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 will 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 proof of any other form of income for **all people living** in the household (ie. tax statements). Please provide copies of your bank statements for the last three months showing your monthly deposits (all accounts). If self-employed, please provide a copy of your most recently files 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 and return it as promptly as possible.

If you have difficulty completing this application or there is an area that is unclear, please call 972-339-4213.

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