



UTE PASS REGIONAL AMBULANCE DISTRICT

PATIENT QUESTIONNAIRE FOR FINANCIAL HARDSHIP DETERMINATIONS

Instructions to Patient

Please complete this form in its entirety and return it to:

Ute Pass Regional Ambulance District
P.O. Box 149
Woodland Park, CO 80866.

Patient Name: _____

Address: _____

City/State/Zip: _____

Responsible party (if different than patient): _____

Address of Responsible Party: _____

City/State/Zip of Responsible Party: _____

I am applying for a Hardship Determination in order that you will consider waiving my co-pay/co-insurance/deductible (or total charges if uninsured) for service and care provided to me on _____(date of service).

I am supplying the following information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources including Social Security benefits, pensions, annuities, dividends, etc. Attached you will find verification of my employment/unemployment status and copies of my federal tax returns or W-2 forms for the previous 2 years.

My insurance information is:

Insurer Name: _____

Insurance Policy/ID Numbers: _____

<u>Monthly Income</u>	<u>Self</u>		<u>Spouse</u>	
Wage/salary	\$ _____		\$ _____	
Social security	\$ _____		\$ _____	
Pension	\$ _____		\$ _____	
Interest income	\$ _____		\$ _____	
Other	\$ _____		\$ _____	
Totals	\$ _____	+	\$ _____	= \$ _____

Statement of Agreement: "I am supplying this information to request that UPRAD waive collection of all or part of the Medicare or other deductible/co-insurance amounts in my case due to financial hardship. I also understand that UPRAD can and will begin to attempt to collect charges should my financial situation improve. I agree to be responsible for any balance remaining after the application of any waiver by UPRAD, if any."

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