



## AMBULANCE TRANSPORT FEE FINANCIAL HARDSHIP WAIVER FORM

<b>PATIENT NAME</b>		<b>DATE OF TRANSPORT</b>		<b>RUN #</b>	
<b>RESPONSIBLE PARTY NAME</b>		<b>RESPONSIBLE PARTY RELATIONSHIP</b>			
<b>RESPONSIBLE PARTY ADDRESS</b>	<b>STREET ADDRESS</b>				
	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>		
<b>HOUSEHOLD INCOME (MONTHLY)</b>		<b>NUMBER OF PERSONS LIVING IN HOUSEHOLD</b>			

Patients attesting to any of the following circumstances will be presumptively eligible for elimination of any balance due. Select all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Patients who have an exemption of property tax<br><input type="checkbox"/> Patients who are covered by Health Safety Net (Free Care)<br><input type="checkbox"/> Patients enrolled in State-funded prescription programs<br><input type="checkbox"/> Patients who are homeless or received care from a homeless clinic<br><input type="checkbox"/> Patients who participate in Women, Infants & Children programs ("WIC")<br><input type="checkbox"/> Patients who are eligible for Food stamps<br><input type="checkbox"/> Patients who are eligible for Subsidized school lunch programs | <input type="checkbox"/> Patients who are eligible for other state or local assistance programs that are unfunded<br><input type="checkbox"/> Patients who provide a valid address that is low income/subsidized housing<br><input type="checkbox"/> Patients who are deceased with no known estate<br><input type="checkbox"/> Patients enrolled in limited-service Medicaid programs<br><input type="checkbox"/> Patients with non-participating out-of-state Medicaid insurance plans<br><input type="checkbox"/> None of these apply |
|---|--|

**Patients who do not fall within any of the above parameters may submit a written narrative of their financial hardship. Please use this space or attach a letter.**

I do hereby request that I, as either the patient, or the party who is financially responsible for the patient, 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 and cannot pay due to financial hardship. I declare that all of the information contained in this document is true and accurate. Further I understand that I may be held liable for any false statements pertaining to this waiver request.

<b>RESPONSIBLE PARTY SIGNATURE</b>		<b>DATE</b>	
<b>RESPONSIBLE PARTY PRINTED NAME</b>			

For questions regarding the hardship waiver process, please call **(617) 492-8484** or via e-mail to: **billing@proems.com**

To submit this this application and all attachments:	
By Mail	By Fax
Pro EMS Solutions 31 Smith Place Cambridge, MA 02138	Fax to 617.588.0624