# CITIZENS AMBULANCE SERVICE

19 Railroad Street, PO Box 224
Wakeman, Ohio 44889
(440) 839-2144
Fax: (419) 581 - 5645

## Hardship Application

This application is for financial hardship consideration. This application will be utilized to determine eligibility for uncompensated transport services based on established criteria. By signing this application, you certify that the information provided below is current and accurate to the best of your knowledge. You also certify that you have utilized available agencies (Medicare, Medicaid, and any other commercial insurance) that provide assistance which may be available for payment of your ambulance charges. Payment received from these agencies for such services will be assigned to the ambulance provider. Information provided in this application will be utilized for financial hardship consideration only. Parties privileged to this information will include the transporting ambulance provider and the billing company only.

Name: ______________________________________________ Date of Birth: __________________________

Address: ___________________________________________________________________________________

Home Phone: ____________________________ Cell Phone: _______________________________________

SS#: ______________________________

Date of Transport: ____________________________ Account #: ___________________________

Are you currently covered under any health insurance plan? Yes _____ No _____
(If yes, please attach a copy of your card)

Do you currently receive Medicaid benefits? Yes _____ No _____
(If yes, please attached a copy of your card)

Are you filing this application on behalf of a deceased patient? Yes _____ No _____
If yes, does the decedent have an estate? Yes _____ No _____

What is your current monthly income? $_____________
What are your current monthly expenses? $_____________

Are you able to pay your balance in monthly installments? Yes _____ No _____
If yes, What amount could you pay per month? ______________

Continued on next page

# CITIZENS AMBULANCE SERVICE

19 Railroad Street, PO Box 224
Wakeman, Ohio 44889
(440) 839-2144
Fax: (419) 581 - 5645

**Proof of income MUST be attached to the completed form.**
**Examples are: Most recent signed & filed Federal and State income tax returns with all applicable W-2/1099 documentation, Social Security and/or Pension Statements, or last 6 months worth of paystubs, or income statements, etc.**

If your income, based on family size, is less than those listed below, charges may be canceled.
If your income is within 20% of those listed below, you could be eligible for a discount.
All incomes above those listed below are eligible for payment plans.

| 2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA | |
|---|---|
| **Persons in family/household** | **Poverty guideline** |
| 1 | $14,580 |
| 2 | $19,720 |
| 3 | $24,860 |
| 4 | $30,000 |
| 5 | $35,140 |
| 6 | $40,280 |
| 7 | $45,420 |
| 8 | $50,560 |
| For families/households with more than 8 persons, add $5,140 for each additional person. | |

Signature of Applicant: ______________________________________________ Date: _____________

Return to:
Mail - PO Box 224, Wakeman, Ohio 44889
Fax - (419) 581-5645
Email - Billing@CitizensAmbulance.com