Compassionate Care Program

Thank you for your interest in our Compassionate Care Program. Please reference the list below for information required to process your application. We will not be able to process your application if it is returned incomplete, or the required documentation is not provided. *Please note that additional documentation not initially requested below may be required following review of your situation.

All Applicants:

- ☐ The previous year's tax return or letter of non-filing from the IRS (1-800-908-9946).
- ☐ Hospital Charity Approval Letter (if applicable)

AND

Employed Applicants:

- ☐ Paycheck stubs or bank statements from the previous three (3) months for the entire household.

Unemployed / Retired Applicants:

- ☐ A letter from your local employment office indicating no wages/benefits are currently being received, or proof of any other sources of income or aid (i.e. SSI, SSA, SSDI, Unemployment, etc.)

Self Employed Applicants:

- ☐ Your quarterly profit and loss statement.

College Students Over 18 Years of Age:

- ☐ Documentation showing current enrollment is required (i.e. student loan documentation, a current class schedule, school account summary, etc.).
- ☐ If claimed as a dependent, the legal guardian's previous tax filing, along with paycheck stubs and bank statements from the previous three (3) months.

Non-US Residents:

- ☐ Proof of residence (passport, visa, check stubs, bank statement, etc.).

Please forward the completed application with all required documentation within 10 business days to:

American Medical Response
Attention: Patient Advocates
4701 Stoddard Dr.
Modesto, CA 95356

Your application for the Compassionate Care program will be thoroughly reviewed, and a letter will be mailed to you informing you of our determination. If you have any questions, please contact our Customer Service Department at 1-800-913-9106.

COMPASSIONATE CARE APPLICATION

CONTACT INFORMATION

Patient Name: _____
Responsible Party: _____
Address: _____
_____
_____
Employer Name: _____

Account #: _____
Account Balance: _____
LOB: _____
Home Phone #: _____
Cell Phone #: _____

HOUSEHOLD SIZE: _____ (Include yourself, spouse and dependents only)

Name	Relationship to Patient	Age

(List additional household members on a separate sheet)

MONTHLY HOUSEHOLD INCOME

Net Wages $_____
SSI, SSA, or SDI $_____
Unemployment $_____
Pension $_____
Cash/Food Assistance $_____
Other Income Source: _____ $_____
Total $_____

MONTHLY MEDICAL EXPENSES

	Description	
Health Insurance Premiums/COBRA	_____	$_____
Pharmacy	_____	$_____
Doctor Payments	_____	$_____
Hospital Payments	_____	$_____
Dental Payments	_____	$_____
Specialist Payments	_____	$_____
Other Medical Expense	_____	$_____
	Total	**$_____**

- I declare that above information is a true and accurate representation of my financial status.
- I understand that American Medical Response is required by law to keep any information I provide confidential.
- I understand that if I do not qualify for a reduction or waiver of charges by the terms of this program, I will remain personally liable for the charges of the services rendered by American Medical Response.
- I certify that there is not any liability or third party coverage pertaining to all transports related to this application.

Signature_____ Date_____