Fire District No. 3

TOWNSHIP OF HANOVER, COUNTY OF MORRIS
PO BOX 511
CEDAR KNOLLS, NEW JERSEY 07927-0511

Dear Applicant,

If you are claiming a financial hardship with regard to a bill or bills received for Emergency Medical Services rendered by Hanover Township Fire District No. 3, the attached form must be completed. The Board of Fire Commissioners will review this form and make a final determination as to the existence of financial hardship.

Please note that if you are a resident of Fire District No. 3, you will not be balance billed for any service. You may be asked to provide insurance information, and that is all. If you reside outside of Fire District No. 3 you will be balance billed with few exceptions. If you have already provided insurance information to our third-party billing agency, please wait for that to be processed. If you have not provided this information please do so before submitting this application.

The cost of providing effective and efficient Emergency Medical Services is born by Fire District No. 3, through the taxes paid by our residents. The Board has a responsibility to our District to make every effort to ensure that the residents of District No. 3 will not bear a disproportionate share of costs, or subsidize emergency medical care for non-residents. All information provided by you will be utilized in determining if hardship exists, or if there are alternatives to writing off the balance due.

The information above must be mailed to the District at the above address. The District will confirm financial responsibility and determine what actions have been taken by our billing company. The District will then assess this application and will respond to you as soon as possible. During this period we will notify the agency currently handling billing as to your request. If you have any questions please feel free to contact our offices at (973) 267-5659 Extension 117.

Sincerely,

The Board of Fire Commissioners

Fire District No. 3

Township of Hanover, County of Morris

AMBULANCE TRANSPORT FEE FINANCIAL HARDSHIP WAIVER

Please Print

Patient Name: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ - _____

Email: _____@_____

Date of Services: _____/_____/_____ Trip Number: _____

Original Charges: $_____ Current Balance: $_____

Employment Status: □ Employed □ Unemployed □ Retired □ Disabled

Gross Monthly Household Income: $ _____

Applicant Completing Form: _____ □ Self

Address if Different Than Above: _____

City: _____ State: _____ ZIP: _____

Phone: (_____) _____ - _____

Email: _____@_____

Are you financially responsible for the patient? □ Yes □ No

Statement of Hardship:

_____

_____

_____

_____

_____

- I do hereby request that I, as 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 and/or that I cannot pay due to financial hardship as described herein.
- I declare that I have provided any insurance information as requested by, and have attempted to work with Coronis Health to rectify this bill.
- I declare that all of the information contained in this document is 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 Hanover Township Fire District No. 3 of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the ambulance transport fee.

Signed: _____ Date: _____

Board Action

Date: _____/_____/_____ □ Approved □ Disapproved □ Sent Back for Additional Information

Coronis Health Notified: _____/_____/_____