Financial Assistance Process

Life Flight Network is able to provide financial assistance on a sliding fee scale to those who qualify because of the support of our Foundation and financial contributions of our donors.

If you have questions or need help completing this application, please contact:
Patient Financial Services Department Monday – Friday 8:00 am to 5:00 pm PST, toll free at 1(866) 883-9998.

These documents will be require after the initial application is received.:

- ☐ Proof of household income
- ☐ Proof of household assets
- ☐ Provide any necessary letter(s) as defined in the application on page 2
- ☐ Provide additional information as requested
- ☐ Sign and date the form

Mail using enclosed envelope, fax completed application, or respond to the secure email with all required documentation to:
Quick Med Claims PO Box 18210 Pittsburgh, PA 15236-0210**; Fax:** (888) 489-8991**.**

BE SURE TO KEEP A COPY FOR YOURSELF.

We will notify you of the final determination of eligibility within 30 business days of receiving a complete financial assistance application, including any additional information or supporting documentation we may request.

Your application is confidential and viewing will be limited to the staff necessary to process the application. By submitting an application for financial assistance, you authorize us to review credit records and make any necessary inquires to confirm financial obligations and information.

Financial Assistance Application Form

Please fill out all information completely. If it does not apply, write "NA". Attach additional pages if needed.

PRESCREENING INFORMATION

Has the patient applied for Medicaid or County Assistance? ☐ Yes ☐ No *May be required to apply before being considered for financial assistance.*

PLEASE NOTE

- We cannot guarantee you will qualify for financial assistance
- Once you send in your application, we may ask for additional information or supporting documentation
- Within 30 business days after we receive your completed application, including any additional information or supporting documentation we may request, we will notify you if you qualify for assistance

PATIENT INFORMATION

Life Flight Network Run Number(s)______________________________ **Date** ____________________________

RESPONSIBLE PARTIES (Responsible Party: Complete if not the patient)

Relationship	First Name	Last Name

FAMILY SIZE

Total Number of Household Family Members________________ ***Must be** verified by tax return or other documentation*

INCOME INFORMATION

You must provide information on your household income. Income verification is required to determine financial assistance.
Please provide proof for application source of income.

- Last year's income tax return (not a summary), including W-2 withholding statement and schedules if applicable; **and**
- Current pay stubs (3 months); **or**
- Written, signed statements from employer or others; if pay stub is not available
- Proof of unemployment compensation (if applicable); **or**
- Social Security Summary (if applicable); **and**
- Pension or retirement income documentation (if applicable)

If you have no proof of income or no income, please attach an additional page with an explanation.

Total Monthly Income	Patient	Responsible Party	Spouse	Other
$	$	$	$	$

ASSET INFORMATION

You must provide information and documentation on household assets.

Please provide three months account statements for all accounts owned by you and/or your spouse, including checking and savings.

Does your household have these assets? Please check all that apply:

☐ Stocks ☐ Bonds ☐ Health Savings Account(s) ☐ Trust(s) ☐ Property (second/vacation home) ☐ Owns a Business

PERSONAL CIRCUMSTANCES

Please provide three months financial situation, circumstances and why you feel you are a candidate for financial assistance.
If you are living with friends or relatives, a signed letter of support is necessary.

AGREEMENT

I understand Life Flight Network may verify information by reviewing credit information provided by a third party company and obtaining information from other sources to assist in determining eligibility for financial assistance. I affirm the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false or incomplete, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

Signature of Responsible Party ____

Date ____________________________