



**FREDERICK COUNTY  
FIRE AND RESCUE SERVICES  
AMBULANCE TRANSPORT BILLING**



**HARDSHIP APPLICATION FORM**

**(This hardship application must be submitted for each ambulance transport fee modification request)**

Applicant Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Applicant Address: \_\_\_\_\_

\_\_\_\_\_

Contact Number: \_\_\_\_\_

Date of Transport: \_\_\_\_\_ Account Number: \_\_\_\_\_

**Service Requesting:**

- ☐ 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, a minimum of two forms of the following documentation is required and must be submitted with your application:

- ☐ Most recent W-2 withholding statement(s)
- ☐ Unemployment check stubs for past 90 days
- ☐ Paycheck stubs for the past 90days for all persons employed in the home
- ☐ Income tax return (most recent signed)
- ☐ Any other information you wish to provide that will help in our decision making process

**Responsible Party (if different from applicant):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from applicant): \_\_\_\_\_

Contact Number: \_\_\_\_\_

In your own words explain why you are requesting a Hardship Waiver:

---

---

---

---

---

---

---

I do hereby 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 as they relate to this Ambulance transport service fee.

By signing this form, I certify that I have no insurance that can be billed for this charge. I declare that all of the information contained in this document and the attachments are true and accurate. Furthermore, I understand that I may be held liable for any false statements pertaining to this waiver request.

I hereby agree to notify Frederick County Fire and Rescue Service's Ambulance Billing Department of any changes in the financial status of the applicant or the responsible party that may affect the ability to pay the Ambulance Transport Fee(s).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

For questions regarding the hardship waiver process, please call 301-600-1644 or via email to [LStokes@Frederickcountymd.gov](mailto:LStokes@Frederickcountymd.gov)

Application and all attachments may be mailed to:

Frederick County Fire and Rescue Services  
Attn: Ambulance Billing Department  
5370 Public Safety Place  
Frederick, MD 21704

---

ADMINISTRATIVE USE ONLY

Account # \_\_\_\_\_

Date of Transport: \_\_\_\_\_

Date Request Received: \_\_\_\_\_

Claim: (Circle)      Approved      Denied

Reason: \_\_\_\_\_

Date Billing Company Notified: \_\_\_\_\_ Approval Signature: \_\_\_\_\_