City of Elkhart

Return to: Fire Department , 500 East Street, Elkhart, IN 46516

Ambulance and/or Medical Services Hardship Application

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1. Contact information for the person incurring ambulance/medical services:
   - Print full legal name:_____
   - Street Address:_____
   - City, State, Zip:_____
   - Telephone Number:_____
   - Date of Birth:_____
2. Ambulance/medical service fees due: $_____
3. Date when ambulance/medical service was used: _____
4. Insurance coverage available for these fees? Yes_____ No_____
   - If yes, to what insurance company did you submit these fees?
     - Name of Insurance Company: _____
     - Address of Insurance Company: _____
     - Policy Number: _____
5. Number of people in your household: _____
6. Total annual household income: _____

   Current household income for the past three months:_____

   ****If income – please provide proof or social security statement****

   ****If no income – please complete the No Income Affidavit on page 2****

I affirm under the pains and penalties of perjury that the statements made herein are true and correct to the best of my knowledge and belief:

Signature of Applicant:_____ Date:_____

Printed Name of Applicant:_____

You must attach to this application:

- Signed and submitted copies of last year's tax returns (for the entire household)

****If none check box** ☐

- Three months of proof of entire household income
- Proof of insurance denials if available

City use only Qualified for: Exemption Forbearance OR Denied: Not qualified

Signature:_____ Date:_____

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Zero Income Affidavit

(for anyone claiming zero income)

If you are claiming no income (zero income) for the past three months, please explain how you pay for your living expenses. (i.e. child support, housing authority, odd jobs, food stamps, spouse works, etc.) Include the amount of assistance received and source.

City use only Qualified for: Exemption Forbearance OR Denied: Not qualified

Signature:_____ Date:_____