# SACRAMENTO METROPOLITAN FIRE DISTRICT

## Application for Low Income Assistance for Medical Billing

| Applicant Information | | | |
|---|---|---|---|
| Name:<br>(First, Middle, Last) | | SSN: | |
| Address: | City: | State: | Zip: |
| Phone: | Email: | | |

| Responsible Party (RP) Information<br>(If not the same as applicant) | | | |
|---|---|---|---|
| Name: | | | |
| Address | City: | State: | Zip: |
| Phone: | Email: | | |

*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)

### 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 ☐ | No ☐ |
| 2. The applicant is covered under a health insurance plan, either as the insured or a dependent of the insured. | Yes ☐ | No ☐ |
| 3. The applicant is on a fixed income subsidized by SSI or _____. | Yes ☐ | No ☐ |
| 4. The applicant is a Medicare subscriber. | Yes ☐ | No ☐ |
| 5. The applicant is unemployed. | Yes ☐ | No ☐ |
| 6. The responsible party is unemployed. | Yes ☐ | No ☐ |

### 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?

*Gross income includes the following taxable or non-taxable revenues:*

- *Salaries / Wages/ Tips*
- *Allowances, Stipends, Gifts*
- *Grants, Scholarships*
- *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:

- Driver's license or other government issued identification
- Power of Attorney (if applicable)

And at least one of the following:

- Current IRS W2 form
- Copies of three current paystubs from the Head of Household
- Unemployment check stubs
- Notarized statement of unemployment
- Documentation of catastrophic illness affecting financial solvency

***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**

| ***For Internal Use Only*** | |
|---|---|
| Approved | Denied |
| Date: | Date Billing Vendor Notified: |