Kendall County EMS Charity Care
1175 N Main, Boerne, TX 78006
830-249-3721

Charity Care Payment Application

The County of Kendall, EMS Department Charity Care Payment Program helps patients and families who are unable to pay all of their medical bills related to services.

You may qualify for a discount through the Charity Care Payment Program if:

- You do not have health insurance
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial hardship criteria

If you have any questions about completing this form, please call (866) 398-8999

Patient Name: ____ **Date of Birth:** _______________

Social Sec. #: __________ - __________ - __________ Date of Service: __________________

Patient's Name/Address: ____

____

Phone#: __________________________________

Responsible Party's Name/Address: ____

Such as parent, guardian, or power of attorney

____

Phone#: __________________________________

Number of People in the household: __________

Charity Care is based on total Gross Income of the household, please list all sources of income.

(Please include copy of wage statement/pay stubs for the past 2 pay periods)

Employer and address: __________________________________ **Pre-Tax Salary: $** ___________ **per week**

____

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____

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____

Other Income: ❒ **Child Support** $ _____________ per month
❒ **Disability** $ _____________ per month
❒ **Alimony** $ _____________ per month
❒ **Unemployment** $ _____________ per month
❒ **Other** $ _____________ per month

❒ **Please include copy of previous year's tax return of responsible party.**

❒ If patient is claimed as a dependent on someone's tax return, include that tax information also.

INSURANCE STATEMENT: (Please check all that apply. Attach copies of all notices)

1) ❒ Have / ❒ Have Not applied for Medicaid to cover these services. If not, please explain reason:
____

2) ❒ Have / ❒ Have Not been rejected by Medicaid. Reason for rejection:
____

3) ❒ Have / ❒ Have Not applied insurance through the Health Care Exchange (www.healthcare.gov)
____

General Comments and Additional Considerations:

____
____
____
____
____

I understand that the information that I provide to Kendall County EMS is confidential and will be used to determine my eligibility for uncompensated services under the Charity Care Payment guidelines established.

Completed By: ____ Relationship: ______________

Signature of patient or responsible party: ______________________________ Date: _____________

Please do not forget to include all supporting documentation

Please return completed form to: Kendall County EMS

PO Box 450
78 Regency Pkwy.
Mansfield, TX 76063