Compassionate Billing Waiver Request Form

Applicant Name: _____ SSN: _____
Applicant Address: _____
Phone Number: _____
Responsible Party (If not the same as Applicant):
Name: _____ SSN: _____
Address (If different than Applicant):_____
_____

In accordance with the Compassionate Billing Policy adopted by the City Council of The City of Fredericksburg, I hereby attest and affirm the following responses to be true and accurate to the best of my knowledge:

Please check the appropriate response:

1.	The applicant is a resident of The City of Fredericksburg.	Y☐N☐
2.	The responsible party is a resident of The City of Fredericksburg.	Y☐N☐
3.	The applicant owns real estate in The City of Fredericksburg.	Y☐N☐
4.	The responsible party owns real estate in The City of Fredericksburg.	Y☐N☐
5.	The applicant pays personal property taxes in The City of Fredericksburg:	Y☐N☐
6.	The responsible party pays personal property taxes in The City of Fredericksburg.	Y☐N☐
7.	The applicant is covered under a health insurance plan either as the insured or a dependent of the insured.	Y☐N☐
8.	The applicant is elderly or disabled and qualifies for real estate tax relief pursuant to City ordinance.	Y☐N☐
9.	The responsible party is elderly or disabled and qualifies for real estate tax relief pursuant to City ordinance.	Y☐N☐
10.	The combined family income of the applicant is less than $100,000 annually.	Y☐N☐
11.	The combined family income of the responsible party is less than $100,000 annually.	Y☐N☐

I hereby request that I, as either the applicant or responsible party for the above-named applicant, be considered for a reduction in my payment responsibilities for ambulance transport services. I understand that I will be held liable for any false statements made herein. I agree to notify The City of Fredericksburg of any change in the status of the applicant or the responsible party that may affect their qualification for reduction in payment responsibility.

Applicants Signature: I understand that checking the box below is equivalent of signing my name.

I Accept: ☐

_____ ☐

Applicant ☐ Responsibility party ☐ Date

ADMINISTRATIVE USE ONLY

Incident#:_____MED3000 Invoice #_____
Date of Service: _____ Date Received: _____
Claim Approved/Denied (Reason):_____
Date MED3000 Notified: _____ Approval Signature: _____
Date: _____

If you have any questions, please call (540) 372-1059.
Please mail completed form to:

Fredericksburg Fire Department
601 Princess Anne St.
Fredericksburg, VA. 22401

(Revised 02/16/09)

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