AMBULANCE TRANSPORTATION FEE FOR SERVICE PROGRAM

HARDSHIP APPLICATION - WAIVER REQUEST

Applicant Name: _____ SSN: _____

Applicant Address: _____

Phone Number: _____

Responsible Party (if not the same as Applicant):
Name: _____ SSN: _____

Address: _____

In accordance with the Ambulance Fee For Service ordinance adopted by the Board of Supervisors of King George County, I hereby attest and affirm the following responses to be true and accurate to the best of my knowledge.

**KGC - King George County*

1. The applicant is a resident of King George County.	☐ YES	☐ NO
2. The responsible party is a resident of King George County.	☐ YES	☐ NO
3. The applicant owns real estate in King George County	☐ YES	☐ NO
4. The responsible party owns real estate in King George Cty.	☐ YES	☐ NO
5. The applicant pays personal property taxes in KGC.	☐ YES	☐ NO
6. The responsible party pays personal property taxes in King George County.	☐ YES	☐ NO
7. The applicant is covered under a health insurance plan either as the insured or a dependent of the insured	☐ YES	☐ NO
8. The median household income of the ***applicant*** is less than $83,642 annually.	☐ YES	☐ NO
9. The combined family income of the ***responsible*** party is less than $83,642 annually.	☐ YES	☐ NO
10. The applicant **MUST** attach appropriate financial documentation (i.e. - tax forms) in order to verify household income. *** Attach all supporting documents to this form.**	☐ YES	☐ NO

Examples of supporting documents can be - prior tax returns, paystubs, social security checks.

Please include a copy of your ambulance billing invoice in addition to your financial documetation. They MUST be sent back with application to be reviewed.

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. I agree to notify King George County of any change in the status of the applicant or the responsible party that may affect their qualification for reduction in payment responsibility.

_____

Signature of: (please check applicant or responsible party below)

☐ APPLICANT

☐ RESPONSIBLE

If you have any questions, please call 540-775-8568
Please mail completed form to:
KING GEORGE EMERGENCY SERVICES
10459 Courthouse Drive, Suite 201
King George, VA 22485
ATTN: Serita Parlett

ADMINISTRATIVE USE ONLY:

Incident: _____ AMB Invoice#: _____

Date of Service: _____ Date Recvd: _____

Claim Approved/Denied (Reason): _____

_____

Date AMB Notified: _____

Approval Signature: _____ Date: _____