TRI-TOWN Emergency Medical Service

Ambulance Payment Plan Application

This application is a tool for Tri-Town Emergency Medical Service to determine the best method for payment of ambulance charges. Payment Plans will be granted based on the applicant's ability to honor payment arrangement and in certain cases the service may reduce or forgive the debt. Ambulance payment plans will be considered on a case by case basis by the Service Director.

Patient's Name		**Date Form Filled Out:**	
Patient's Address		**Phone #:**	

Authorized Representative:		**Relationship to the Patient:**	
Authorized Representative Address:		**Phone #:**	

Authorized Representative is the person who has the legal responsibility to make financial and medical decisions on behalf of the patient. Copy of the DPOA for Healthcare and Finances shall accompany this form if the patient is not a minor.

Please list all ambulance charges that are to be considered as part of this Ambulance Payment Plan. Only ambulance charges listed will be considered. Please indicate the Date of Service, the Incident or Run Number and the portion of the ambulance bill that was not covered by health or auto insurance. All of this information can be found on your billing statement.

Date of Service	Incident or Run #	Ambulance Charge ($)		Date of Service	Incident or Run #	Ambulance Charge ($)

Total of all ambulance charges indicated above that are considered to be the patient's responsibility:	

Was/were check(s) sent by an insurance company to the patient or Authorized Representative for the purpose of covering the ambulance charges?	☐ YES *If "YES" please indicate the check amount:*	☐ NO

Monthly Household Income:		**Number of Dependents in Household:**	

☐Weekly ☐Monthly payment applicant is proposing:	$

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You must provide the following documentation to complete the application process:

- Last filed Federal Income Tax Return (of all family members who reside on the property)
- A photocopy of your current Mortgage Statement(s) and any other debts.
- Last 3 months of all bank account statements (including checking, savings, IRA and Money Market Accounts, etc…)
- Last 4 weeks of check stubs (of all family members who reside on the property)
- 401(k) and other retirement account statements
- Copies of all current monthly expenses

Do you own other real estate property if so current market value?_____

Please state the reason you are requesting a payment plan for the ambulance charges and your plan to stay current with the payment plan:

(Continue on another sheet if necessary)

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I hereby swear that the information contained in the application and the validity of the documents attached are true to the best of knowledge. False statements are punishable by the penalties as set forth by law.

_____ _____

Applicant's Signature Date

Subscribed and sworn to before me:

_____ **My commission expires:** _____

(Notary Public or Justice of the Peace)

For Service Use Only:

Total Amount needed to be paid:_____

☐ Payment Schedule: $_____ every ☐week / ☐month for a total of _____Payments.

☐ Reduction of Amount owed to: $_____ (may be combined with a payment schedule)

☐ Payment Plan Rejected: Reason: _____

☐ Recommend the service Board of Directors forgive listed debt to the service.

_____

Service Director Date

(*For Appeals and Director's Recommendation to Forgive the Listed Debt to the Service*)

☐Accept Service Director's Recommendation ☐Reject Service Director's Recommendation

_____

Chairman Member 1 Member 2

_____

Member 3 Member 4 Member 5

_____

Member 6 Date Approved/Rejected