FIRE DEPARTMENT
900 Second Street
Alexandria, Virginia 22314

Felipe Hernandez
Fire Chief

Phone (703) 746-5200
Fax (703) 838-5093

ALEXANDRIA FIRE DEPARTMENT
FINANCIAL HARDSHIP APPLICATION

Alexandria Fire Department treats all patients regardless of their ability to pay and is sensitive to those struggling financially. Individuals who can demonstrate financial hardship and would like to be considered for a reduction in the fees associated with an ambulance transport may complete and submit this form to the mailing address listed above or by email: Moises.Ybarra@alexandriava.gov . Prior to submitting the application, please review your current insurance policy to understand what your plan covers; it is possible they have not paid their obligated amount. Applicants should also include proof of income and any additional documentation that may support their financial hardship claim. Applicants may continue to receive invoices during the application review process. You may call EM|MC Management Consultants at (800) 849-5603) for assistance with this form.

PATIENT		
Name:		Date of Birth:
Street Address:		
City:	State:	Zip Code:
Telephone Number:	Date of Service:	Account#
Monthly Household Gross Income:	Number of Dependents:	

APPLICANT		
Name:		
Street Address:		
City:	State:	Zip Code:
Telephone Number:		
Monthly Household Gross Income:	Number of Dependents:	

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List of attached documentation	
☐ Current IRS W-2 form	☐ Copies of head of household's last 2 paystubs
☐ Most recent income tax return	☐ Documents from employers or welfare agencies
☐ Notarized statement of unemployment	☐ Documents demonstrating financial hardship
☐ Unemployment check stub	☐ Other (list):

I, as the applicant, request to be considered for a reduction in the payment responsibilities as they relate ot the ambulance transport noted above. By signing this form, I certify that all of the information contained in this document and the attachments are true and accurate.

_____ _____
Signature Date

_____
Printed Name

Administrative Use Only

Incident#:	Account#:	Balance: $ _____	Level of Service: ☐ BLS ☐ ALS 1 ☐ ALS 2
Date Received:	Resolution: ☐ Adjust Fee to: $ _____ ☐ Deny Request		
Comments:			
Approver Printed Name & Title:		Approver Signature:	
Date billing company notified of resolution:		Billing Company notified by (print name):	