|  |  |
| --- | --- |
| Patient Name: | SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| City, State and Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Patient Phone: | Patient Email: |
| Patient Date of Birth: | EMS Transport Date: |
| Monthly Household Gross Income: | Number of dependents living in household: |
| Responsible Party Name (if different from patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address (if different from patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State and Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  List of attached supporting documentation (examples: *financial aid approval from hospital, social security statement, unemployment commission letter, homeless shelter letter, two current pay stubs or the first page of last year’s tax return*): | |
|  | |
|  | |
|  | |

I do hereby request that I, as either the applicant, or the party who is financially responsible for the applicant, be considered for a waiving of the payment responsibilities as they relate to this EMS ambulance transport service fee. ***By signing this form I certify that I have no insurance that can be billed for this charge or the remaining balance after primary insurance payment and agree that if I am reimbursed for these charges then this waiver is void and I must forward payment for these services.*** I declare that all of the information contained in this document and the attachments are true and accurate. Further I understand that I may be held liable for any false statements pertaining to this waiver request. I hereby agree to notify the City of Fairfax of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the EMS ambulance transport fee.

\_

Signature Date

Print Name

For questions regarding the hardship waiver process call 703-385-7940 or e-mail [emsbilling@fairfaxva.gov](mailto:emsbilling@fairfaxva.gov)

Mail this application and all supporting documents to:

# City of Fairfax EMS Billing

# 4081 University Drive

# Fairfax, VA 22030

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Administrative Use OOnly* | | | | |
| Incident #: |  | | Date Received: |  |
| Account #: |  | | Date Vendor Notified: |  |
| Request: (circle) | Approved | Denied | Patient Responsibility: |  |
| Date Patient Notified: |  |