STAFFORD CO FIRE RESCUE
AMBULANCE TRANSPORTATION SERVICE

FINANCIAL HARDSHIP CERTIFICATION FORM

THIS FORM MUST BE SUBMITTED FOR EACH AMBULANCE TRANSPORT BILLING

APPLICANT NAME:____

SOCIAL SECURITY NUMBER:_______________________________________

ADDRESS:____

____

PHONE NUMBER:____

RESPONSIBLE PARTY
NAME IF NOT THE
APPLICANT: ____

MONTHLY HOUSEHOLD
GROSS INCOME: $________________ HOUSEHOLD SIZE (# of People): __________________

I am requesting a waiver of payment for my ambulance transport fee. I agree that I have no insurance that can be billed for this charge, and that this statement is made in good faith.

_________________________________ _________________________________
Signature Date

If you have questions please call 800-355-1753.
Please mail completed form to:
STAFFORD CO FIRE RESCUE
P.O. BOX 62349
VIRGINIA BEACH, VA 23466

ADMINISTRATIVE USE ONLY

DAB Invoice#:____

_____ Approved Payment Responsibility of ____ % Revised Amount Due: $____________________

_____ Claim Denied Due to_____________________________________

Date DAB notified: _____________ Approval Signature/Date_____________________________