

REQUEST FOR TRANSPORT FEE HARDSHIP WAIVER

A NEW HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT

Transported Patient Name: _____ Date of Birth ___/___/___

Date of Service: ___/___/___ Incident Number (if known) _____

Home Address: _____

Applicant Phone: _____ Alternate Phone: _____

Monthly Household Gross Income: _____ Number of Dependents living in Household: _____

List of attached documentation:

- W-2 withholding statements or unemployment check stubs for the past 90 days
- Pay check stubs for the past 90 days for all persons employed in the home
- Income tax return (most recent signed 1040 and/or W-2)
- Application forms from Medicaid or other State-funded medical assistance program
- Forms from employers or welfare agencies
- Other (list): _____

Responsible Party (if different from applicant):

Name: _____ Relationship to Patient: _____

Address (if different from applicant): _____

_____ How much are you able to pay each month? _____

I do hereby request that I, as applicant or the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this EMS transport service fee. By signing this form I certify that I have no insurance that can be billed for this charge. 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 Summit County EMS / Park City Fire District of any change in the financial status of the applicant or the responsible party that may affect the ability to pay this EMS transport fee.

Signature Date

Printed Name

For questions regarding the hardship waiver process, call 435-940-2511 or via e-mail to billing@pcfd.org

Mail completed applications and supporting documents to:

Med USA

Attn: *Summit County Ambulance / PCFD*
PO Box 95970, South Jordan, UT 84095

Administrative Use Only Approved Signature _____ Vender Notified _____

Incident # _____ Invoice # _____

Date of Service: _____ Date Received: _____

Waiver Disposition (circle) Approved Denied Reason: _____
