Return to: Elkhart City Controller, 229 S. 2nd St., Elkhart, IN 46516

APPLICATION FOR EXEMPTION OR FORBEARANCE OF AMBULANCE AND/OR MEDICAL SERVICE FEES

1. Name, address and telephone number of the person incurring ambulance and/or medical services:

____
Printed Name

____
Street Address

____
City, State, Zip

______________________ ______________________
Telephone Number Date of Birth

2. Amount of ambulance and/or medical service fees due: $______________

3. Date ambulance and/or medical services were rendered: ______________

4. Is any insurance coverage available for these ambulance and/or medical service fees?
Yes ________ No ________

If Yes, to what insurance company did you submit these fees?

Name and address of Insurance Company ______________________________

______________________________ Policy Number ______________

5. Number of persons in the family unit: ______________

6. Total income from all sources for all members of the family unit for the past tax year: $______________

7. Current income for the past three months for the family unit: $______________

I affirm under the pains and penalties for perjury that the statements made herein are true and correct to the best of my knowledge and belief. Date: ______________________

____
Signature of Applicant

____
Printed Name of Applicant

YOU MUST ATTACH TO THIS APPLICATION:

- signed and submitted copies of federal income tax returns for the family unit from the past tax year; if none, state none filed
- paycheck stubs or other written verification of any income received by the family unit for the past three months
- insurance company denials of coverage, if any

For City Use Only: Determination of Exemption or Forbearance by City Controller

Qualified for: Exemption Forbearance DENIED: Does Not Meet Qualifications

Date ______________ Signature ______________________________