Compassionate Care Program

Thank you for your interest in our Compassionate Care Program. Please refer to the list below for information required to process your application.

We will not be able to process your application if it is returned incomplete, or the required documentation is not provided.

***Please note that additional documentation not initially requested below may be required following review of your situation.**

All Applicants:

Proof of Income for entire household (at least one of the following):

- ☐ Previous year tax return or letter of non-filing from the IRS (1-800-908-9946) (only relevant pages, e.g., 1040 Form that includes income and dependents)
- ☐ Hospital Charity Approval Letter (if applicable)
- ☐ Award letter from local Department of Human Services (DHS) or Department of Family Services (DFS)
- ☐ Paycheck stubs (if employed) or bank statements from the previous two (2) months for the entire household
- ☐ A letter from your local employment office indicating no wages/benefits (if unemployed or retired) are currently being received, or proof of any other sources of income or aid (i.e. SSI, SSA, SSDI, Unemployment, etc.)
- ☐ Your quarterly profit and loss statement (if self-employed)

Please forward the completed application with all required documentation within 10 business days to:

American Medical Response
Attention: Patient Advocates
4701 Stoddard Rd.
Modesto, CA 95356

Your application for the Compassionate Care program will be thoroughly reviewed, and a letter will be mailed to you informing you of our determination. If you have any questions, please contact Customer Care at 1-800-913-9106.

COMPASSIONATE CARE APPLICATION

CONTACT INFORMATION

Patient Name: _____ Account #: _____
Responsible Party: _____ Account Balance: _____
Address: _____ LOB: _____
_____ Home Phone #: _____
_____ Cell Phone #: _____
Employer Name: _____

HOUSEHOLD SIZE: _____ (Include yourself, spouse and dependents only)

Name	Relationship to Patient	Age

(List additional household members on a separate sheet)

MONTHLY HOUSEHOLD INCOME

Net Wages $_____
SSI, SSA, or SDI $_____
Unemployment $_____
Pension $_____
Cash/Food Assistance $_____
Other Income Source: _____ $_____
Total $_____

MONTHLY MEDICAL EXPENSES

Description

Health Insurance Premiums/COBRA _____ $_____
Pharmacy _____ $_____
Doctor Payments _____ $_____
Hospital Payments _____ $_____
Dental Payments _____ $_____
Specialist Payments _____ $_____
Other Medical Expense _____ $_____
Total $_____

- I declare that above information is a true and accurate representation of my financial status.
- I understand that American Medical Response is required by law to keep any information I provide confidential.
- I understand that if I do not qualify for a reduction or waiver of charges by the terms of this program, I will remain personally liable for the charges of the services rendered by American Medical Response. I understand that all decisions are final.
- I certify that there is not any liability or third-party coverage pertaining to all transports related to this application.

Signature_____ Date_____