

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: <input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> 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:

<p>Return Completed Forms To:</p> <p>EHS Ground Ambulance Operations Attn: Billing Supervisor 239 Brownlow Ave., Suite 300 Dartmouth, NS B3B 2B2</p> <p>Telephone: (902) 832-8337 or toll-free 1-888-280-8884 Fax: (902) 832-2954</p>	<p>For Office Use Only. Do Not Write In This Area.</p> <p>File # _____</p> <p>Date Rec'd: _____ Date F'wd _____</p> <p>Date Processed: _____</p>
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Ambulance Fee Assistance Program

Please complete the following checklist. This information will be used to help determine your eligibility to have your service waived under the financial hardship category. In order to allow EHS to verify your financial situation, it is also necessary to submit your "Notice of Assessment" from the Canada Revenue Agency for the most recent tax year. Eligibility is determined based on the criteria below as well as the applicant's net income and family unit size. For full details, please consult the EHS Service Fee Appeals website at <http://www.gov.ns.ca/health/ehs/fee.asp> or contact EHS as outlined above.

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1. Demographics: Patient Age Gender	Age: _____ <input type="checkbox"/> Male <input type="checkbox"/> 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).	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have more than one Ground Ambulance service fee outstanding?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you married (includes living common-law)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 or more
6. Are you a recipient of Employment Support and/or Income Assistance through the Nova Scotia Department of Community Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. To your knowledge, are you eligible for any Federal/Provincial Government Programs that cover the cost of Ground Ambulance transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Do you have third party insurance that would cover the cost of the Ground Ambulance transportation?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:
