AMBULANCE TRANSPORT FEE FINANCIAL HARDSHIP WAIVER FORM

PATIENT NAME		**DATE OF TRANSPORT**		**ACCOUNT #**	
RESPONSIBLE PARTY NAME		**RESPONSIBLE PARTY RELATIONSHIP**			
RESPONSIBLE PARTY CONTACT INFORMATION	**STREET ADDRESS**				
	CITY		**STATE**	**ZIP**	
	PHONE #		**EMAIL ADDRESS**		
HOUSEHOLD INCOME (MONTHLY)		**NUMBER OF PERSONS LIVING IN HOUSEHOLD**			

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

- ☐ Covered by Health Safety Net (Free Care)
- ☐ Enrolled in a limited-service Medicaid program
- ☐ Out-of-state Medicaid plan that does not participate with this service
- ☐ Homeless or receives care through a homeless clinic
- ☐ Lives in low-income or subsidized housing (valid address required)
- ☐ Unemployment
- ☐ Excessive medical or other debts
- ☐ Bankruptcy
- ☐ Property tax exemption (e.g., senior, veteran, disability)
- ☐ Eligible for a state or local assistance program that is currently unfunded
- ☐ Catastrophic situation (e.g., major illness, injury, natural disaster)
- ☐ Patient is deceased and there is no known estate
- ☐ Uninsured or without active health insurance coverage
- ☐ None of the above apply

Please use this space to provide any additional information regarding your financial circumstances for review. Supporting documentation or a written statement may be attached.

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.

RESPONSIBLE PARTY **SIGNATURE**		**DATE**	
RESPONSIBLE PARTY **PRINTED NAME**			

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

To submit this application and all attachments:		
By Mail	By Email	By Fax
Pro EMS Solutions 31 Smith Place Cambridge, MA 02138	Email to Billing@ProEMSSolutions.com	Fax to 617.588.0624