# WILTON VOLUNTEER AMBULANCE CORPS
# BILLING HARDSHIP PROGRAM APPLICATION

Patients who are unable to pay their outstanding ambulance bill and are claiming a hardship can request a financial hardship review of their ambulance charges. This form must be submitted within 90 days of the date of service for which the hardship is being requested.

Patients Name: ________________________________ Date of Birth: ________________________________
Address: ________________________________________________________________________________
Date(s) of Service: __________________________ Balance(s) Due: ____________________________
Last 4 digits of patient SSN: ___________

**I am requesting a (choose one of the following):**

☐ Reduction amount of $ ______________________
☐ Write-off of entire amount (must be requested within 30 days of billing)
☐ Monthly payment plan of $___________/month ($20 minimum)

Responsible Party Name: ___________________________ Relationship: _______________________
Responsible Party Address (if different than patient): ______________________________________________
Responsible Party Phone Number: __________________________

You may be requested to submit additional forms for multiple claims.

**Attach documentation, 2 of any of the following:**

☐ An Approved Hospital Financial Assistance Documentation Form
☐ Income Tax Return (most recent and signed)
☐ Death Certificate

Any other information you wish to provide that will help in our decision making process.

In your own words, explain why you are submitting a request for hardship: __________________________
______________________________________________________________________________________

As the applicant or the party who is financially responsible for the applicant, I request that the cost associated with this EMS transport be considered for hardship. By signing this form I certify that I have no insurance coverage that may be billed for either this charge or for the remaining balance after my primary insurance payment, if any. I declare that all of the information contained in this document and the attachments are true and accurate. Further, I understand that I may be held liable for any false statements pertaining to this waiver request. I agree that within 90 days of the date of transport I will notify the Wilton Volunteer Ambulance Corps of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the EMS Transport Fee. This shall apply to new additional or updated insurance information.

__________________________________________ _____________________

Signature Date

Please submit this completed form, along with the required documentation to:
**Wilton Volunteer Ambulance Corps, 234 Danbury Rd, Wilton, CT, 06897**