CITY OF SACRAMENTO FIRE DEPARTMENT
EMERGENCY MEDICAL SERVICES

Financial Services Application

Please complete both pages of this application. **Failure to complete the application or include necessary financial documents will result in the denial of your request**. Completion of this document does not guarantee your request will be approved. **Return all forms and required documentation by mail to: City of Sacramento Fire Department, PO Box 269110, Sacramento, CA 95826.**

All information relating to financial hardship requests will be kept confidential.

Patient Name: _____

Address 1: _____ City: _____

Address 2: _____ State: _____

Telephone #: _____ Zip: _____

Email: _____

Date of Birth: _____ SS#: _____

Date of Service: _____ Run #: _____ Incident #: _____

Person completing this application (if different than patient above):

Name: _____ Telephone #: _____

Relationship to Patient: _____

Please describe patient indigent circumstances (If more space is needed, please attach a separate sheet):

_____

_____

_____

_____

_____

_____

_____

_____

Number of family members (*include self, spouse and dependents only*) living in household: _____

Check here if unemployed: ☐ How long? _____

LIST ALL CURRENT EMPLOYERS FOR ALL EMPLOYED PERSONS IN THE HOME (if more space is needed, please attach a separate sheet):

Family Member 1 Name		
Employer:		
Address:		
Contact Person:		Telephone#:
Family Member 2 Name		
Employer:		
Address:		
Contact Person		Telephone #:

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Please provide documentation of proof of income. Appropriate documentation of financial hardship would **require** the items from section one. Section two can only be included as a supplement, and not a substitution for section one:

1. Documented proof that patient is at or below the current Health and Human Services Poverty Guidelines. https://www.federalregister.gov/documents/2025/01/17/2025-01377/annual-update-of-the-hhs-poverty-guidelines

- ☐ Unemployment check stubs for the last 90 days (if unemployed)
- ☐ Paycheck stubs for the last 90 days of **all** employed persons in the home
- ☐ 2 Years of Income Tax return (most recent **signed** 1040 and W-2)
- ☐ Proof of all other income received in the last 90 days

2. Patient has other circumstances that indicate financial hardship. These can be situations such as:

- ☐ Proof of bankruptcy settlement (if applicable)
- ☐ A copy of application previously submitted for Medicaid or other State funded medical assistance programs
- ☐ Catastrophic situations (death or disability in family, divorce, etc.) or other documentation, that demonstrates the patient, would be unable to pay medical bills and still be able to pay for other basic necessary expenses

MONTHLY FAMILY INCOME AND SOURCE

	Family Member 1	**Family Member 2**	**Dependents**
Monthly Salary (Gross)	$ _____	$ _____	$ _____
Public Assistance Benefits	$ _____	$ _____	$ _____
Unemployment Benefits	$ _____	$ _____	$ _____
Social Security Benefits	$ _____	$ _____	$ _____
Worker's Compensation	$ _____	$ _____	$ _____
Child Support	$ _____	$ _____	$ _____
Other (Alimony, etc.)	$ _____	$ _____	$ _____
Sub total	$ _____	$ _____	$ _____
TOTAL FAMILY INCOME	$ _____		

I hereby acknowledge that the information given herein is true and correct. I authorize the City of Sacramento Fire Department to verify any information contained in this document for the sole purpose of assessing financial need.

_____

Signature of person making request Date (mm/dd/yyyy)

_____

Printed Name of person making request