



AMBULANCE TRANSPORT FEE FINANCIAL HARDSHIP WAIVER FORM

PATIENT NAME		DATE OF TRANSPORT		RUN #	
RESPONSIBLE PARTY NAME		RESPONSIBLE PARTY RELATIONSHIP			
RESPONSIBLE PARTY ADDRESS	STREET ADDRESS				
	CITY	STATE	ZIP		
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:

- | | |
|---|--|
| <input type="checkbox"/> Patients who have an exemption of property tax
<input type="checkbox"/> Patients who are covered by Health Safety Net (Free Care)
<input type="checkbox"/> Patients enrolled in State-funded prescription programs
<input type="checkbox"/> Patients who are homeless or received care from a homeless clinic
<input type="checkbox"/> Patients who participate in Women, Infants & Children programs ("WIC")
<input type="checkbox"/> Patients who are eligible for Food stamps
<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
<input type="checkbox"/> Patients who provide a valid address that is low income/subsidized housing
<input type="checkbox"/> Patients who are deceased with no known estate
<input type="checkbox"/> Patients enrolled in limited-service Medicaid programs
<input type="checkbox"/> Patients with non-participating out-of-state Medicaid insurance plans
<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.

RESPONSIBLE PARTY SIGNATURE		DATE	
RESPONSIBLE PARTY PRINTED NAME			

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 617.492.1213