Advanced Medical Transport
of Central Illinois
Save Lives. It's what we do.

**Advanced Medical Transport**

***1718 N Sterling Ave***

***Peoria, IL 61604-3831***

***(309) 494-6203 or (855) 268-2455 (855-AMT-BILL)***

***www.amtci.org***

# Financial Assistance Program Application Process

Advanced Medical Transport is a not-for-profit organization that provides both emergency and non-emergency transportation. As part of our commitment to provide chartable services to patients in our community, a Financial Assistance Program has been developed. This program provides discounts on transportation charges for patients that meet pre-determined household income and family size requirements. Discounts range from 10 to 100 percent based on applicant eligibility. If you are under 21 years of age and a full time student, this application needs to be completed by your family.

The following documentation should be included with your application:

- Bank statements for the past 2 months
- Pay stubs for the last 3 pay periods
- W-2 forms for the most recent tax year
- Federal tax forms for the most recent year if filed
- Self-employed applicants should submit tax forms for the past 3 yrs
- Pension benefits
- Unemployment benefits ( if you are receiving or have received within the year reported)
- Social Security or Social Security Disability benefits
- Please provide a letter if none of the above apply indicating how you support yourself if you have special circumstances and/or cannot complete the application in its entirety

Please return your completed application along with the required documentation to the address listed above. For assistance with your questions, please contact our Customer Service Department at ***(309) 494-6203 or (855) 268-2455 (855-AMT-BILL)***

# Advanced Medical Transport Financial Assistance Program Application

| Patient Information | | | | |
|---|---|---|---|---|
| Patient Name | Social Security # | Birth Date | Age | Marital Status |
| | | | | |
| Patient Address (Street, City, State and Zip code) | | | | |
| | | | | |
| Responsible Party's Name | Social Security # | Birth Date | Relationship to Patient | |
| | | | | |
| Dependent Name(s) | Age(s) | Dependent Name(s) | Age(s) | |
| | | | | |
| | | | | |
| | | | | |

| Patient's Employer Information | | Spouse's/Responsible Party's Employer Info. | |
|---|---|---|---|
| Name: | | Name: | |
| Street: | | Street: | |
| City, State, Zip: | | City, State, Zip: | |
| Job Title: | | Job Title: | |
| # of Years Worked: | | # of Years Worked: | |
| Work Phone #: | | Work Phone #: | |

| Income | | |
|---|---|---|
| **Income Source - Employment** | **Hours Worked per Week** | **Hourly Wage or Salary** |
| Patient | | $ |
| Spouse/Responsible Party | | $ |
| **Income Source - Other** | **Gross Monthly Income** | |
| Patient | $ | |
| Spouse/Responsible Party | $ | |
| Working Children | $ | |
| Social Security | $ | |
| Pension(s) | $ | |
| Child Support | $ | |
| SSI/SSDI | $ | |
| Unemployment | $ | |
| Other Income (commissions, tips, rental property, farm or interest income) | $ | |
| **Total Monthly Gross Income** | $ | |
| **Annual Gross Income** (multiply Total Monthly Gross income by 12) | $ | |

I certify that my annual gross household income for last year was $_____ and that there are _____ people in my family.

| Banking Information | | | |
|---|---|---|---|
| **Name of Bank** | **Type of Account** | | **Acct Balance** |
| | ☐ Checking | ☐ Savings | $ |
| | ☐ Checking | ☐ Savings | $ |
| | ☐ Checking | ☐ Savings | $ |

**Advanced Medical Transport Financial Assistance Program Application (pg2)**

| Property Owned | | | |
|---|---|---|---|
| | **Yes/No** | **Property Location** | **Approx Value $** |
| Home | | | $ |
| Rental Property | | | $ |
| Farm Land | | | $ |
| Other | | | $ |
| | **Yes/No** | **Make/Model/Year** | **Approx Value $** |
| Vehicle #1 | | | $ |
| Vehicle #2 | | | $ |

**Total Approx Value of Property Owned** **$**

| Expenses | | | |
|---|---|---|---|
| | **Monthly Payment** | **Payment Made To** | **Total Amount Due** |
| Rent/Mortgage | $ | | $ |
| | $ | | $ |
| Car Loans | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| Hospital Bills | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| | $ | | $ |
| Doctor bills | $ | | $ |
| Health Insurance | $ | | $ |
| Medications | $ | | $ |
| Gas/Electric | $ | | $ |
| Telephone/Cell | $ | | $ |
| Cable/Satellite | $ | | $ |
| Groceries | $ | | $ |
| Credit Card | $ | | $ |

**Total Monthly Expenses** **$** **Total Amount Due**

| Have you applied for Medicaid and/or any other state/county assistance? _____Yes _____No | |
|---|---|
| Application Date | Program(s) Applied For: |
| | |
| | |
| | |

I acknowledge indebtedness to Advanced Medical Transport for services received and billed to me. I have applied for Medicaid and/or any other third party benefits for which I am eligible. All Medicare, Medicaid, or insurance benefits due to me have been applied to this account(s). I am financially unable to pay the balance due and request financial assistance for the outstanding balance(s). I certify that the information submitted is true and accurate.

Patient or Responsible Party Signature:_____ Date:_____

IMPORTANT: Income Verification must be submitted with Financial Assistance Program Application. These items include: Pay Stubs, W-2 Form, Social Security Information, Tax Forms, and Bank Statements.