Department of Public Safety
Emergency Medical Service – Billing Division
6575 North "W" Street
Pensacola, Florida 32505
Telephone: (850) 471-6500

Hardship Application

The following may be furnished by the patient, guardian or person with legal authority and knowledge of the patient's financial status. The application must be fully completed to be considered, including required documentation. A patient may be considered for financial assistance based upon the submitted financial documentation of the applying individual and their household, and the U.S. Census Bureau of Poverty Threshold.

Please return the application and supporting documentation to include verification of employment or unemployment status and the stated Source of Incomes.

If no Tax forms have been completed and submitted to the IRS in the past two years, please call the IRS at 1-800-829-0922 or 1-800-829-1040 to request a 4506T Transcript Letter of Non-Filing to indicate that no Tax forms have been filed due to lack of income for each of the past two calendar years.

Account No: _____ Date of Service: _____

PATIENT INFORMATION:

Name: _____ Contact No:_____

Date of Birth: _____ Social Security No: _____

Address: _____ City: _____ State: _____ Zip: _____

Is the patient the same as the person responsible for the bill (guarantor)? Yes_____ No_____

- If no, please provide guarantor information.

Guarantor Name: _____ Relationship to patient: _____

Date of Birth: _____ Social Security No: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact No: _____

Is the patient covered by any insurance? Yes_____ No_____

- If yes, please complete the **Insurance Information** Section below.
- If no, is the patient eligible for coverage by their employer, spouse, or parent's employer? Yes_____ No_____
- If no, was insurance lost due to a life-changing event (job loss, marriage, divorce, or children no longer covered on parent's insurance)? Yes_____ No____

INSURANCE INFORMATION:

Insured Name: _____ Relationship to patient: _____

Insurance Policy Number: _____ Group Number: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Insurance Phone No: _____

HOUSEHOLD INFORMATION: (list all those living in your household, their age, relationships to patient)

Legal Name	Age	Relationship to Patient	Source of Income

INCOME: (please provide information on the income of all the household members and submit copy with application)

Source of Income	Payee	Monthly Gross Amount
Wages/Salary		$
Social Security Benefits		$
Unemployment Benefits		$
Retirement/Pensions		$
Rental Property/Unearned Income		$
Other (List:)		$

Total Income: _____

I hereby certify that the application and attached information is true and accurate to the best of my knowledge.

_____

Signature of Patient Date

_____

Signature of Guarantor (if different than patient) Date

You may submit your completed application online to:
EMSHardship@myescambia.com

Or

Mail application to:
Escambia County EMS
ATTN: Billing Manager
6575 North W Street
Pensacola, FL 32503