after ordinary and necessary business expenses for self-employment. Do not subtract household bills or payroll deductions.

Income sources to report

Include wages, net self-employment income, Social Security, SSI/SSDI, retirement or pension, unemployment, workers' compensation, disability, recurring cash assistance, alimony or child support received, interest, dividends, net rental or royalty income, net realized investment gains, and other recurring cash income.

Income detail

For frequency, enter weekly, every two weeks, twice monthly, monthly, or annually.

Household member	Income source or employer	Frequency	Gross or net amount	Document attached?
			$	[ ] Yes [ ] No
			$	[ ] Yes [ ] No
			$	[ ] Yes [ ] No
			$	[ ] Yes [ ] No
			$	[ ] Yes [ ] No
			$	[ ] Yes [ ] No

Estimated annual household income	$_____
Has household income changed recently?	[ ] No [ ] Yes. Date and explanation: _____
Expected income change, if known	

Do not count SNAP, WIC, other noncash benefits, tax refunds, loan proceeds, repayment of principal, or unrealized investment gains.

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SECTIONS 5-6

Documents and No-Income Statement

Attach reliable documentation for each income source reported in Section 4.

5. Supporting-document checklist

[ ]	Pay stubs covering the most recent three months
[ ]	Year-to-date earnings statement, W-2, or recent federal tax return
[ ]	Social Security, retirement, pension, disability, unemployment, workers' compensation, or other benefit letter
[ ]	Current self-employment profit-and-loss statement and supporting records
[ ]	Interest, dividends, rental, royalty, or realized-investment-income documentation
[ ]	Bank statements because other reliable income verification is unavailable
[ ]	Sponsor-hospital financial-assistance decision letter
[ ]	Insurance explanation of benefits, denial, or other payer information
[ ]	Other: _____

6. No-income statement

Complete this section only if the household currently has no countable income. If any household member has income, list it in Section 4 instead.

Date household income ended	
How food, housing, utilities, and other needs are currently paid	
Expected source or date of future income, if known	
Person providing support, if any	Name: _____ Relationship: _____ Phone: _____

[ ] No-income certification: I certify that the household currently receives no countable income and that the explanation above is complete and accurate.

Next step: After completing this page, review and sign the certification on the final page.

SECTION 7

Certification and Signature

Read each statement before signing and returning the application.

7. Applicant certification and authorization

[ ] I certify that the information and documents provided with this application are true and complete to the best of my knowledge.

[ ] I authorize CareFlite and its authorized billing agents to verify information reasonably necessary to evaluate this application and to request clarification when needed.

[ ] I agree to report any insurance, governmental, employer, liability, settlement, or other third-party payment relating to this transport. CareFlite may adjust assistance as necessary to prevent duplicate payment.

[ ] I understand that assistance applies only to the CareFlite accounts and service dates identified in CareFlite's written decision.

Signature

Patient, guarantor, or authorized applicant signature	Date

Printed name	Relationship to patient

Before mailing: Make a copy for your records. Mail the completed application and supporting documents to CareFlite Charity Care at the address shown below.

CareFlite Charity Care
1630 Corporate Court
Irving, Texas 75038