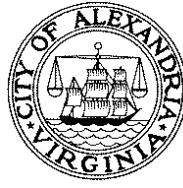
**FIRE DEPARTMENT****900 Second Street****Alexandria, Virginia 22314****Felipe Hernandez**
Fire Chief**Phone (703) 746-5200**
Fax (703) 838-5093**ALEXANDRIA FIRE DEPARTMENT**
FINANCIAL HARDSHIP APPLICATION

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:	

**FIRE DEPARTMENT**

900 Second Street

Alexandria, Virginia 22314

Felipe Hernandez
Fire ChiefPhone (703) 746-5200
Fax (703) 838-5093**List of attached documentation**

<input type="checkbox"/> Current IRS W-2 form	<input type="checkbox"/> Copies of head of household's last 2 paystubs
<input type="checkbox"/> Most recent income tax return	<input type="checkbox"/> Documents from employers or welfare agencies
<input type="checkbox"/> Notarized statement of unemployment	<input type="checkbox"/> Documents demonstrating financial hardship
<input type="checkbox"/> Unemployment check stub	<input type="checkbox"/> Other (list):

I, as the applicant, request to be considered for a reduction in the payment responsibilities as they relate to 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: <input type="checkbox"/> BLS <input type="checkbox"/> ALS 1 <input type="checkbox"/> ALS 2
Date Received:	Resolution: <input type="checkbox"/> Adjust Fee to: \$ _____ <input type="checkbox"/> Deny Request		
Comments:			
Approver Printed Name & Title:		Approver Signature:	
Date billing company notified of resolution:		Billing Company notified by (print name):	