{Company Name}

Financial Hardship Policy

Purpose:

{Company Name} hereinafter referred to as (“XYZ”) has established this policy in an order to maintain consistency in assisting uninsured and indigent patients who request a reduction or waiver of certain ambulance charges and/or copayment amounts.

This policy outlines XYZ’s policies and procedures in relationship to the application and approval process for indigent patients. XYZ will take into account the overall financial circumstances of the applicant and apply this policy consistently.

If approved, XYZ may elect to reduce or waive certain amounts which are due from non-subscribers who can successfully demonstrate that paying ambulance fees would cause significant financial hardship.

Financial Hardship Criteria:

XYZ will take into account a range of factors when deciding whether the full payment of the ambulance charges will cause the applicant financial hardship. In making the decision whether to waive the fee, XYZ will compare the amount earned, living expenses, assets and debts. Written verification, when available, may be required to substantiate and verify information contained in the financial hardship application.

XYZ uses a combination of the current year’s federal poverty guidelines to help in determining if an applicant qualifies for a financial hardship waiver.

In applying these guidelines, XYZ will also consider and take into account any other income and expenses including money earned in the entire household. Income and employment status verification may be required; including tax returns; check stubs, etc.

1. Whether payment of the ambulance charges will affect the applicant’s ability to pay for the following living expenses:
   - food and clothes;
   - rent or mortgage payments;
   - any other basic needs; or
   - any special needs (for a serious illness or disability)

2. Whether the applicant owns any assets, such as a car or house. Assets also include:
   - investments;
   - money in the bank;
   - cash on hand for short term expenses; and
   - money designated for special needs.

3. Whether the applicant has any debts.

{Company Name}

Application Process for Financial Hardship

An application for a financial hardship waiver of ambulance charges and fees must be made in accordance with **{Company Name}** , hereinafter referred to as (*"XYZ"*), policy entitled "**Financial Hardship".**

Applicants can request and complete a **Financial Hardship Application Form.** The form can be obtained by calling (412) XXX-XXXX or by visiting the XYZ Business office at ____, during normal business hours. Forms can also be requested, through submission of a written request, to the above listed address for the XYZ Business Office.

If applying in person, please be prepared to offer written verification of the necessary information about your financial circumstances. If you have difficulty performing any of these tasks, please contact XYZ at (412) XXX-XXXX. Applicants are required to return the completed forms and submit all required documentation to XYZ.

Required Information:

XYZ requires independent information to support claims of financial hardship including verification of expenses and income. The information submitted will be treated confidentially and will only be reviewed by XYZ administrative staff involved in processing requests for waiver of ambulance charges.

Time Frame:

After an application and verification information is received, XYZ will consider the overall financial situation of the applicant and then render a decision. XYZ has designated the authority to grant or reject requests for financial hardship waivers to the Executive Director. All decisions will be made within 10 working days from the time that XYZ receives and reviews all required information.

Applicants will receive a notification letter outlining whether or not the application has been approved or rejected. If your request for waiver of the charges is rejected, XYZ will provide the applicant with a written summary and explanation of its decision.

XYZ administrative staff will maintain all documentation related to the financial hardship waiver process. This documentation will include all supporting documentation including the waiver request and all documents provided in support of the request.

Verification of ongoing qualification for financial hardship will be conducted at any time the applicant requests a waiver of ambulance charges or other applicable copayment amounts.

In applying these guidelines, XYZ will also consider and take into account all other income and expenses; including money earned in the entire household. Income and employment status verification may be required; including tax returns; check stubs, etc.

{Company Name}

Application Process for Financial Hardship (con't)

Income shall be annualized from the date of request based on documentation provided, and upon verbal information provided by the patient or their designee. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Any denial of "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

PLEASE COMPLETE ATTACHED APPLICATION AND FINANCIAL STATEMENT.

YOUR REQUEST CAN NOT BE PROCESSED UNLESS THE APPLICATION AND FINANCIAL STATEMENT IS FULLY COMPETED AND SIGNED!

{Company Name}

Financial Hardship Application

Please complete the application and attached financial statement. Please return all forms and required documentation (in person or by mail) to {Company Name and address}, (telephone 412-xxx-xxxx or by fax to 412-xxx-xxxx)

All information relating to financial hardship requests will be kept confidential.

Patient Name: ____

Address 1: ____

Address 2: ____

Telephone #: ______________________

DOB: ____/____/______ SS #: ___________________________

Date of Service: ____/____/______ Alternate Date of Service: ____/____/______

Name of Person completing this Application (if different than patient listed above)

____ Telephone #: _____________

Relationship to Patient: ____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):________

PLEASE LIST ALL CURRENT EMPLOYERS:

Check Here if UNEMPLOYED. HOW LONG?:______________________

Employer 1: ____

Address: ____

Contact Person:_________________________________ Telephone:_____________________

Employer 1: ____

Address: ____

Contact Person: _________________________________ Telephone: _____________________

{Company Name}

Financial Hardship Application (con't)

Please provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof that patient is at or below 135% of the current federal poverty guidelines (see attachment A for current federal HHS guidelines). Documents may include but not limited to:

   W-2 withholding statements or unemployment check stubs for the past 90 days
   Pay check stubs for the past 90 days for all persons employed in the home
   Income tax return (most recent signed 1040 and/or W-2)
   Proof of all other income received in the past 90 days
   Application Forms from Medicaid or other State-funded medical assistance program
   Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

   Proof of all outstanding debts or bills (copies of bills, statements; late notices, etc.)
   Proof of bankruptcy settlement (if applicable)
   Catastrophic situations (death or disability in family, divorce) ***or other documentation which demonstrates the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses.***

3) Please describe patient indigent circumstances: ____________________________________

____

MONTHLY FAMILY INCOME & SOURCE			
	Patient	Spouse	Dependants
Monthly Salary (Gross)	$____________	$____________	$____________
Public Assistance Benefits	$____________	$____________	$____________
Unemployment Benefits	$____________	$____________	$____________
Social Security Benefits	$____________	$____________	$____________
Workman's Compensation	$____________	$____________	$____________
Child Support	$____________	$____________	$____________
Other (Alimony, Etc.)	$____________	$____________	$____________
Subtotal:	$____________	$____________	$____________
TOTAL FAMILY INCOME	$_____________________		

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE ***{Company Name}*** *TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.*

____ ____/____/____

Signature of Person Making Request Date

____

Printed Name of Person Making Request:

{Company Name}

Financial Hardship Application - Attachment B

2009 HHS Poverty Guidelines

(48 Contiguous States and D.C.)

Number of Persons in Family or Household	48 Contiguous States and D.C.	135% Threshold Established by XYZ
1	$10,830	$14,621
2	$14,570	$19,670
3	$18,310	$24,719
4	$22,050	$29,768
5	$25,790	$34,817
6	$29,530	$39,866
7	$33,270	$44,915
8	$37,010	$49,964
For each additional person, in families exceeding eight members, add >>>>>>	$3,740	$14,621

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199–4201