Hampton Treasurer's Office

Financial Hardship Certification Form

911 Ambulance Transportation

Applicant Name: _____ Date of Birth: _____

Address:_____

Name of Responsible Party (if not the applicant): _____

Relationship to Patient: _____ Phone Number: _____

EMS Account Number: _____ Date(s) of Service: _____

Required Documents:

- Paystubs (last 30 days for ALL persons employed within the home)
- Primary Bank Statements (dated within the last 60 days)
- Tax Forms – 1040 and/or W-2
- Proof of all monthly bills and all outstanding bills.
- Other (indicate documents attached) _____

NUMBER OF FAMILY MEMBERS (living in the household): _____

EMPLOYER: _____ IF UNEMPLOYED, HOW LONG? _____

EMPLOYER ADDRESS: _____

SPOUSE'S EMPLOYER: _____ IF UNEMPLOYED, HOW LONG? _____

EMPLOYER ADDRESS: _____

OTHER FAMILY MEMBERS' EMPLOYER(S): INCLUDE NAME, EMPLOYER AND ADDRESS.

_____

_____

MONTHLY FAMILY INCOME & SOURCE

____Patient ____Spouse ____Responsible Party ____Children

Monthly Salary (Gross) $ _____ Unemployment Benefits $ _____

Public Assistance Benefits $_____ Social Security Benefits $ _____

Workman's Compensation $ _____ Other: $ _____

Gross Monthly Household Income $ _____

I hereby request of the Hampton Treasurer's Office that I, as the applicant or responsible party for the above-named applicant, be considered for a reduction in my payment responsibility. I certify that I have no insurance that may be billed for this charge, that the above information is true and accurate to the best of my knowledge, and that I will be held responsible for any false statements made herein. I authorize the Hampton Treasurer to verify any information contained in this document for the purpose of assessing financial need. I also agree to notify the Treasurer's Office if my situation changes and the reduction is no longer necessary.

_____ _____

Patient/Responsible Party Date