EHS GROUND AMBULANCE

Ambulance Fee Assistance Program Form

Please use the form below to appeal the fee levied on care received from the EHS Ground Ambulance system.

Tell Us About You

Name:		Agency/Facility:
Address:		City & Province:
Postal Code:	Phone (Home):	Phone (Work):
Are you a: ❑Patient ❑Relative ❑Friend ❑Other (please specify)		

Please supply as many details as possible in the following fields. Any information you can provide increases our ability to appropriately review and respond to your appeal.

Patient Name:	Patient Phone #:
Civic Location:	Date of Occurrence: (dd/mm/yy)
Invoice #:	Municipality/ Community:

Return Completed Forms To: EHS Ground Ambulance Operations **Attn: Manager of Billing** 239 Brownlow Ave., Suite 300 Dartmouth, NS B3B 2B2 ambulancebilling@emci.ca Telephone: (902) 832-8337 or toll-free 1-888-280-8884 **Fax: (902) 832-2954**	For Office Use Only. Do Not Write In This Area. File # _____ Date Rec'd: _____ Date F'wd _____ Date Processed: _____

Ambulance Fee Assistance Program

Please complete the following checklist. This information will be used to help determine your eligibility to have your service fee waived under the financial hardship category. In order to allow EHS to verify your financial situation, it is also necessary to submit your household's "Notice of Assessment" forms from the Canada Revenue Agency for the most recent tax year. Eligibility is determined based on the criteria below as well as the household's assessed income and family unit size. Application must be received by the billing office within 90 days from the date the invoice was issued. For full details, please consult the EHS Service Fee Appeals website at http://novascotia.ca/dhw/ehs/ambulance-fees.asp or contact EHS as outlined above.

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1. Demographics: Patient Age Gender	Age:_____ ❑Male ❑Female
2. Are you 19 years old or older? (*note – patients who were under the age of 19 and resided with their parent(s)/guardian(s) at the time of the invoice must have their parent(s)/guardian(s) appeal on their behalf).	❑Yes ❑No
3. Do you have more than one Ground Ambulance service fee outstanding?	❑Yes ❑No
4. Are you married (includes living common-law)?	❑Yes ❑No
5. How many dependents do you have? A child of the patient or the patient's spouse, who is: 1. Financially dependent on either, and is under 19, or 2. under 25 and enrolled full-time in an education institution, or 3. over 18 and disabled.	❑0 ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10 or more
6. Are you a recipient of Employment Support and/or Income Assistance through the Nova Scotia Department of Community Services?	❑Yes ❑No
7. To your knowledge, are you eligible for any Federal/Provincial Government Programs that cover the cost of Ground Ambulance transportation?	❑Yes ❑No
8. Do you have third party insurance that would cover the cost of the Ground Ambulance transportation?	❑Yes ❑No

For purposes of verifying my financial situation:

❑ 1. I am including the "Notice of Assessments" for my household, received from the Canadian Revenue Agency

I certify that the information I have provided on behalf of the patient/or for my eligibility is correct. I also give permission to allow the Nova Scotia Department of Health and Wellness or agents acting on its behalf to review my financial information for the purposes of determining if I am eligible to have my service fee from the EHS Ground Ambulance system waived on the basis of financial hardship.

Signature:

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