Contra Costa County Fire-EMS

FIRST LAST
STREET ADDRESS
CITY, ST, ZIP

Thank you for your interest in our Compassionate Care Program. Please reference the list below for information required to process your application. We will not be able to process your application if it is returned incomplete, or the required documentation is not provided.

All Applicants:

- ☐ The previous year's tax return or letter of non-filing from the IRS (1-800-908-9946).

AND

Employed Applicants:

- ☐ Paycheck stubs or bank statements from the previous three (3) months.

Unemployed / Retired Applicants:

- ☐ A letter from your local employment office indicating no wages/benefits are currently being received, or proof of any other sources of income or aid (i.e. SSI, SSA, SSDI, Food Stamps, Unemployment, Cash Assistance, etc.).

Self Employed Applicants:

- ☐ Your quarterly profit and loss statement.

College Students Over 18 Years of Age:

- ☐ Documentation showing current enrollment is required (i.e. student loan documentation, a current class schedule, school account summary, etc.).

Non-US Residents:

- ☐ Proof of income (check stubs, bank statement, proof of hospital charity, etc.).

Please forward the completed application with all required documentation within 10 business days to:

CCC Fire-EMS
Attention: Compassionate Care Program / Robin Holcomb
4005 Port Chicago Hwy, Suite 250
Concord, CA 94520
Robin.Holcomb@cccfpd.org

Your application for the Compassionate Care program will be thoroughly reviewed, and a letter will be mailed to you informing you of our determination. If you have any questions, please contact our Customer Service Department at 1-925-941-3300 ext 1401.

COMPASSIONATE CARE APPLICATION

CONTACT INFORMATION

Patient Name: _____
Responsible Party: _____
Address: _____
_____
_____
_____
Employer Name: _____

Account #: _____
Account Balance: _____
D.O.B _____
Home Phone #: _____
Cell Phone #: _____

HOUSEHOLD SIZE: _____ (Include yourself, spouse and dependents only)

Name	Relationship to Patient	Age

(List additional household members on a separate sheet)

MONTHLY HOUSEHOLD INCOME

Net Wages $_____
SSI, SSA, or SDI $_____
Unemployment $_____
Pension $_____
Cash/Food Assistance $_____
Other Income Source: _____ $_____
Total **$_____**

MONTHLY MEDICAL EXPENSES

Description

Health Insurance Premiums/COBRA _____ $_____
Pharmacy _____ $_____
Doctor Payments _____ $_____
Hospital Payments _____ $_____
Dental Payments _____ $_____
Specialist Payments _____ $_____
Other Medical Expense _____ $_____
Total **$_____**

- I declare that above information is a true and accurate representation of my financial status.
- I understand that CCC Fire-EMS is required by law to keep any information I provide confidential.
- I understand that if I do not qualify for a waiver of charges by the terms of this program, I will remain personally liable for the charges of the services rendered by CCC Fire-EMS. Appeal rights may be granted if my initial application is denied; however, any appeal must be submitted in writing to CCC FIRE-EMS within 30 days of the date on the original determination letter. I understand that all appeal decisions are final.
- I certify that there is not any liability or third party coverage pertaining to all transports related to this application.

Signature_____ Date_____