



Request for EMS Transport Fee Waiver

**CHRISTIANSBURG RESCUE SQUAD
EMS TRANSPORT BILLING PROGRAM**

THIS FORM MUST BE SUBMITTED FOR EACH EMS TRANSPORT INCIDENT BILLED

PATIENT NAME: _____

ADDRESS: _____

DATE OF SERVICE _____ **INVOICE #** _____

**RESPONSIBLE PARTY
NAME IF NOT THE
PATIENT:** _____

YEARLY HOUSEHOLD (ADJUSTED) GROSS INCOME: \$ _____

NUMBER OF DEPENDENTS: _____

***PLEASE INCLUDE A COPY OF YOUR MOST RECENT FEDERAL OR STATE INCOME TAX RETURN.
IF A COPY IS ALREADY ON FILE IT MUST BE LESS THAN ONE YEAR OLD.**

EMS transport fee may be waived if the adjusted gross income (as established by your Federal Income Tax Return or similar document) is less the two hundred percent (200%) of the published Federal Poverty rate as established by the United States Department of Health and Human Services. SEE REVERSE ADJUSTED GROSS INCOME LIMITATIONS.

I am applying to Christiansburg Rescue Squad to request a waiver of payment for my EMS transport fee. I certify that I have no insurance that can be billed for this charge, that the above information is true and accurate to the best of my knowledge, and that I will be held responsible for any false statements made herein.

Signature / Date

If you have any questions, please call (540) 382-9518 x4008. Please mail completed form and applicable documents to:

**CHRISTIANSBURG RESCUE SQUAD
100 E MAIN ST
CHRISTIANSBURG, VA 24073**

ADMINISTRATIVE USE ONLY

Annual Gross Income based on information provided: \$ _____

EMS-MC Invoice#: _____

____ Approved

____ Claim Denied Due to _____

Date EMS-MC notified: _____

Approval/Signature/Date _____

Persons in Family or Household	Poverty Guideline for VA	200% of Poverty Guideline for VA
1	\$11,490	\$22,980
2	\$15,510	\$31,020
3	\$19,530	\$39,060
4	\$23,550	\$47,100
5	\$27,570	\$55,140
6	\$31,590	\$63,180
7	\$35,610	\$71,220
8	\$39,630	\$79,260