



**Town of Guilderland, New York
Fee Waiver Request**

**Please complete, sign, and return this request to:
Emergency Medical Services, 200 Centre Drive, Albany, NY 12203 – Ph: (518) 456-3600**

Patient Information

Patient Name: 1. _____ **Date of Birth:** 2. _____ **Social Security Number:** 3. _____

Home Address: 4. _____ **City:** 5. _____ **State:** 6. _____ **Zip code:** 7. _____

Home Phone: 8. _____ **Work Phone:** 9. _____ **Cell Phone:** 10. _____

Employment Information:

11. Employed Unemployed Retired 12. Gross Income? _____

IN REVIEWING ELIGIBILITY UNDER THE FINANCIAL HARDSHIP FEE WAIVER POLICY, THE EMS DEPARTMENT MAY REQUIRE PROOF OF THE CURRENT INCOME

13. Describe sources of Income? _____

14. Health Insurance: Medicare Medicaid Private Insurance
 Medicare Supplement None

15. Number of Family Members in Household: _____ Adults _____ Children

16. Name of Person completing form: _____ Relationship: _____

17. Briefly describe the basis for your request (attach extra sheet if necessary)

I hereby request that I, as the patient or responsible party for the patient, be considered for a reduction in my payment responsibilities for fees for ambulance transport and other services. I understand that I will be held liable for any false statements made herein. I also understand that the Town reserves the right to require proof of income in consideration of this request and to verify any information contained in this document for the sole purpose of assessing financial need.

Signature of Patient or Legal Representative **Date** **Relationship (if any)**