Galesburg Hospitals' Ambulance Service

2175 Windish Drive, Galesburg, IL 61401 • (309) 342-5144 Fax (309) 342-4834

Financial Assistance Program
Application Process

Galesburg Hospitals' Ambulance Service (GHAS) is a not-for-profit organization that provides both emergency and non-emergency transportation. As part of our commitment to provide charitable services to patients in our community, a Financial Assistance Program has been developed. This program provides discounts on transportation charges for patients that meet pre-determined household income and family size requirements. Discounts range from 10 to 100 percent based on applicant eligibility. If you are under 21 years of age and a full time student, this application needs to be completed by your family.

Applicants, who wish to apply for financial assistance, must complete our Financial Assistance Program Application and provide the required documentation to be considered for a discount. If this application is incomplete or returned without the appropriate documentation, the application will be denied.

The following documentation should be included with your application:

- Bank statements for the past 2 months
- Pay stubs for the last 3 pay periods
- W-2 forms for the most recent tax year
- Federal tax forms for the most recent tax year (if filed)
- Self-employed applicants should submit federal tax forms for the past 3 tax years
- Pension benefits (if you are receiving)
- Unemployment benefits (if you are receiving or have received within the year reported)
- If you are unemployed & have not worked during the past year, please include a letter that clearly documents how you support yourself
- Social Security or Social Security Disability benefits

Please return your completed application along with the required documentation in the enclosed envelope. For assistance with your questions, please contact our office at (309) 342-5144.

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Request for GHAS Charity Assistance

Patient	Demographics	Spouse (or Responsible Party)
	Name	
	Social Security #	
	Date of Birth	
Street:	Address	Street:
City: State: Zip:		City: State: Zip:
	Telephone #	
	Employer	
	Employer Telephone #	
	Hire Date	
$ /	Wage / Hours Worked Week	$ /
Marital Status ☐ Single	☐ Married ☐ Widowed	☐ Divorced ☐ Legally Separated
	Financial Information	
$ ❑ week ❑ 2weeks ❑ month	Paid Wages/ How Often	$ ❑ week ❑ 2 weeks ❑ month
	SS / SSI / SSD Received	
	Pension Received	
	Child Support / Alimony I Foster Care)Public Assistance Received	
	Other Monthly Income	
	Total Monthly Income	
	Child Support Paid by You	
	Gross income Calculation = $	

Family Size: Means the number of persons obligated to pay the charges incurred plus the total number of their natural or adopted children residing in their home(s) who are either less than 20 years old or Legally Disabled.

Legal Family Size Calculation =

Name:	birth date	relationship
Name:	birth date	relationship
Name:	birth date	relationship
Name:	birth date	relationship

Financial Information

Account Type	Name of Bank		Account Balance
Checking Account:			
Savings Account:			
Money Market / CD Accounts:			
Stock, Bonds & Mutual Funds:	Date of Investment:	Name of Institution:	Market Value:

Income verification:
GHAS may require an uninsured patient who is requesting an uninsured discount to provide documentation of family income. Acceptable family income documentation shall include any one of the following.

(A) a copy of the most recent tax return;
(B) a copy of the most recent W-2 form and 1098 forms;
(C) copies of the 2 most recent pay stubs;
(D) written income verification from an employer if paid in cash; or
(E) one other reasonable form of third party income verification deemed acceptable to GHAS.

Asset verification:
GHAS may require an uninsured patient who is requesting an uninsured discount to certify the existence of assets owned by the patient and to provide documentation of the value of such assets. Acceptable documentation may include statements from financial institutions or some other third party verification of an asset's value. If no third party verification exists, then the patient shall certify as to the estimated value of the asset.

I have received GHAS Charity Assistance within the last 12 months. ❑ Yes ❑ No If yes, when?

Please note that GHAS uses a third party to verify the financial information submitted. If the information submitted does not closely match, you may be required to complete additional income worksheets.

I certify that everything stated in this Application and on the documents submitted is true. I understand that if any information is untrue, financial assistance will be reversed or denied. By signing this Application, I authorize you to verify all information submitted.

Signature(s): ______________________________ Date: