S.M.E.M.P.S.
Southern Marin Emergency Medical Paramedic System

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EMS AND AMBULANCE TRANSPORT HARDSHIP WAIVER, FEE REDUCTION, AND PAYMENT APPLICATION

(Note: An application must be submitted for each EMS/Ambulance Financial Hardship Fee Adjustment Request)

Eligibility shall be primarily based on income status at or below 300% of the Federal Poverty Level.

APPLICANT INFORMATION:

Patient Name:_____
Date of Birth: ____ / ____ / _____
Address:_____
City: _____ State:___ Zip: _____
Phone Number: (_____) _____ - _____ Email:_____
# of Household Members: _____ # of Dependents: _____
Total Monthly Income (Gross) $_____
(If married, provide combined gross income)
Date of EMS Transport: _____

Service Requesting:

☐My EMS/Ambulance charges to be waived.
☐My EMS/Ambulance charge to be reduced.
☐Establishment of a payment plan for my EMS/Ambulance charge that better suits my ability to pay.

Monthly household gross income: _____

Number of dependents living in household: _____

In order for your application to be considered for approval, one or more of the below documents must be submitted with your application:

☐Paycheck stubs for the past 90 days for all adults employed in the home.

☐Bank and other financial institution statements for the past 90 days.
☐Any other information demonstrating financial hardship you wish to provide that will help in our decision-making process.

Responsible Party (if different from applicant):

Name: _____ Relationship: _____

Address (if different from above applicant): _____

Contact Number: _____

In your own words, explain why you are requesting a fee Waiver, Reduction, or Payment Plan:

I do hereby request that I, as either the applicant or the party who is financially responsible for the applicant, be considered for a waiver, reduction, or payment plan, with respect to my payment responsibilities as they relate to this EMS transport service fee. By signing this form, I certify that I am uninsured and currently have no insurance which can be billed for this charge. I declare that all of the information contained here within this document, along with all attachments, is true and accurate. Furthermore, I understand that I will be held liable for any false statements and/or information provided, pertaining to this request. I hereby agree to notify the Southern Marin Emergency Medical Paramedic System of any change to my financial status, or the financial status of the responsible party, which may affect the ability to pay EMS charges.

Signature: _____ Date: _____

Print Name: _____

For questions, please contact the SMEMPS EMS Officer at
415-473-6095 or via e-mail at matt.watson@marincounty.gov.

Submit your application and verification documents to:
Wittman Enterprises
LLC PO BOX 269110
Sacramento, CA 95826

Administrative Use Only

Incident number: _____

Date of transport: _____

Date request received: _____

Claim: ☐ Approved ☐ Denied

Date billing company notified: _____

Reason: _____

Executive Officer Approval Signature: _____

EMS Officer Approval Signature: _____

The U.S. Department of Health and Human Services (HHS) issues annual poverty guidelines to determine financial eligibility for various federal programs.
For 2026, the guidelines are as follows. Eligibility shall be primarily based on income status at or below 300% of the Federal Poverty Level. (*Multiply the income threshold by 3.*)

For the 48 Contiguous States and the District of Columbia:

Persons in Family/Household	Poverty Guideline
1	$15,960
2	$21,640
3	$27,320
4	$33,000
5	$38,680
6	$44,360
7	$50,040
8	$55,720

For families/households with more than 8 persons, add $5,680 for each additional person