3 Hook Road
P.O. Box 672
Rhinebeck, NY 12572
Phone: (845) 876-0338
Fax: (845) 876-7071
www.ndpems.com

Charity Care Application

Name: ____

Address: ____

Home Phone: ____________________Work Phone: ________________

Social Security #: __________________Monthly Income: _____________
Proof of income must be attached. Please provide a copy of your most recent Income Tax Return. **** MUST INCLUDE COPIES OF ALL SCHEDULES FROM INCOME TAX RETURNS **** (If income is different than last year's tax return, please provide additional proof of current income.)
Employers Name: ____

Employers Address: ____

Number of Dependents in family (including Self): ___________________

Name of patient applying for: ___________________________________

Relationship: ____________________ Account #: ___________________

Have you applied for Medicaid? Yes ___________ No ______________

If no, indicate reason: ____
If you have been denied Medicaid, a copy of denial must be attached.

List any special
Circumstances: ____
____

I understand that the information, which I submit, is subject to verification by Northern Dutchess Paramedics, Inc. and subject to review by Federal and/or State enforcement agencies. I certify that the above information is true and correct.

Signature of Applicant: ________________________________Date: __________
** ALL INFORMATION MUST BE COMPLETE FOR APPLICATION TO BE PROCESSED ****