Financial Hardship Application

All information relating to the financial hardship request will be kept confidential

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Social Security No: _____ Phone No: _____
Address: _____
Name of Spouse: _____ Date of Birth: _____
Parent's Name (if a minor): _____
Date of Service: _____ Account No: _____

Did you apply for Pennsylvania Medical Assistance? _____ When? _____
Were you approved or denied? _____ (If denied include a copy of the denial)

MONTHLY HOUSEHOLD INCOME, ASSETS & EXPENSES

INCOME: (Monthly)

Please include the most recent Federal tax return or W-2

Wages: $_____
Pension: $_____
Alimony: $_____
Social Security: $_____
Child Support: $_____
Unemployment: $ _____
Workers Comp: $_____
Other (Explain): $_____

ASSETS:

Please include a copy of the past three months' statements

Bank Name: _____

Balance: Checking $_____ Savings$ _____ Retirement $_____

EXPENSES: (Monthly)

Use additional sheets if needed

Mortgage/Rent: $_____
Electric: $_____
Heat: $_____
Water/Sewer: $_____
Groceries: $_____
Garbage: $_____
Hospital/Dr. Visits: $_____
Other (Explain): $_____

Phone: $_____
Cable: $_____
Fuel/Auto: $_____
Car Insurance: $ _____
Car Payment: $_____
Child Care: $_____
Prescriptions: $_____
Other (Explain): $_____

DEPENDENTS

The family unit will consist of those people who meet the federal guidelines and qualify as tax-deductible dependents of the family. Please list your dependents:
(Use additional pages if needed)

Total number of household members (including the patient): _____

	Legal Name	Relationship	Age	Date of Birth
1.				
2.				
3.				
4.				
5.				

I certify that the information provided to EmergyCare for eligibility for charity care is true, correct, and complete. I understand that any incorrect, fraudulent, or intentionally withheld information may result in the denial of charity relief and/or the revocation of any charity benefits already received. As a result, I will be required to pay in full for the services rendered to me and/or my dependant(s). I agree to be responsible for any balance remaining after any waiver application by EmergyCare (if any). Should my financial situation improve, EmergyCare can and will begin to attempt to collect on any charges that were waived.

_____ _____

Patient/Responsible Party Signature Date

Responsible Party Phone No: _____

Application Process for Financial Hardship

Eligibility for charity will be considered for those individuals who are uninsured, underinsured, and ineligible for any government health care benefit program, and who are unable to pay for the services EmergyCare provided. The granting of charity shall be based on an individual's determination of financial need, and shall not consider age, gender, race, social or immigration status, sexual orientation or religious affiliation.

Required Information:

EmergyCare requires the most recent Federal tax return or W-2 as verification of income. EmergyCare also recommends that the applicant apply for medical assistance and if denied include a copy of the denial. You can apply for Pennsylvania Medical Assistance at your local County Assistance Office or online at http://www.dpw.state.pa.us/applyforbenefits/index.htm

Time Frame:

EmergyCare requires that all applications be returned within **20 business days**. After the application and verification information is received, EmergyCare will consider the overall financial situation of the applicant and then render a decision.

Applicants will receive notification stating whether the application has been approved or rejected. If the application is rejected and additional documentation of financial need is received to support charity care, the request may be reviewed and considered per the guidelines.

In applying these guidelines, EmergyCare will also consider and consider all other income and expenses, including money earned in the entire household as well as retirement accounts.

EmergyCare Billing Department will maintain all records related to the financial hardship waiver process. This documentation will include the waiver request and all documentation provided in support of the request.

Application Process for Financial Hardship (con't)

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient or their designee. The annualization process will also take into consideration seasonal employment and temporary increase and/or decrease to income.

EmergyCare can and will begin to collect on any charges that were waived should the applicant's financial situation improve.

The Ambulance Billing Specialist handling your account is listed below. If you have any questions please contact, he/she directly at 814-870-1030 or 800-814-1038.

PLEASE COMPLETE ATTACHED APPLICATION

YOUR REQUEST CANNOT BE PROCESSED UNLESS THE APPLICATION IS FULLY COMPLETED AND SIGNED!

Ambulance Billing Specialist: _____

Application Sent On: December 4, 2025