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:

  San Francisco Fire Department EMS
  Ambulance Billing
  P.O. Box 059745
  Los Angeles, CA 90074-9745

IMPORTANT NOTES:

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

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	☐Yes	☐No	$_____
General Assistance	☐Yes	☐No	$_____
Social Security	☐Yes	☐No	$_____
Disability Pension	☐Yes	☐No	$_____
Unemployment Compensation	☐Yes	☐No	$_____
Other Source of Income	☐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.

Signature	Date
Print Name	Relationship (if not patient):