



SACRAMENTO METROPOLITAN FIRE DISTRICT

Application for Low Income Assistance Program

Applicant Information				
Name: <small>(First, Middle, Last)</small>			Incident / Run#:	
Address:		City:	State:	Zip:
Phone:		Email:		
Responsible Party (RP) Information <small>(If not the same as applicant)</small>				
Name:				
Address		City:	State:	Zip:
Phone:		Email:		
<p><i>In accordance with the Low-Income Assistance for Medical Billing Policy adopted by the Sacramento Metropolitan Fire District Board of Directors, I hereby attest and affirm the following responses to be true and accurate to the best of my knowledge. _____(Initial)</i></p>				
A. BACKGROUND INFORMATION				
Please check the appropriate response for each of the following:				
1. The applicant or RP is a resident within Metro Fire's jurisdiction.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2. The applicant is covered under a health insurance plan, either as the insured or a dependent of the insured.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3. The applicant is on a fixed income subsidized by SSI or _____.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
4. The applicant is a Medicare subscriber.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
5. The applicant is unemployed.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
6. The responsible party is unemployed.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
B. INCOME INFORMATION				
1. How many adults reside in your household?				
2. How many children reside in your household?				
3. What is your combined annual gross income? _____				
<p><i>Gross income includes the following taxable or non-taxable revenues:</i></p> <ul style="list-style-type: none"> • Salaries / Wages/ Tips • Allowances, Stipends, Gifts • Spousal/Child Support • IRA's/ Pensions/ Annuities • Interest/ Dividends • Rental Income/ Royalties • Business Income • Social Security Benefits • Veterans Benefits • Disability Benefits • Unemployment Benefits 				

To see current US Poverty Guidelines, visit: <https://aspe.hhs.gov/poverty-guidelines>.



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NOTE: Verifying documents to be submitted with request form:

Billing Invoice(s)

Proof of Identity

- Drivers License
- State ID Card
- Power of Attorney (if applicable)
- Passport
- Birth Certificate

Proof of Income

- Most recent IRS tax return
- IRS W2, 1099, 1040 forms
- Check Stubs / Pay Stubs
- Income Benefit Letter(s)
- Other documentation which establishes current monthly income

I hereby request that I, as either the applicant or responsible party, for the above-named applicant, be considered for a waiver or reduction in my payment responsibilities for ambulance transport services and/or medical assessment. I understand that I will be held liable for any false statements made herein. I agree to notify the Sacramento Metropolitan Fire District of any change in the status of the applicant or the responsible party that may affect their qualification for reduction in payment responsibility.

If completing electronically: I understand that checking the box below is equivalent of signing my name.

Signature _____ Date _____
 Applicant Responsible Party

Please email completed form to emsbilling@metrofire.ca.gov or mail to:
Metro Fire
Attn: EMS Division
10545 Armstrong Ave, Suite 200
Mather, CA 95655