Financial Hardship

THIS FORM MUST BE SUBMITTED FOR EACH AMBULANCE TRANSPORT BILLING.

*1. Applicant Name:

Name:

*2. Date of Incident:

MM DD YYYY

Date / /

*3. Location of Incident:

Address:

City/Town:

*4. Contact Information:

Address:

City/Town:

State:

ZIP:

Email Address:

Phone Number:

5. Name of the responsible party, if not the applicant:

*6. Monthly Household Gross Income:

- less than $20,000
- $20,000 to $35,000
- $35,000 to $50,000
- greater than $50,000

7. Household Size (# of people):

*8. I am requesting a waiver of payment for my ambulance transport fee. I agree that I have no insurance that can be billed for this charge, and that this statement is made in good faith and is true.

- TRUE
- FALSE

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If you have any questions please call 866-724-4142.

Please click "DONE" to submit.