

**Coweta County  
EMS Billing Hardship Application**

For questions regarding the hardship waiver process call 770-254-3900 or  
via e-mail to [ems@coweta.ga.us](mailto:ems@coweta.ga.us)

Hand-deliver or mail this application and all attachments to:  
Coweta County Fire Rescue  
483 Turkey Creek Road  
Newnan, Ga 30263

Applicant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last 4 Digits of Social Security Number: \_\_\_\_\_

Applicant Address: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Date of EMS Transport: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>2024 Federal Poverty Guidelines</b>		
Persons in Household	Monthly Income	Annual Income
1	\$1,255	\$15,060
2	\$1,703	\$20,440
3	\$2,152	\$25,820
4	\$2,600	\$31,200
5	\$3,048	\$36,580
6	\$3,497	\$41,960
7	\$3,945	\$47,340
8	\$4,393	\$52,720
For each additional person, add:	\$448	\$5,380

Coweta County may waive the patient's financial responsibility for EMS transport services on a case -by-case basis where the patient qualifies under our financial hardship guidelines or is a resident of Coweta County and on Medicare. Financial hardship is defined as annual household income being equal to or less than 100% of the Federal Poverty Guidelines. The determination of financial hardship is applicable to the current EMS transport only. To waive or reduce future payments, the patient must again prove financial hardship. If a patient does not qualify for a financial hardship waiver, a payment plan may be arranged with the billing services provider, Digitech at 855-313-5980.

Monthly Household Gross Income: \_\_\_\_\_

Number of Family Members Living in Household: \_\_\_\_\_ Adults \_\_\_\_\_ Children

On Medicare: \_\_\_\_\_ Yes \_\_\_\_\_ No

### **Required Supporting Documentation:**

**A copy of the EMS invoice or statement must be provided with the hardship application.**

**A copy of the most recent signed tax return AND a minimum of one of the following documentations must be provided with the hardship application:**

If on Medicare-

\_\_\_\_\_ Social Security Benefit Letter

If Employed-

\_\_\_\_\_ Most recent W-2 withholding statement

\_\_\_\_\_ Paycheck stubs for the past 90 days for all persons employed in the home

If Unemployed-

\_\_\_\_\_ Unemployment check stubs for past 90 days

\_\_\_\_\_ Wage Report from DOL

**\*IF THE REQUIRED DOCUMENTS ARE NOT PROVIDED, THE APPLICATION WILL BE DENIED**

Responsible Party (if different from applicant):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address (if different from applicant): \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

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I do hereby request that I, as either the applicant, or the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this EMS transport service fee.

**By signing this form, I certify that I have no insurance that can be billed for this charge. I declare that all of the information contained in this document and the attachments are true and accurate. Furthermore, I understand that I may be held liable for any false statements pertaining to this waiver request. I also understand that Coweta County reserves the right to require proof of income in consideration of this request and to verify any information contained in this document for the sole purpose of assessing financial need.**

I hereby agree to notify Coweta County of any change in the financial status of the applicant or the responsible party that may affect the ability to pay the ambulance transport fees.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Printed Name: \_\_\_\_\_

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**Coweta County Administrative Use Only**

Date of transport: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date request received: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Waiver Application (circle one):          Approved          Denied

Comment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date Billing Contractor Notified: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Authorizing Signature: \_\_\_\_\_