AMBULANCE TRANSPORTATION
REVENUE RECOVERY PROGRAM

COMPASSIONATE BILLING CERTIFICATION FORM

THIS FORM MUST BE COMPLETED FOR EACH
AMBULANCE TRANSPORT BILLING

Applicant Name: _____ SSN:_____
Applicant Address:_____
Phone Number:_____

Responsible Party (If not the same as Applicant):
Name:_____ SSN:_____
Address (If different than Applicant):_____
_____

In accordance with the Compassionate Billing Policy adopted by the Board of Supervisors of Spotsylvania County, I hereby attest and affirm the following responses to be true and accurate to the best of my knowledge:

Please check the appropriate response:

1.	The applicant is a resident of Spotsylvania County.	Y ☐ N ☐
2.	The responsible party is a resident of the County.	Y ☐ N ☐
3.	The applicant owns real estate in Spotsylvania County.	Y ☐ N ☐
4.	The responsible party owns real estate in Spotsylvania County.	Y ☐ N ☐
5.	The applicant pays personal property taxes in Spotsylvania County:	Y ☐ N ☐
6.	The responsible party pays personal property taxes in Spotsylvania County.	Y ☐ N ☐
7.	The applicant is covered under a health insurance plan either as the insured or a dependent of the insured.	Y ☐ N ☐
8.	The applicant is elderly or disabled and qualifies for real estate tax relief pursuant to County ordinance.	Y ☐ N ☐
9.	The responsible party is elderly or disabled and qualifies for real estate tax relief pursuant to County ordinance.	Y ☐ N ☐
10.	The combined family income of the applicant is less than $100,000 annually.	Y ☐ N ☐
11.	The combined family income of the responsible party is less than $100,000 annually.	Y ☐ N ☐

I hereby request that I, as either the applicant or responsible party for the above-named applicant, be considered for a reduction in my payment responsibilities for ambulance transport services. I understand that I will be held liable for any false statements made herein. I agree to notify Spotsylvania County of any change in the status of the applicant or the responsible party that may affect their qualification for reduction in payment responsibility.

_____ _____
Signature of: Date
☐ Applicant
☐ Responsibility party

If you have any questions, please call (540) 507-7922.
Please mail completed form to:
Spotsylvania Fire and Rescue
P. O. Box 398
Spotsylvania, VA 22553

ADMINISTRATIVE USE ONLY

Incident#:_____ DAB Invoice #:_____
Date of Service:_____ Date Received:_____
Claim Approved/Denied (Reason):_____
_____
Date DAB Notified:_____ Approval Signature:_____
(Form Revision 02/23/06 Date:_____