

## **Financial Assistance Program** **Application Process**

Advanced Medical Transport of Central Illinois (AMTCI) is a not-for-profit organization that provides both emergency and non-emergency transportation. As part of our commitment to provide charitable services to patients in our community, a Financial Assistance Program has been developed. This program provides discounts on transportation charges for patients that meet pre-determined household income and family size requirements. Discounts range from 10 to 100 percent based on applicant eligibility. If you are under 21 years of age and a full time student, this application needs to be completed by your family.

Applicants, who wish to apply for financial assistance, must complete our Financial Assistance Program Application and provide the required documentation to be considered for a discount. If this application is incomplete or returned without the appropriate documentation, the application will be denied.

The following documentation should be included with your application:


- Bank statements for the past 2 months
- Pay stubs for the last 3 pay periods
- W-2 forms for the most recent tax year
- Federal tax forms for the most recent tax year (if filed)
- Self-employed applicants should submit federal tax forms for the past 3 tax years
- Pension benefits (if you are receiving)
- Unemployment benefits (if you are receiving or have received within the year reported)
- If you are unemployed & have not worked during the past year, please include a letter that clearly documents how you support yourself
- Social Security or Social Security Disability benefits

Please return your completed application along with the required documentation in the enclosed envelope. For assistance with your questions, please contact our Customer Service Department at (309) 494-6203.



**Advanced  
Medical Transport**  
of Central Illinois

**Financial Assistance Program Application**

<b>Patient Name</b>		<b>Soc Sec #</b>	<b>Birth Date</b>	<b>Age</b>	<b>Marital Status</b>
<b>Responsible Party's Name</b>		<b>Soc Sec #</b>	<b>Birth Date</b>	<b>Relationship to Patient</b>	
<b>Guarantor Address</b>			<b># of Years</b>	<b>Home Telephone #</b>	
<b>Dependent Name(s)</b>		<b>Ages</b>	<b>Dependent Name(s)</b>		<b>Ages</b>
<b>Employer Information</b>			<b>Spouse's Employer Information</b>		
<b>Name:</b>			<b>Name:</b>		
<b>Street:</b>			<b>Street:</b>		
<b>City, State, Zip:</b>			<b>City, State, Zip:</b>		
<b>Job Title:</b>			<b>Job Title:</b>		
<b># of Years Worked:</b>			<b># of Years Worked:</b>		
<b>Work Phone #:</b>			<b>Work Phone #:</b>		
<b>Income Information</b>					
<b>Income Source</b>	<b>Hourly Worked</b>	<b>Hourly Wage</b>	<b>Gross Annual Income</b>		
1. Patient		\$	\$		
2. Spouse/Responsible Party		\$	\$		
3. Working Children			\$		
4. Social Security			\$		
5. Pension(s)			\$		
6. Child Support			\$		
7. SSI/SSDI			\$		
8. Unemployment			\$		
9. Commissions			\$		
10. Tips			\$		
11. Rental Property			\$		
12. Farm Income			\$		
13. Interest Income			\$		
<b>Total Monthly Gross Income</b>					\$
<b>Banking Information</b>					
<b>Name of Bank</b>		<b>Checking Acct Balance</b>		<b>Savings Acct Balance</b>	
		\$		\$	
<b>Property Information</b>					
<b>Property Owned</b>	<b>Yes</b>	<b>No</b>	<b>Property Location</b>		<b>Approx Value \$</b>
Home					
Rental Property					
Farm Land					
<b>Other Property</b>	<b>Yes</b>	<b>No</b>	<b>Make/Model/Year</b>		<b>Approx Value \$</b>
Vehicle #1					
Vehicle #2					

Monthly Expenses	Monthly Payment	Payment Made To	Total Amount Due
Rent/Mortgage	\$ _____	_____	\$ _____
Car Loans	\$ _____ \$ _____	_____	\$ _____ \$ _____
Hospital Bills	\$ _____ \$ _____ \$ _____ \$ _____	_____	\$ _____ \$ _____ \$ _____ \$ _____
Doctor Bills	\$ _____ \$ _____ \$ _____ \$ _____	_____	\$ _____ \$ _____ \$ _____ \$ _____
Other Expenses	Monthly Payment	Other Expenses	Monthly Payment
Gas/Electric Company	\$ _____	Health Insurance	\$ _____
Telephone/Cell	\$ _____	Groceries	\$ _____
Cable/Satellite	\$ _____	Medications	\$ _____

**IMPORTANT:** Enclose Income Verification: Pay Stubs W-2 Form Soc Sec Info Tax Forms Bank Statements

### INCOME CERTIFICATION

I certify that my gross household income for last year was \$ \_\_\_\_\_ and that there are \_\_\_\_\_ people in my family.

Have you applied for Medicaid and/or any other state/county assistance? \_\_\_\_\_ Yes \_\_\_\_\_ No

Application Date	Program(s) Applied for:

I acknowledge indebtedness to Advanced Medical Transport for services received and billed to me. I have applied for Medicaid and/or any other third party benefits for which I am eligible. All Medicare, Medicaid, or insurance benefits due me have been applied to this account(s). I am financially unable to pay the balance due and request financial assistance for the outstanding balance(s). I certify that the information submitted is true and accurate.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This Section for Office Use Only	
<input type="checkbox"/> Applied/not eligible for Medicaid	<input type="checkbox"/> No program/not disabled/no dependent children
<input type="checkbox"/> Balance is spenddown, co-pay or deductible	<input type="checkbox"/> No insurance benefits available
<b>Additional comments:</b>	
Eligible for _____ % financial discount	Approved by: _____ Date: _____
<input type="checkbox"/> Not eligible/Exceeds charity guidelines	Denied by: _____ Date: _____