CITY OF KERRVILLE FIRE & EMS DEPARTMENT
CHARITY CARE PROGRAM
FINANCIAL ASSISTANCE APPLICATION

Please review the Charity Care Program Notice for more information and qualifications.
(Note: An application form must be submitted for each individual transport request)

Applicant Full Name: _____

SSN: _____

Applicant Address (Street, City, State, Zip): _____

_____

Contact Number: _____

Date of EMS Transport: _____

Account #: _____

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, one or more of the below documents must be submitted with your application:

☐ W-2 withholding statements or unemployment check stubs for past 90 days
☐ Paycheck stubs for the past 90 days for all persons employed in the home
☐ Income tax return (most recent signed)
☐ Any other information described on the Financial Assistance program rules, which may include documentation of eligibility of any Federal / State Aid Programs

Responsible Party (if different from applicant):

Name:_____Relationship: _____

Address (if different from above applicant): _____

_____

Contact Number: _____

In your own words explain why you are requesting Financial Assistance:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I do herby request that I, as either the applicant, or the party who is financially responsible for the applicant, am considered for a reduction in the payment responsibilities as they relate to this EMS transport service fee. By signing this form, I certify that I am uninsured and currently have no insurance which can be billed for this charge. I declare that all of the information contained here within this document, along with all attachments, is true and accurate. Furthermore, I understand that I will be held liable for any false statements and/or information provided, pertaining to this waiver request. I hereby agree to notify the City of Kerrville, Texas of any change to the financial status of the applicant, or responsible party, which may affect their ability to pay the EMS Transport Fee.

Signature:_____ Date:_____

Print Name: _____ Relationship:_____

For questions regarding the Financial Assistance program process, please contact 830-895-9806 or via email at emsbilling@kerrvilletx.gov.

Applications with all attachments can be mailed to:
Kerrville Fire & EMS Department
87 Coronado
Kerrville, Texas 78028

Administrative Use Only

Incident #:_____Account Number: _____

Date of transport:_____

Date request received:_____

Claim Status: ___Approved ___Denied

Final Resolution:_____

_____

_____

Name of Billing or Collection Company: _____

Date Notified:_____

Fire Chief (or designee) Approval Signature: _____

Chief Financial Officer (or designee) Approval Signature: _____