

AMBULANCE INVOICE  
REFERENCE NUMBER

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Please provide the Ambulance Invoice Reference Number of the invoice(s) for which you are seeking fee remission.

**APPLICANT INFORMATION**

|                                   |               |                            |                             |             |
|-----------------------------------|---------------|----------------------------|-----------------------------|-------------|
| APPLICANT LEGAL LAST NAME         |               | APPLICANT LEGAL FIRST NAME | APPLICANT LEGAL SECOND NAME |             |
| PERSONAL HEALTH (CARECARD) NUMBER |               | BIRTHDATE (YYYY/MM/DD)     | DAYTIME TELEPHONE NUMBER    |             |
| APT. / UNIT NUMBER                | STREET NUMBER | STREET NAME                |                             |             |
| CITY                              |               |                            | PROVINCE                    | POSTAL CODE |

**FINANCIAL INFORMATION**

*You must file your income tax return by April 30th each year.*

|   |   |           |
|---|---|-----------|
| <b>TAX YEAR</b>   | This information is from my income tax return for the year <input type="text" value="2"/> <input type="text" value="0"/>    |           |
| <b>NET INCOME</b>   |   |           |
| Enter your net income (from your income tax return or Notice of Assessment)<br><i>NOTE: If net income is a negative number (e.g.--\$2,300), enter 0</i>       | \$  | 1         |
| Enter the net income of your spouse<br><i>NOTE: If net income is a negative number (e.g.--\$2,300), enter 0</i>   | \$  | 2         |
| TOTAL NET INCOME (add lines 1 and 2)  | \$  | 3         |
| <b>AGE</b><br><i>Claim \$3,000 for each person who is 65 or older this year.</i>  | <b>DEDUCTIONS ALLOWED BY THE BC AMBULANCE SERVICE</b>   |           |
|   | SPOUSE - claim \$3,000  | \$ 4      |
|   | If you are 65 or older this year, claim \$3,000.00  | \$ 5      |
| <b>CHILDREN</b><br><i>Claim \$3,000 for each child claimed as a dependant on your income tax return.</i>  | If your spouse is 65 or older this year, claim \$3,000.00   | \$ 6      |
|   | CHILDREN _____ x \$3,000.00 = \$  |           |
|   | <b>minus</b> one half of the child care expenses claimed on your (and/or your spouse's) income tax return (1/2 of line 214) | -\$       |
| <b>DISABILITY</b><br><i>If you claimed a disability on your income tax return for yourself, your spouse or child, claim \$3,000 for each disabled person.</i> | Difference (if a negative number, enter 0)  | \$ → \$ 7 |
| <i>If you claimed attendant or nursing home expenses in place of disability, enclose photocopies of receipts.</i>   | Universal Child Care Benefit reported on your (and/or your spouse's) income tax return (line 117)                           | \$ 8      |
| <i>The maximum deduction for disability is \$3,000 per person.</i>  | DISABILITY _____ x \$3,000.00 =   | \$ 9      |
|   | Registered Disability Savings Plan income reported on your (and/or your spouse's) income tax return (line 125)              | \$ 10     |
|   | TOTAL DEDUCTIONS (add lines 4 to 10)  | \$ 11     |
| <b>ADJUSTED NET INCOME</b><br><i>Is net income from your income tax return minus above deductions allowed by the BC Ambulance Service.</i>                    | ADJUSTED NET INCOME (subtract line 9 from line 3)   | \$ 12     |

**This form must be signed. WE CANNOT ACCEPT UNSIGNED FORMS.**

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**AMBULANCE FEE REMISSION**

A fee charged for ambulance service may only be remised pursuant to the *Financial Administration Act*, Health Emergency Act Remission Regulation. The Regulation enables remission of the ambulance fee when another person or an insurer refuses to pay the fee as a result of a delay in issuing the initial invoice and this refusal to pay creates a great hardship for the patient.

The Remission Regulation includes two (2) provisions for invoicing delays. The delay must be either greater than 12 months from the date service was provided, or the delay must result in an insurer refusing to pay. When either of these circumstances apply the fee can be remised only if imposing the fee would cause great hardship for the patient. You satisfy the great hardship requirement of the Regulation if your adjusted net income (line 10) is less than \$42,000.

**Along with the completed and signed Application for Fee Remission form, please provide:**

- n **a copy of applicant's (and spouse's, if applicable) most recent Canada Revenue Agency Notice of Assessment**
- n **other documents that you feel may support your claim of financial hardship**
- n **if someone has Power of Attorney or another legal representation agreement and is signing on your behalf, include a copy of the agreement**

**DECLARATION AND CONSENT - MUST BE SIGNED**

**Please read and sign. If you are married or living and cohabiting in a marriage-like relationship, your spouse must also sign.**

The information obtained will be relevant to and used solely for the purpose of determining and verifying your financial hardship application for ambulance fee remission and will not be disclosed to any other party. This authorization is valid for the taxation year prior to the signature of this application and the year of the signature.

**Please mark this box (X) if someone has Power of Attorney or another legal representation agreement and is signing on your behalf, and include a copy of the agreement with your application.**

|                                       |                                      |                           |
|---------------------------------------|--------------------------------------|---------------------------|
| APPLICANT SIGNATURE                   | SPOUSE'S SIGNATURE                   | DATE SIGNED<br>YYYY/MM/DD |
| APPLICANT FIRST INITIAL AND LAST NAME | SPOUSE'S FIRST INITIAL AND LAST NAME |                           |

**Send to:**

BC Emergency Health Services  
BC Ambulance Service - Ambulance Billing  
PO Box 9676 Stn Prov Govt  
Victoria BC V8W 9P7

**Contact:**

BC Emergency Health Services  
BC Ambulance Service - Ambulance Billing  
Telephone: (250) 356-0052 (Victoria)  
Toll Free: 1 800 665-7199  
Fax: (250) 356-0581 (Victoria)  
Web: www.bcehs.ca

The personal information requested on this form is collected under the authority of the *Financial Administration Act* for the purpose of administering the *Emergency Health Services Act Remission Regulation* and is subject to the *Freedom of Information and Protection of Privacy Act*.

If you have questions about the collection of information by BC Emergency Health Services, please call the Manager of Financial Services (250) 953-3256, PO Box 9676 Stn Prov Govt, Victoria BC V8W 9P7