

## **DEFENDERS OF TOMORROW™**



**877.800.5668** 

## Financial Assistance Application

Please complete this application as accurately as possible and attach all requested documentation. There is space on the back of this form to include any additional information or to explain any missing documentation. For help on filling out the form, contact us at:

patientforms@airmethods.com						
Patient Name:		SSN:		Date of Birth:		
A. Household Information						
Is a parent or other financially responsible individual completing this application for the patient? YES   NO   If "yes," please provide the name and other information for the financially responsible individual below and answer all remaining questions in this application for that individual instead of for the patient.						
Name:			SSN: -	-	Date of Birth:	
Spouse (or check if N/A □):			SSN: -		Date of Birth:	
Total number of persons in household (including patient and financially responsible individual):						
B. SIGNIFICANT LIFE EVENTS						
In the past 12 months, have you experienced any of the following? Only answer if you would like us to consider these events in deciding if you are eligible for assistance. Please attach proof of each event, such as a notice of foreclosure/eviction, death certificate, etc.						
Lost your job? □ Fi	led for bankruptcy?	Been	evicted? □	□ Death in immediate family? □		
Filed for divorce?   Foreclosure on house?   Became disabled?   Any other life event we should consider?   If you checked any of the above, please provide the date(s) of the event(s):						
C. Wages or Salary Information						
Are you employed? YES □ NO □			Is your spouse employed? YES □ NO □			
Your employer:			Spouse employer:			
Your position/title:			Spouse Position/title:			
Wages/Salary: \$per Hour Wk Mnth Year (circle one)			Wages/Salary: \$per Hour Wk Mnth Year (circle one)			
If hourly, average hours worked:per Wk Mnth (circle one)			If hourly, average hours worked:per Wk Mnth (circle one)			
D. OTHER SOURCES OF INCOME AND ASSETS/RESOURCES						
If anyone in the household (including you or your spouse) has additional sources of income, please list each such source of income below. Include disability payments, unemployment compensation, rental income, investment returns, or any other income.						
Source:	Who received the income?		Amour (circle	nt: \$per Wk Mnth Year		
Source:	Who received the income?		Amour (circle	nt: \$per Wk Mnth Year		

Please include all savings accounts, checking accounts, stocks, bonds, etc., but do not include retirement accounts (401(k)s or IRAs) or other resources that you cannot access without penalty.

Please provide the total amount of any other resources and liquid assets available to you: \$\_



## **DEFENDERS** OF **TOMORROW**™

Patient Name:		SSN:	Date of Birth:			
E. INCOME VERIFICATION AND APPLICATION ATTESTATION						
<ul> <li>Tax Return (Form 1040 or 1040EZ)</li> <li>IRS Form W-2 or Employer Verification</li> <li>Copy of Paycheck or Paycheck Stub</li> <li>Bank Statements</li> <li>Spousal Support</li> </ul>	on / Remittance	Social Security, Workers' Compensation or Unemployment Compensation Determination Letter     Proof of Participation in Governmental Assistance programs (WIC, food stamps, housing assistance, etc.)				
If you cannot provide documentation of y  F. MONTHLY EXPENSES	your income, you must	ехріані міту посон тіе раск от т	IIS IOIIII.			
RENT / MORTGAGE	\$	CREDIT CARD PAYMENTS	\$			
GROCERIES	\$	LOAN PAYMENTS	\$			
AUTO LOANS	\$	OTHER:	\$			
Cable / Internet	\$	OTHER:	\$			
CELL PHONE / HOME PHONE	\$	OTHER:	\$			
UTILITIES (GAS, WATER, TRASH, ELECTRIC)	\$	OTHER:	\$			
		TOTAL EXPENSES	\$			
ADDITIONAL	INFORMATION OR EXPLAN	NATION FOR MISSING DOCUMENTATION	NO			
significant life events. You may also use consider, that did not fit on the application	triis space to provide a	ny additional information that you	u tnink we snoula know or			
By signing below, I attest that all information provided in this application is true and factual to the best of my knowledge, and I understand I will forfeit all rights to financial assistance if I have falsified any information.						
Signature of Patient or Responsible Part	у	Date				