

DATE: \_\_\_\_\_



**Missaukee County – EMS Department**



**FINANCIAL ASSISTANCE APPLICATION**

Patient's Legal Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

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Street Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ ZIP: \_\_\_\_\_

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Social Security #: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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Responsible Party Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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Do you file taxes?  Yes  No      Do you have a Health Savings Account?  Yes  No

Do you have one or more checking accounts?  Yes  No      Do you have one or more savings accounts?  Yes  No

Checking balance(s) \$ \_\_\_\_\_      Savings balance(s) \$ \_\_\_\_\_

Were you a Michigan resident at the time of your ambulance service?  Yes  No

List all persons living in your household:

NAME	AGE	RELATIONSHIP	MONTHLY INCOME* (IF 18+ YEARS OLD)

\*Income Includes employment wages, unemployment, alimony, VA benefits, Social Security, lump sum payments, gov't assistance, annuities, pension, 401K/403B/457K distributions, self-employment earnings, workers compensation, cash receipts.

INSURANCE QUESTIONNAIRE	YES	NO
Do you have insurance coverage of any kind? If yes, what?		
Have you lost insurance coverage within the last 60 days?		
Was the ambulance service you received related to an auto accident?		
If yes, please provide auto insurance name and claim number:		
Was your ambulance services related to an accident at work?		
If yes, please provide name of employer and workers comp insurance info, if known:		
Are you a veteran?		

  

GOVERNMENT ASSISTANCE QUESTIONNAIRE	YES	NO
Have you applied for Medicaid?		
Are you receiving or have you applied for Social Security Disability payments?		
Have you been or do you expect to be disabled and unable to work for 12 months or more?		
Are you legally blind or on dialysis?		

PLEASE PROVIDE THE FOLLOWING INFORMATION:	Attached	Not applicable
1. Copy of most recent Federal Income Tax Forms (including all schedules & attachments)		
2. Copy of Medicaid determination letter		
3. Copy of the last 3 months of household checking and savings account statements		
4. Copy of the last 3 months proof of household income* (all occupants 18+ years old)		

Reminder: \* Income includes all of the following:

- Employment wages/salary
- Unemployment benefits
- Self-employment/cash jobs
- Workers Compensation
- Installment Payments (i.e., short-term or long-term disability)
- VA benefits
- Alimony
- Social Security, SSI
- Lump Sum Payments (i.e., insurance settlements)
- Government Assistance (i.e., food stamps)
- Annuities
- Pension/Retirement Benefits
- 401K/403B/457K
- Any other Income

**PROOF OF NO INCOME:** This question **MUST** be completed if you are claiming no income.

Briefly explain how you are financially supported and amount of that support, either on a monthly or annual basis:

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ASSETS:	VALUE
1. Home	
2. Any other real estate (i.e., vacation property, vacant land)	
3. Automobiles/ATVs/Boats/Campers, etc.	
4. Certificates of Deposit, total 401K/403B/457K account value, investment accounts	
5. Other assets	

**CERTIFICATION:**

By signing this document, I affirm the answers on this application are true. Should a subsequent review of this financial assistance application reveal that information provided therein was either incorrect or fraudulent, the decision to provide financial assistance may be reversed and the responsible party will be billed. I understand that the information that I submit is subject to verification by Missaukee County, including consultation with credit reporting agencies, and subject to review by federal and/or state agencies and others as required.

PATIENT SIGNATURE \_\_\_\_\_  
 APPLICANT OR REPRESENTATIVE SIGNATURE \_\_\_\_\_  
 RELATIONSHIP (IF NOT PATIENT) \_\_\_\_\_  
 DATE \_\_\_\_\_

**MAIL COMPLETED APPLICATION AND ALL DOCUMENTATION TO:**  
 EMS Director, Missaukee County EMS, PO Box 800, Lake City MI 49651  
 For assistance, call: 231-839