Lakes Region

7/18/2017

# Hardship Application

DEAR PATIENT,

Enclosed is your application for a hardship discount. Please include the following information for determining what discount will be given. Not supplying the information requested or a reasonable substitute may disqualify you for assistance.

Return the following information:

1. Complete Hardship Discount form.
2. Copy of your 2016 Federal Income Tax Forms.
   a. Include all attachments and schedules
3. Documentation of your 2015 income.
   a. Valid Documents include a recent pay or disability pay stub.
4. A letter outlining any unusual circumstances that you feel might affect your ability to pay.
5. Written documentation from your county outlining if you have been approved/denied for Medical Assistance.

If the Hardship application form and the other paper work are not returned by (15 business days), your application may not be considered. If there is some reason that you are unable to return the forms by the above date, please contact me prior to the deadline.

The Hardship Discount Program will affect Lakes Region EMS, Inc. accounts only. It is intended as a form of assistance in the time of financial emergency.

Sincerely,

Kim D
Patient Accounting
651-277-4911 x101

LOCATION
40245 Fletcher Ave.
North Branch, MN
55056

PHONE
Office:
651.277.4911
Interfacility:
651.224.8994

FAX
651.674.4628

WEB
lrems.com

Lakes Region

Lakes Region EMS may discount a part, or all, of the ambulance bill owed. The Amount of discount depends upon financial need. In order to determine those who need a discount from those who merely do not wish to pay their fair share of the cost of ambulance service, the following form will need to be completed, signed and returned to the Lakes Region EMS, Inc. business office. Lakes Region EMS, Inc. reserves the right to check with employers, bankers and others to investigate facts, which can lead to a fair resolution of the account.

Patient Name ___________________________Account Number____________________

Person completing this form____________________ Relationship_________________

Address __________________________________________________________________

Phone Number (Day)________________________ (Evening) ____________________

Balance Owed $__________________ Discount Requested $_____________________

## Patient or Responsible Party Information

Employer Name ____________________________________________________________

Employer Address __________________________________________________________

Phone Number (      ) _________________ Name of Supervisor___________________

Hourly Rate $_________ Hrs worked per week ______ Mthly Take Home $_______

## Spouse Employment Information

Employer Name ____________________________________________________________

Employer Address __________________________________________________________

Phone Number (      ) _______________ Name of Supervisor _____________________

Hourly Rate $_________ Hrs worked per week ______ Mthly Take Home $_______

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## Assets

Name of Bank ____________________ Phone Number _________________________

Address of Bank ________________________________________________________

Checking Acct # __________________________ Current Balance ________________

Savings Acct # ____________________________ Current Balance ________________

Total current balance of Certificate of Deposits (CD's) $________________________

Total current value of all liquid assets, including stocks. bonds, cash value of life

insurance, etc $________________________

Monthly income from all sources, EXCLUDING wages listed above. Include rental

properties, Social Security checks, disability income, etc. $______________________

Automobiles (Year, Make & Model):
______________________________________________________________________

______________________________________________________________________

Age of dependents _______, _______, _______, _______, _______, _______, _______

## Monthly Expenses

| | | |
|---|---|---|
| Housing: If Rent, monthly rental is | $_______________ | If home owner: |
| If Own, monthly payment | $________________ | Balance Owed $________________ |
| Utilities (heat, electricity, Water. Sewer) | $________________ | Market Value $ ________________ |
| Telephone (including cell phones) | $________________ | |
| Satellite Television | $________________ | |
| Internet | $________________ | |
| Child Care | $________________ | |
| Medical Care | $________________ | |
| Transportation | $________________ | |
| Insurance (Car, life, medical, etc.) | $________________ | |
| Miscellaneous | $________________ | |
| | | |
| TOTAL MOTNTHLY EXPENSES | $________________ | |

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## Other

List additional bills you owe that have bearing on your ability to pay this bill:

______________________________________________________________________

______________________________________________________________________

Do you have any insurance or legal action pending which could be directly related to your bill? If so, please list Name, Address & Phone Number of your attorney and/or insurance agent.

______________________________________________________________________

______________________________________________________________________

Have you received any insurance or Medicare reimbursement for Lakes Region EMS, Inc.? If so, please describe below:

______________________________________________________________________

______________________________________________________________________

**I certify that all of the information provided is complete, true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services rendered by Lakes Region EMS, Inc. I hereby grant permission for Lakes Region EMS, Inc., any employees or agents to fully investigate the data herein, as well as to contact employers, bankers, creditors, or others who may have knowledge of my financial condition for the purpose of proving my need for a discount of the Lakes Region EMS, Inc. ambulance charges. The patient, or responsibility party, needs to sign below in order for us to investigate to determine the amount of discount.**

Signature: ________________________________________ Date _______________

Relationship to patient __________________________________________________

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