LIFENET
6225 St. Michael Dr., Texarkana, Texas 75503 (903) 832-8531/Fax (903) 832-0215

Financial Assistance Program

At LifeNet, we are proud of our mission to provide emergency ambulance and air medical service regardless of ability to pay. We believe that no one should delay seeking needed emergent medical care because they lack health insurance or are worried about their ability to pay for their care. That's why we have a Patient Financial Assistance Program that provides free or discounted services to eligible patients.

What is LifeNet's Patient Financial Assistance Program?
Our Patient Financial Assistance Program helps to make our services available to everyone in our community. This includes people who don't have health insurance and can't pay their ambulance bill, as well as patients who do have insurance but are unable to pay the portion of their bill that insurance doesn't cover.

In some cases, eligible patients will not be required to pay for services; in others, they may be asked to make partial payment.

Who Is Eligible?
Patients who are uninsured and do not qualify for government-sponsored insurance programs, and with family income up to 500 percent of the Federal Poverty Guidelines may be eligible for our program. Our customer service representatives will work with you to determine if you qualify. Please remember that access to emergency ambulance service is not affected by eligibility for financial assistance.

How to Apply
We know that use of the ambulance can be stressful both for the patient and his or her family, so we try to make applying for the Patient Financial Assistance Program as easy as possible.

LifeNet, Inc
6225 St. Michael Drive
Texarkana TX 75503
903 832 8531 or 800 832 6395

Financial Assistance Application

For cases in which a patient is unable to make monthly payments or pay their LifeNet bill because of a fixed income or a financial hardship a Charitable write off or reduced charges are available if the following conditions are met. You must provide verification of your income.

W2 forms… Income tax return… Social Security forms… Food stamps

To be eligible to receive uncompensated or reduced charges, your household income must at or below the following levels to receive the discounts indicated.

Household Size	Annual Household Income				
1	10,400	15,600	20,800	26,000	31,200
2	14,000	21,000	28,000	35,000	42,000
3	17,600	26,400	35,200	44,000	52,800
4	21,200	31,800	42,400	53,000	63,600
5	24,800	37,200	49,600	62,000	74,400
6	28,400	42,600	56,800	71,000	85,200
7	32,000	48,000	64,000	80,000	96,000
8	35,600	53,400	71,200	89,000	106,800
Charitable Write off Or Discount	100%	80%	60%	40%	20%

Application for Conditional Determination or Eligibility

Patient Name_____ Date_____

Address_____

Phone Number _____ Cell Phone _____

Email Address_____

Social Security Number_____

Guarantor (if different from patient) _____

Employer_____

Number of dependents_____ Relationship to patient_____

How much is your yearly income? (Before taxes and deductions) $_____

How much other income do you get each year? (Before taxes) $_____

How much income do other household members receive yearly? $_____

How many people are in your household? _____

If the patient and the applicant are not the same person, complete the following:
Name_____ Social Security #_____

If the Conditional Determination of Eligibility is approved, you may be eligible for uncompensated services or reduced charges upon completion of this application. LifeNet Inc requires that you provide written or other satisfactory documentation of information entered. False, incomplete, misleading, or inadequate documentation will not be approved.

Patients who qualify for Uncompensated LifeNet Services receive a discount of 100% of charges. Patients who qualify for Reduced Charges will receive a percentage discount based on their verified financial information and are responsible for any remaining balances.

LifeNet Inc

Charity Check List

Patient Name_____ Run #_____

Income Information	Yes	No	If yes, amount	Monthly/Yearly
Child Support	O	O	_____	_____
Wages	O	O	_____	_____
Food Stamps	O	O	_____	_____
SSI/ Social Security	O	O	_____	_____
Work Comp	O	O	_____	_____
Unemployment	O	O	_____	_____
Other Income	O	O	_____	_____

Number of members in household _____

Name	Employed Yes	Employed No	Relationship	Age
_____	O	O	_____	_____
_____	O	O	_____	_____
_____	O	O	_____	_____
_____	O	O	_____	_____
_____	O	O	_____	_____
_____	O	O	_____	_____
_____	O	O	_____	_____

Please provide documentation for all above listed income.

Patient Signature _____Date_____

Approved by LifeNet Inc_____Date_____