CITY OF EL PASO FIRE DEPARTMENT FMS TRANSPORT
FINANCIAL ASSISTANCE APPLICATION

(Note: An Assistance application form must be submitted for each individual transport request)

Applicant Name: _____

SSN: _____

Applicant Address: _____

_____

Contact Number: _____

Date of EMS Transport: _____

Service Requested:

- ⎦ My ambulance fee be waived
- ⎦ My ambulance fee be reduced
- ⎦ Establishment of a payment plan that better suits my ability to pay

Monthly Household Gross Income:_____Number of dependents living in household:_____

In order for your application to be considered for approval, one or more of the below documents must be submitted with your application:

- ⎦ W-2 withholding statements or unemployment check stubs for past 90 days
- ⎦ Paycheck stubs for the past 90 days for all persons employed in the home
- ⎦ Income tax return (most recent signed)
- ⎦ Any other information described in the Financial Assistance program rules.

Responsible Party (if different from applicant):

Name:_____Relationship: _____

Address (if different from above applicant): _____

_____

Contact Number: _____

In your own words explain why you are requesting Financial Assistance:

_____

_____

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I do herby request that I, as either the applicant, or the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities related to this EMS transport service fee. **By signing this form, I certify that I am uninsured and currently have no insurance which can be billed for this charge. I declare that all of the information contained herein, along with all attachments, is true and accurate. Furthermore, I understand that I will be liable for any false statements and/or information provided, pertaining to this waiver request.** I hereby agree to notify the City of El Paso, Texas, by and through the El Paso Fire Department, of any change to the financial status of the applicant, or responsible party, which may affect their ability to pay the EMS Transport Fee.

Signature:_____ Date:_____

Print Name: _____

For questions regarding the Financial Assistance program process, please contact Deborah Olivas at (915)212-5606 or via e-mail at OlivasD@elpasotexas.gov

Applications with all attachments mailed to:
El Paso Fire Dept.
Attn: Charity Care
PO Box 450
Mansfield, TX 76063
Customer Service 1-888-987-1477

Administrative Use Only

Incident #:_____ Invoice Number: _____

Date of transport:_____

Date request received:_____

Claim: (circle) Approved Denied

Percentage of discount: _____

Reason:_____

Date Billing Company Notified:_____

Finance Administrator Approval Signature: _____ Date: _____

Fire Chief Approval Signature: _____ Date: _____