Town of Union Emergency Medical Service
Request for Transport Financial Hardship Waiver

Patient Name: _____ SSN: _____ Date of Service: _____

Patient Address: _____

Patient Phone: _____ Date of Birth: _____

Monthly Household Gross Income: _____ Number of Dependents Living in Household: _____
(Attach W-2, Pay Stubs etc.)

Patient Account # on Invoice: _____

Responsible party (if different from patient):

Name: _____ Relationship: _____

Address (if different from patient): _____

I do hereby request that I, as the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this EMS transport fee. By signing this form, I certify that I have no insurance that can be billed for this charge. I declare that all the information contained in this document and the attachments are true and accurate and I may be held liable for any false statements pertaining to this waiver request. I agree to notify the Town of Union of any change in the financial status of the responsible party which may affect the ability to pay the EMS Transport Fee. I further agree to allow the Town of Union to verify my financial records by whatever means they deem feasible.

_____ _____
Signature Date

_____
Print Name

For questions regarding this form call 207-785-3658.
Mail this application and documentation to:
Town of Union Emergency Medical Service
PO Box 186
Union, ME 04862

Administrative Use Only

Incident #: _____ Invoice #: _____
Date of Service: _____ Date Received: _____

Request (circle one): Approved Denied
Reason: _____
Date Billing Agent Notified: _____
Signature: _____
