Essex County Emergency Services

AMBULANCE HARDSHIP CERTIFICATION FORM

THIS FORM IS TO BE SUBMITTED FOR EACH AMBULANCE TRANSPORT

Applicant Name: _____

Social Security Number: _____

Address: _____

_____

Phone Number: _____

Responsible Party Name (if not applicant): _____

Responsible Party Address (if not the same as applicant): _____

_____

Monthly Household Gross Income: $_____

(PLEASE PROVIDE PROOF OF INCOME OR WAIVER WILL BE DENIED)

Household Size (# of people): _____

Insurance Information (if any): _____

I hereby request that I, as either the applicant or the responsible party for the above-named applicant, be considered for a reduction in my payment responsibilities for ambulance transport services. I understand that I will be held liable for any false statements made herein. I agree to notify Essex County of any change in the status of the applicant or the responsible party that may affect their qualification for reduction in payment responsibility.

_____ _____

Signature of: ( )Applicant ( )Responsible Party Date

If you have any questions, please call (804) 333-4593. Please mail the completed form to:
P.O. Box 70, Warsaw, VA 22572

ADMINISTRATIVE USE ONLY

Invoice #: _____

Approved: _____ Payment Responsibility of _____% Revised amount due: _____

Denied: _____

Approval Signature: _____