

FINANCIAL HARDSHIP PROGRAM APPLICATION

City and County of San Francisco
San Francisco Fire Department EMS
Ambulance Billing
P.O. Box 059745
Los Angeles, CA 90074-9745



PROGRAM ELIGIBILITY:

Must have a gross family household income **at or below 300% Federal Poverty Level (FPL)**.

Annual Income to Meet 300% FPL

Household Size	1	2	3	4	5	6
Annual Income	\$46,950	\$63,450	\$79,950	\$96,450	\$112,950	\$129,450

More information on FPL can be found on <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

INSTRUCTIONS FOR APPLYING:

- Complete and sign this application.
- Provide income documentation, including:
 - Your Federal Income Tax Return (prior year)
 - Your two (2) most current pay stubs (if married, include spouse's pay stubs) OR Affidavit of Income
- Submit your application and verification documents to:
San Francisco Fire Department EMS
Ambulance Billing
P.O. Box 059745
Los Angeles, CA 90074-9745

IMPORTANT NOTES:

- If insurance payment was sent directly to insurer, the application will not be considered until insurance payment is remitted to SFFD.

Patient Name:

Date of Birth:

Account #:

Address:

City:

State:

Zip Code:

Phone #:

Email:

of Household Members:

of Dependents:

Total Monthly Income (Gross) \$

(If married, provide combined gross income)

What kind of health insurance do you have?

Policy#:

If you are unable to provide a required document, please state document and reason why:

If there are any extenuating circumstances that will impact the review of the application, please explain:

I declare the answers given are true and correct to the best of my knowledge. I understand that the information I have provided will be verified. I understand that the information will be used to screen for eligibility. I understand that if my information is found to be false, I will be held responsible for the full amount of any fee for medical services received from San Francisco Fire Department.

Signature

Date

Print Name

Relationship (if not patient):