Philadelphia Fire Department
Emergency Medical Services
Financial Hardship Application

To be considered, this application must be completed, signed, and sent to:
Philadelphia Fire Department – EMS, PO Box 8500 Lockbox 9437, Philadelphia, PA 19178.

By way of this application, I am requesting that the City of Philadelphia waive collection of all or part of the deductible or co-insurance amounts associated with ambulance transport services I (or a person I represent) received. I agree to provide the information requested that will facilitate the review of my application. I understand that the final decision may result in a partial or complete waiver. I agree to be responsible for any outstanding balance after a waiver decision has been made and I understand that I may request consideration of a payment plan for any outstanding balance not waived. I also understand that the City of Philadelphia can and will begin to attempt to collect charges should my financial situation improve. I further understand that this application is to request waiver of the following service date only. If I receive additional services, I acknowledge that I will have request a hardship application related to those additional service dates.

Patient Name: _____

Date of service: _____

Bill number: _____

Authorization for Use or Disclosures of Protected Health Information

I authorize the Philadelphia Fire Department (PFD) to share information from the Financial Hardship Application and any necessary supporting information to the Office of Administrative Review (OAR) for purposes of reviewing my Financial Hardship Application.

I understand that:

- I may revoke this authorization at any time by writing to PFD via email at pfd.emsbilling@phila.gov or via US mail addressed to PFD EMS Billing Officer, 240 Spring Garden Street, Philadelphia, PA 19123. I understand that email will result in a timelier revocation of my authorization. If information has already been shared with OAR for the Financial Hardship Application review, this will only prevent additional information from being shared in the future..

- This authorization expires 30 days after a final determination is made regarding my application.
- Information shared for this Financial Hardship Application review is no longer protected by federal privacy regulations and may be shared again as needed to process my Financial Hardship Application.
- Failure to sign this authorization may make it so that I cannot take part in the Financial Hardship Application review process, but it will not otherwise affect my ability to receive treatment from EMS, if applicable.
- I may refuse to sign this authorization.

Patient Name: _____

Patient Signature: _____

Date: _____

Contact Address: _____

In circumstances when the patient is unable to sign on their own behalf or has an authorized representative (such as parent, guardian, etc.), this application can be signed and submitted by the patient's authorized representative. If you are signing this application on behalf of the patient as their authorized representative, please include proof of your authority to represent the patient where appropriate (for example: power of attorney documentation).

Name of Authorized Representative: _____

Authorized Representative Signature: _____

Date: _____

Contact Address: _____

Please complete the table on the next page and include additional information as needed when submitting this application. Failure to provide all necessary information will result in returned forms to the requestor, delaying the review process.

If asking for financial hardship in the following cases, please send additional information listed.

- Recent W2 or 1099 (documentation regarding wages earned)
- Supplemental security income (SSI) or social security disability income (SSDI) statements
- Public assistance/welfare statement
- Unemployment compensation statement
- Bankruptcy discharge letter or other bankruptcy documentation
- Death certificate
- Any other related or pertinent information regarding income

Return signed, completed application to:

Philadelphia Fire Department – EMS
PO Box 8500 Lockbox 9437
Philadelphia, PA 19178

{rest of page left blank intentionally}

Justification for Financial Hardship Application

How many people live in your household: _____

Describe or provide your insurance coverage at the time of service: _____

Complete the following table:

Monthly Income	Self	Spouse	Household
Wage/Salary	$	$	$
Social Security	$	$	$
Public assistance	$	$	$
SSI/SSDI	$	$	$
Pension	$	$	$
Unemployment Compensation	$	$	$
Other: *Please specify.*	$	$	$
Total	$	$	$