GIBSON COUNTY AMBULANCE SERVICE
225 N. HART ST. PRINCETON, IN 47670
OFFICE: 812- 385-8967 FAX: 812-386-5127
DAVID POND, DIRECTOR
MICHELLE MASON, ADMIN. ASST.

Application for Long Term Payment Plan for Hardship

PLEASE ATTACH THE FOLLOWING INFORMATION TO THIS APPLICATION AND RETURN IT WITHIN 15 BUSINESS DAYS AFTER RECIEIVING THIS APPLICATION

1.) Copies of the last 3 months check stubs
2.) Copies of medical bills

Patient Information (please print)

Name: _____
First Middle Last

Address:_____
Number Street City State Zip

Home phone:_____ Cell phone:_____

Employer: _____
Name Address

Work phone number:_____ Occupation: _____

Please list all persons in your household:

Name & Relationship Age Do you claim as Dependent for Tax Purpose

_____
_____
_____
_____

Have you ever filed for bankruptcy?_____ If so, when?_____

Are you currently delinquent with monthly payments for other products or services? (circle one)
Yes No
If yes please explain: _____
_____
_____
_____

Statement of Income

List all sources of household income:	Monthly
Patient Net Income	
Patient Spouse Net Income	
Public Assistance	
Social Security	
Unemployment Compensation	
Child Support	
Total:	

Household Expenses	Monthly
Mortgage/Rent	
Utilities (electric, gas, water)	
Telephone	
Other Medical Expenses (attach copies)	
Other pertinent expenses	
Total:	

I certify the information I stated above is correct. I agree to provide Gibson County Ambulance Service with any and all information ***within 15 days,*** if there any changes in my income, property, expenses, persons in my household, address, or phone number. I understand that if I do not qualify as having a financial hardship that I will be personally responsible for the charges for the services provided to me by Gibson County Ambulance Service. I agree that I must provide supporting documentation if requested. I also understand that if I qualify for a financial hardship discount that if I do not make monthly payments all of the hardship discount given ***will be removed*** and the account(s) will be sent to collections.

Patient/Responsible Party's Signature:_____ Date:_____