



**CITY OF MANASSAS
EMS BILLING PROGRAM**

Request for EMS Billing Hardship Waiver

A NEW HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT

Applicant Name: _____ SSN: _____
 Applicant Address (include City, State & Zip): _____
 Applicant Phone Number: _____ Date of Birth: _____
 Responsible Party (if different from applicant)
 Name: _____ Relationship: _____
 Address (if different from applicant): _____

Monthly Household Income: \$ _____ Household Size (# of people): _____

I HAVE ATTACHED THE FOLLOWING RECENT DOCUMENTATION TO CERTIFY THAT THE ABOVE-REFERENCED GROSS INCOME IS TRUE AND ACCURATE:
 (Please check all of the following that apply)

Paycheck Stub (dated within last 60 days)
 Primary Bank Statement (dated within last 60 days)
 Tax Forms (most recent year)
 Other (indicate documents attached): _____

I hereby request of the City of Manassas 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 can 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 also agree to notify the City of Manassas if my situation changes and the reduction is no longer necessary.

Signature: _____ Date: _____

Print Name: _____

For questions regarding the hardship waiver process, please call 703-257-8458
 or via email to tlupton@manassasva.gov
 Mail this application and all attachments to:

**City of Manassas
 EMS Billing
 9324 West Street, Suite 103
 Manassas, VA 20110**

Administrative Use Only
 Incident #: _____ Invoice #: _____ Date of Service: _____
 Date Received: _____ Claim: Approved Denied
 Claim Denied Due to: _____
 Vendor Notified: _____ Approval Signature: _____