City of Xenia

EMS PATIENT QUESTIONNAIRE FOR FINANCIAL HARDSHIP DETERMINATIONS

Instructions to Patient

Please complete this form in its entirety and return it to, PO Box 2030 Mount Vernon, OH 43050-7230

Patient Name:_____

Address:_____

City/State/Zip_____

Responsible Party (if different than patient):_____

Address of Responsible Party:_____

City/State/Zip of Responsible Party:_____

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 on my employment/unemployment status, copies of my federal tax returns or W-2 forms for the previous year.**

My insurance information is:

Insurer Name:_____

Insurance Policy/ID Numbers: _____

Monthly Income: _____

Number of people in household: _____

	Self:	**Spouse:**	
Wage/Salary	$_____	$_____	
Social Security	$_____	$_____	
Pension	$_____	$_____	
Interest Income	$_____	$_____	
Other Income	$_____	$_____	
Total	**$_____**	**$_____**	**= $_____**

Statement of Agreement: "I am supplying this information to request that City of Xenia waive collection of all or part of my charge due to financial hardship. I also understand that City of Xenia can and will begin to collect charges should my financial situation improve. I agree to be responsible for any balance remaining after the application of any waiver by City of Xenia.

Patient/Responsible Party

Signature:_____**Date:**_____