County of Fluvanna, Virginia

Form 1.3 - Ambulance Fee Waiver Request

Submit for to: Fluvanna County Finance Department, P.O. Box 540, 132 Main Street, Palmyra, VA 22963 – Ph: (434) 591-1930

Section A - PATIENT INFORMATION				
Patient's Name	Date of Birth	Social Security Number		
Home Address	City	State	Zip Code	
Home Phone	Cell Phone	Work Phone		
Date(s) of Ambulance Service?				
Household member who is **Fire, Rescue, or Law Enforcement** person currently volunteering in or employed by Fluvanna County? (Name:_____)	☐ Yes ☐ No	*If YES for either item, skip Section B and go to Section C*		
Patient is a Victim of a crime and has filed a claim under the Compensating Victims of a Crime Code and whose bill should be paid by the Virginia Victims Fund directly.	☐ Yes ☐ No			

Section B - FINANCIAL INFORMATION		
Employment Information ☐ Employed ☐ Unemployed ☐ Retired	Gross Household Income	Source(s) of Income
Health Insurance: ☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Medicare Supplement ☐ None		
Number of Family Members living in household (including patient):	Adults:	Children:
Are you currently eligible for Elderly, Disabled, or Disabled Veteran Tax Relief?	☐ Yes ☐ No	
Briefly describe why you are requesting a waiver or reduction of fees.		
Name of Person Completing Form (if not patient)	Relationship to Patient	Telephone

SECTION C – CERTIFICATION AND SIGNATURE		
I hereby request that I, as either the patient or responsible party for the above-named patient, 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 also understand that the County reserves the right to require proof of income in consideration of this request and to verify any information contained in this document for the sole purpose of assessing financial need.		
Signature of Patient or Legal Representative	Date	Relationship to Patient

FLUVANNA COUNTY STAFF USE ONLY			
Date Received:	Date of Service:	Incident #:	Billing Invoice #:
Financial hardship verified? ☐ Yes ☐ No	Reviewer Comments:		
If Yes, % reduction of charges: _____			
Billing notified? ☐ Yes ☐ No	Signature		Date