**Loudoun County Combined Fire-Rescue System**

**EMS TRANSPORTATION REIMBURSEMENT PROGRAM**

Request for EMS Transport Fee Hardship Waiver

|  |  |
| --- | --- |
| Date:  | Date of Transport: |
|  |  |
| Account Number:  | Balance Due: |
|  |  |
| Patient Name: |  |
| Responsible Party Name: | Relationship to Patient: |
|  |  |
| Patient Mailing Address: | Preferred Phone Number: |
| Alternate Phone Number: |
|  |  |
| Patient Date of Birth: | Last 4 digits of SSN: *XXX-XX*-\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Monthly, Gross Household Income: $ | Number of dependents living in household:  |

*A NEW HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT*

List of attached documentation, please choose ONE:

□ Approved Hospital Financial Assistance documentation

□ Copies of the two most recent pay stubs OR written income verification from an employer if paid in cash

□ Primary Bank Account Statement

□ Tax Forms (most recent year)

□ Death Certificate

As the applicant or the party who is financially responsible for the applicant, I request that the fees associated with this EMS transport be waived. By signing this form I certify that I have no insurance coverage that may be billed for either this charge or for the remaining balance after my primary insurance payment, if any. 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 agree that within 90 days of the date of transport I will notify the EMS Transportation Reimbursement Program of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the EMS Transport Fee. This shall apply to new, additional or updated insurance information.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Submit this application and any attachments by**:

Postal Mail: LC-CFRS PO Box 7101 Leesburg, VA 20177-7101

Fax: 703-771-5359

Email: emscostrecovery@loudoun.gov

Upload: <http://www.loudoun.gov/emsreimbursement>

For questions regarding the hardship waiver process call 703-737-8782 or send an e-mail to: emscostrecovery@loudoun.gov

Administrative Use Only

Incident #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vendor Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim: (circle) Approved Denied Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approval Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Patient Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Method: (circle) Phone Mail

LC-CFRS Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LCDFREM-DS-2015Jun