FAIRFAX COUNTY FIRE AND RESCUE DEPARTMENT

Request for Ambulance Fee Waiver

THIS FORM MUST BE SUBMITTED FOR EACH AMBULANCE TRANSPORT INCIDENT BILLED

APPLICANT NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____(W)_____(H)_____(C)

****MONTHLY* HOUSEHOLD *GROSS* INCOME FOR ALL ADULTS WHO WORK AND SHARE INCOME AND EXPENSES IN YOUR HOUSEHOLD: $_____**

HOUSEHOLD SIZE (number of people):_____

***You must provide documentation to substantiate your monthly household gross income. Attach two current pay stubs or last year's tax return. Other acceptable documents: financial aid approval from Inova or other hospital; social security statement; unemployment commission letter; homeless shelter letter.*

If you claim no income, attach a letter of explanation.

I am applying to Fairfax County Fire and Rescue Department to request a waiver of payment for my ambulance transport fee. 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.

_____	_____	_____
Signature	**Printed Name**	**Date**

If you have any questions please call 703-246-2266. Please mail completed form and applicable documents to:

FAIRFAX COUNTY VIRGINIA
P.O. BOX 630232
BALTIMORE, MD 21263-0232