Liberty Ambulance Service
Financial Hardship Request Form

Patient
Name:_____
Address:_____
City/State/Zip:_____

Responsible Party (if different than patient):_____
Address:_____
City/State/Zip:_____

I am applying for a Hardship Determination in order that you will consider waiving my co-pay/co-insurance/deductible (or total charges if uninsured) for service and care provided to me. (Circle one.)

I am supplying the following information so that you can make an accurate determination of my financial situation. The monthly dollar amount provided is from all sources including Social Security benefits, pensions, annuities, dividends, etc. Attached you will find verification of my employment/unemployment status and copies of my federal tax returns or W-2 forms for the previous 2 years as well as other information I feel should be considered in determining my ability to pay.

My insurance is
_____

Monthly Income	Self		Spouse		
Wage/salary	$_____		$_____		
Social security	$_____		$_____		
Pension	$_____		$_____		
Interest income	$_____		$_____		
Other	$_____		$_____		
Totals	$_____	+	$_____	=	$_____

Total size of household: _____

Patient Signature: _____ Date: _____