Richmond County Emergency Services

Ambulance Hardship Certification Form

THIS FORM MUST BE SUBMITTED FOR EACH AMBULANCE TRANSPORT

Applicant Name: ____

Social Security Number: ____

Address: ____

____

Phone Number: ____________________________________

Responsible Party Name if not applicant: ____

Responsible Party Address if not the same as applicant: ______________________________

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Monthly Household Gross Income: $______________________

PLEASE PROVIDE A COPY OF YOUR MOST RECENT TAX RETURN. IF YOU DO NOT FILE A TAX RETURN, PLEASE CONTACT THE OFFICE FOR ALTERNATIVE PROOFS OF INCOME.

Insurance Info (if any):

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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 made herein. I agree to notify Westmoreland 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: ( ) Applicant ( ) Responsible Party Date

If you have any questions, please call (804) 333-4593. Please mail completed form to:

PO BOX 70, Warsaw, VA 22572

ADMINISTRATIVE USE ONLY

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Invoice # ________________

Approved ___________ Payment Responsibility of ______% Revised amount due: ______

Denied ____________________

Approval Signature_______________________________________