



**City of Newport Beach Fire Department**  
**Ambulance Billing Office**  
P.O. Box 269110, Sacramento, CA 95826-9110  
Phone: 800-906-6552 (Billing Office)

## **Application for Financial Hardship Paramedic Service User Fees**

The following application may be used to be considered for a financial hardship waiver or reduction of the Paramedic Service User Fees adopted by City Council (Resolution 2015-76) for the City's Emergency Medical Services (EMS). Upon completion, the application packet will be forwarded to the Fire Department for review and consideration.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Run/Incident Number (if known): \_\_\_\_\_

Date of Service: \_\_\_\_\_

Remaining Balance: \_\_\_\_\_

Please note that your application will not be considered without completion and submittal of the proper documentation. Failure to comply with these guidelines will result in denial of your request. If you have any additional questions or need assistance in completing this form, please contact our billing office at (800) 906-6552.

1. Are you presently employed (Circle one)?    Yes    or    No

2. If you answered yes to the above, list employer: \_\_\_\_\_

3. Are you the sole source of income in your household (Circle one)?    Yes    or    No

4. How many members (including yourself) are in your household? \_\_\_\_\_

5. Please list the names and ages of all members of your household:

Name	Relationship	Age
_____		
_____		
_____		
_____		
_____		
_____		

6. What is your total family income before taxes and deductions per month from all sources?

Your employment \$ \_\_\_\_\_

Total other household member(s) employment \$ \_\_\_\_\_

Unemployment \$ \_\_\_\_\_

Pension or Retirement \$ \_\_\_\_\_

Alimony \$ \_\_\_\_\_

Child Support \$ \_\_\_\_\_

Welfare/S.S.I./A.D.C \$ \_\_\_\_\_

Social Security \$ \_\_\_\_\_

Other \$ \_\_\_\_\_ Other \$ \_\_\_\_\_

**Total Gross Household Income (per month) \$ \_\_\_\_\_**

7. Please select and complete one or more of the following:

\_\_\_\_\_ I hereby request a waiver of my balance for paramedic services for the following reasons:

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\_\_\_\_\_ I wish to request a payment plan. If my request for payment plan is approved, I am able to pay the following amount each month: \$ \_\_\_\_\_

8. Include a copy of your last year's tax return for all members who contribute to your household income. Requested documents enclosed (Circle one)?    Yes    or    No

9. Declarations:

I declare under penalty of perjury that these answers are full and true statements of my financial situation to the best of my knowledge and belief.

I understand that if I am determined eligible, a waiver or reduction will be applied to the balance remaining after all insurance payments have been posted.

I understand that any approved waiver, reduction, or payment plan offered may become null and void in the event that I default on my payments.

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<b>Print Name</b>	<b>Signature</b>	<b>Date</b>
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