financial hardship program application



City and County of San Francisco

San Francisco Fire Department EMS

Ambulance Billing

P.O. Box 059745

Los Angeles, CA 90074-9745

# INSTRUCTIONS FOR APPLYING:

* Complete and sign this application
* Provide income documentation, including:

Your Federal Income Tax Return (prior year)

Your two (2) most current pay stubs (if married, include spouse’s pay stubs) OR Affidavit of Income

Your most current Federal or State Compensation Statement

(i.e. Unemployment, Disability, Social Security, or General Assistance)

Proof of any hospital write-offs, charity write-offs, or any hospital reductions

Your most current savings and checking account statements from any financial institution

If you recently lost your job, please provide documentation of last day worked and financial situation

Proof of residency such as:

* + - Current Utility Bill
    - Property Tax Bill
    - Rental/Lease Agreement
    - California Driver’s License or ID
    - Current Bank Statement
    - Affidavit of Support (from family member or friend who provides room and board or financial support)
* Submit your application and verification documents to:

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# important notes:

* If insurance payment was sent directly to insurer, the application will not be considered until insurance payment is remitted to SFFD.

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| Patient Name: | Social Security #: | |
| Date of Birth: | Account #: | |
| Address: | City: | |
| State: | | Zip Code: |
| Phone #: | | Email: |
| # of Household Members: | | # of Dependents: |
| Monthly Rent $ | | Monthly Mortgage $ |
| Total Monthly Income (Gross) $ | | (If married, provide combined gross income) |
| Are you currently employed? | | Yes No |
| Employer Name: | | Employer Phone #: |
| Do you receive any of the following?    Food Stamps  General Assistance  Social Security  Disability Pension  Unemployment Compensation  Other Source of Income | | Yes No $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes No $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If other, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What kind of health insurance do you have? | | Policy#: |
| If you are unable to provide a required document, please state document and reason why: | | |

I declare the answers given are true and correct to the best of my knowledge. I understand that the information I have provided

will be verified. I understand that the information will be used to screen for eligibility. I understand that if my information is found

to be false, I will be held responsible for the full amount of any fee for medical services received from San Francisco Fire Department.

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| Signature Date |  |
|  |  |
| Print Name Relationship (if not patient): |  |