Firefighter Behavioral Health Alliance

2126 Albury Ave
North Las Vegas, NV 89086
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Karen Dill (847) 977-1304 – kdill@ffbha.org
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Medical Financial Assistance Application

Applicant Information

Full Name: _____ Date: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Relationship to First Responder: _____ Name of First Responder: _____ Marital Status: _____

Reason for assistance: _____

Do you have insurance coverage: YES ☐ NO ☐ Do you have a co-pay: NO ☐ YES ☐ Amount: $

Do you already have a medical professional assisting you? YES ☐ NO ☐ Name: Address: Phone: _____

Do you need help finding a medical professional? YES ☐ NO ☐

Estimate # of visits: _____

Proof of income

Total # of people within the household including yourself:

Total monthly income of household: Include all types of income $

Please submit documentation to support your financial situation.

Attached is:

☐ Pension ☐ Disability ☐ Other form sources of income

☐ Most recent Federal Tax Return ☐ W-2 ☐ One month of paychecks

Patient Delaration

Patient Declaration – By signing below, I affirm that my answers, proof of income documents are complete, true and accurate to the best of my knowledge.
I understand that:

- Completing this form does not guarantee that I will qualify for the Firefighter Behavioral Health Alliance Medical Financial Assistance Program.
- Firefighter Behavioral Health Alliance may verify the accuracy of the information I have provided and ask for more financial and insurance information.
- Firefighter Behavioral Health Alliance reserves the right to cancel the Medical Financial Assistance Program at any time.
- I understand that the funds provided here are a grant and does not need to be repaid.
- I understand that I am responsible to providing my insurance information to my medical professional.
- I understand that Firefighter Behavioral Health Alliance is NOT responsible for insurance billing, etc.
- I understand that this grant is a maximum of 10 co-pays or $300.00 and will be paid directly to my provider.
- I understand that I will provide an invoice on a timely basis from my provider in order for Firefighter Behavioral Health Alliance to process the payment. I will email the invoice to Karen Dill at kdill@ffbha.org or fax to 888-788-5047.
- I understand that Firefighter Behavioral Health Alliance will not ask you about your appointments, outcome, medications, etc. If you decide to discuss with Jeff Dill, it will be held in confidence.
- I understand if I am in urgent need of care, I will contact my medical professional or call 9-1-1, not Firefighter Behavioral Health Alliance.
- I understand that any information regarding the amount of funds provided by Firefighter Behavioral Health Alliance is confidential and will not be shared to anyone other than my medical professional.

Patient name: _____
(Please print)

Patient signature: _____

Date: _____