

**CITY OF OLIVETTE FIRE DEPARTMENT
EMS TRANSPORT BILLING PROGRAM**

Request for Transport Fee Hardship Waiver

THIS HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT WAIVER REQUEST

Applicant Name: _____ SSN: _____

Applicant Address: _____

Monthly Household Gross Income: _____ Number of dependents living in household: _____

List of attached documentation: _____

Responsible Party (if different from applicant)

Name: _____ Relationship: _____

Address (if different from applicant): _____

I do hereby request that I, as either the applicant, or the party who is financially responsible for the applicant, be 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 have no insurance that can be billed for this charge. I declare that all of the information contained in this document and the attachments are true and accurate. Further I understand that I may be held liable for any false statements pertaining to this waiver request. I hereby agree to notify the City of Olivette of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the EMS Transport Fee.

Signature: _____ Date: _____

Print Name: _____

For questions regarding the hardship waiver process call the City of Olivette Finance Director at 314-993-0444 or via e-mail to rjohnson@olivettemo.com Mail this application and all attachments to:
City of Olivette-Finance Office
9473 Olive Blvd.
Olivette, MO 63132

Administrative Use Only

Incident #: _____ Invoice Number: _____

Date of Service: _____ Date Received: _____

Claim: (circle) Approved Denied Reason: _____

Billing Company Notified _____ Approval Signature _____