Charity Care Payment Application

The County of Kendall, EMS Department Charity Care Payment Program helps patients and families who are unable to pay all of their medical bills related to services.

You may qualify for a discount through the Charity Care Payment Program if:

- You do not have health insurance
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial hardship criteria

If you have any questions about completing this form, please call (866) 398-8999

Patient Name: _____ **Date of Birth:** _____

Social Sec. #: _____ - _____ - _____   Date of Service: _____

Patient's Name/Address: _____

_____

Phone#: _____

Responsible Party's Name/Address: _____
Such as parent, guardian, or power of attorney

_____

Phone#: _____

Number of People in the household: _____

Charity Care is based on total Gross Income of the household, please list all sources of income.
(Please include copy of wage statement/pay stubs for the past 2 pay periods)

- -

Employer and address: _____ **Pre-Tax Salary: $** _____ **per week**

_____

- -

Employer and address: _____ **Pre-Tax Salary: $** _____ **per week**

_____

- -

Employer and address: _____ **Pre-Tax Salary: $** _____ **per week**

_____

Other Income: ☐ **Child Support** $ _____ per month

☐ **Disability** $ _____ per month

☐ **Alimony** $ _____ per month

☐ **Unemployment** $ _____ per month

☐ **Other** $ _____ per month

☐ **Please include copy of previous year's tax return of responsible party.**

☐ If patient is claimed as a dependent on someone's tax return, include that tax information also.

INSURANCE STATEMENT: (Please check all that apply. Attach copies of all notices)

1) ☐ Have / ☐ Have Not applied for Medicaid to cover these services. If not, please explain reason:
_____

2) ☐ Have / ☐ Have Not been rejected by Medicaid. Reason for rejection:
_____

3) ☐ Have / ☐ Have Not applied insurance through the Health Care Exchange (www.healthcare.gov)
_____

General Comments and Additional Considerations:
_____
_____
_____
_____
_____

I understand that the information that I provide to Kendall County EMS is confidential and will be used to determine my eligibility for uncompensated services under the Charity Care Payment guidelines established.

Completed By: _____ Relationship: _____

Signature of patient or responsible party: _____ Date: _____

Please do not forget to include all supporting documentation

Please return completed form to: Kendall County EMS

PO Box 1996
San Antonio, TX 78297-1996