Ambulance Billing
Los Angeles Fire Department
P.O. Box 845257
Los Angeles, CA 90084-5257
(888) 772-3203

REQUEST FOR EMS BILLING LOW INCOME ASSISTANCE

(Official Use Only)
RECEIVED ON:

PATIENT AND ACCOUNT INFORMATION (Required)

*** THIS FORM WILL NOT BE PROCESSED IF INFORMATION IS MISSING OR INCOMPLETE. ***

Full Name (First, Middle, and Last Name)

Date of Service | Account Number

Street Address | Apt. #

Daytime Phone | Alternative Phone

City | State | ZIP Code

E-mail (if any)

QUALIFICATIONS

Patients transported by ambulance by the Los Angeles Fire Department may be exempt from payment of fees if they qualify for low-income status pursuant to Los Angeles Administrative Code Section 22.210.2. To receive assistance, patients must demonstrate that they are either currently enrolled in a qualifying Los Angeles Department of Water and Power (LADWP) or Los Angeles County Department of Public Social Services (DPSS) low income program or that their total combined, unadjusted household (HH) gross income does not exceed the levels listed below:

HH Size	Maximum Combined Annual Gross Income	HH Size	Maximum Combined Annual Gross Income
1-2	$32,480	4	$49,200
3	$40,840	5	$57,560 (+ $8,360 for each person above 5)

GROSS INCOME (unadjusted) = all taxable and non-taxable revenues including but not limited to:

- Salaries / Wages / Tips
- Allowances / Stipends / Gifts
- Grants / Scholarships
- Spousal / Child support
- IRAs / Pensions / Annuities
- Interest / Dividends
- Rental income / Royalties
- Business income
- Social Security benefits
- Veteran benefits
- Disability benefits
- Unemployment benefits

APPLICATION INSTRUCTIONS

Please select one of the following three options and submit the application within 30 days of the initial billing date along with copies of supporting documentation. The LAFD will not return any documents submitted.

Option #1 – Current Enrollment in Qualifying LADWP or L.A. County Low Income Program

Select the program the patient is currently enrolled in and submit copies of the supporting documentation.

A. LADWP – Check one and submit a complete copy of patient's most recent bill showing enrollment.

☐ Low Income Discount Program (LIDP) ☐ Lifeline Rate Program

B. L.A. County DPSS – Check one and submit a copy of patient's current award letter (Notice of Action).

☐ CalWORKs ☐ CAPI ☐ General Relief ☐ Ability-to-Pay ☐ Refugee Cash Assistance ☐ CalFresh

Option #2 – Limited Income (Social Security, Disability, or Unemployment Benefits)

If the patient's only source of income is social security, disability, or unemployment benefits and total, combined household income does not exceed the income levels on the reverse side, please select the applicable option below and submit copies of the required documentation.

- ☐ Patient's previous year's Social Security Benefit Statement with verification of non-filing*.
- ☐ Patient's previous year's SSI Disability Award Letter with verification of non-filing*.
- ☐ Patient's Unemployment benefits approval letter.

*Verification of Non-Filing for Previous Tax Year: a free IRS tax transcript may be obtained by calling the Internal Revenue Service's automated phone transcript service at 1-800-908-9946, mailing a completed Form 4506-T, or submitting the request through the IRS website at https://www.irs.gov/individuals/tax-return-transcript-types-and-ways-to-order-them.

Option #3 – Low Income (Combined Household Gross Income Below Maximum Levels)

A patient may qualify for low income assistance by demonstrating that their household total combined, unadjusted gross income does not exceed the income levels listed on the reverse side. Provide the following requested information and supporting documentation for all household members:

A. Household Information: No. of Adults_____ + Children_____ = _____ Total Household Size

B. Submit a complete copy of the previous year's IRS Tax Return for all household members and any person who claims the patient as a dependent. Include all pages (front and back) of the following:
- Federal Income Tax Return Form (i.e., Form 1040, 1040EZ, 1040A, etc.)
- W2s, 1099s, etc. (All W2s, 1099s, etc. must total the amount reported on the tax return)
- Attached Schedules (i.e., Schedule A, B, C, D, K1, etc.)

SUBMISSION REQUIREMENTS AND INSTRUCTIONS

Applications must be filed within 30 days of the initial billing date. Mail (do not fax) a complete application and supporting documentation to:

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Untimely or incomplete requests will be denied and no application will be considered if the account is delinquent or has been referred for collections. The Department will review the application and may request additional information before making its determination. Once a determination is made, the decision is final and not subject to further review or appeal. Applicants will be notified of the determination by mail.

PATIENT ACKNOWLEDGEMENT AND SIGNATURE (Required)

I certify under penalties of perjury that the information and supporting documentation provided pursuant to this request is correct and complete. I understand that if I am the recipient of funds as a result of a legal settlement/judgement or insurance payment related to this account, or if I receive the discount without qualifying for it, I will be required to pay back the discount I received.

_____ _____

Patient Signature Date

Print Clear Form