

**Financial Assistance Process**

**Life Flight Network** is able to provide financial assistance on a sliding fee scale to those who qualify because of the support of our Foundation and financial contributions of our donors.

**If you have questions or need help completing this application, please contact:**

Patient Financial Services Department Monday – Friday 8:00 am to 5:00 pm PST, toll free at 1(866) 883-9998.

**In order for your application to be processed, you must:**

Return a completed application with the requested documentation within 30 days from receipt of the application

Porperty (excluding primary residence Owns a business

Provide the requested documentation regarding your household income

Porperty (excluding primary residence Owns a business

Provide the requested documentation regarding your household assets

Porperty (excluding primary residence Owns a business

Provide any necessary letter(s)

Porperty (excluding primary residence Owns a business

Provide additional information as requested

Porperty (excluding primary residence Owns a business

Sign and date the form

Porperty (excluding primary residence Owns a business

**Mail using enclosed envelope or fax completed application with all required documentation to:**

Quick Med Claims PO Box 18210 Pittsburgh, PA 15236-0210**; Fax:** (888) 489-8991**.**

**BE SURE TO KEEP A COPY FOR YOURSELF.**

We will notify you of the final determination of eligibility within 30 business days of receiving a complete financial assistance application, including any additional information or supporting documentation we may request.

Your application is confidential and viewing will be limited to the staff necessary to process the application. By submitting a financial assistance application, you give your consent for us to make necessary inquires to confirm financial obligations and information and to review credit information.

**There. When you need us.® www.lifeflight.org**



**Financial Assistance Application Form**

Please fill out all information completely. If it does not apply, write “NA”. Attach additional pages if needed.

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| --- | --- | --- | --- | --- |
| **PRESCREENING INFORMATION** | | | | |
| **Has the patient applied for Medicaid or County Assistance?** Yes  No *May be required to apply before being considered for financial assistance.*  Porperty (excluding primary residence Owns a business  Porperty (excluding primary residence Owns a business | | | | |
| **PLEASE NOTE** | | | | |
| * We cannot guarantee you will qualify for financial assistance * Once you send in your application, we may ask for additional information or supporting documentation * Within 30 business days after we receive your completed application, including any additional information or supporting documentation we may request, we will notify you if you qualify for assistance | | | | |
| **PATIENT INFORMATION** | | | | |
| **Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LFN Run Number(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total Owed LFN$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **RESPONSIBLE PARTIES (may be the same as patient)** | | | | |
| **Responsible Party Relationship First Name Last Name DOB SS# Occupation Present Employer** | | | | |
|  | | | | |
| **Spouse of Responsible Party First Name Last Name DOB SS# Occupation Present Employer** | | | | |
|  | | | | |
| **FAMILY SIZE**  **Total Number of Household Family Members\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Must be*** *verified by tax return or other documentation* | | | | |
| **INCOME INFORMATION** | | | | |
| **You must provide information on your household income. Income verification is required to determine financial assistance. Please provide proof for every identified source of income.** | | | | |
| * Last year’s income tax return (not a summary), including W-2 withholding statement and schedules if applicable; and * Current pay stubs (3 months); or * Written, signed statements from employer or others; or * Proof of unemployment compensation; or * Social Security Summary; and * Pension or retirement income documentation   **If you have no proof of income or no income, please attach an additional page with an explanation.** | | | | |
| **Total Monthly Income** | **Patient** | **Responsible Party** | **Spouse** | **Other** |
| **$** | **$** | **$** | **$** | **$** |
| **ASSET INFORMATION** | | | | |
| **You must provide information and documentation on household assets.** | | | | |
| **Please provide three months detail checking(s) and saving(s) account statements for all accounts owned by you and/or your spouse.** | | | | |
| **Does your household have these assets? Please check all that apply:**  Stocks Bonds 401K Health Savings Account(s) Trust(s) Property (excluding primary residence) Owns a Business  Porperty (excluding primary residence Owns a business  Porperty (excluding primary residence Owns a business  Porperty (excluding primary residence Owns a business  Porperty (excluding primary residence Owns a business  Porperty (excluding primary residence Owns a business | | | | |
| **PERSONAL CIRCUMSTANCES** | | | | |
| **You must provide a letter stating your financial situation, circumstances and why you feel you are a candidate for financial assistance. If you are living with friends or relatives, a signed letter of support is necessary.** | | | | |
| **AGREEMENT** | | | | |
| I understand Life Flight Network may verify information by reviewing credit information provided by a third party company and obtaining information from other sources to assist in determining eligibility for financial assistance. I affirm the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false or incomplete, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.  **­­­­­­­­­­­­­­­­­­­­­­­ Signature of Responsible Party Signature of Spouse**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |