

ELY AREA AMBULANCE SERVICE

Financial Hardship Policy

Purpose:

ELY AREA AMBULANCE SERVICE hereinafter referred to as (“EAAS”) 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 EAAS’s policies and procedures in relationship to the application and approval process for indigent patients. EAAS will take into account the overall financial circumstances of the applicant and apply this policy consistently.

If approved, EAAS 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:

EAAS 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, EAAS 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.

EAAS 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, EAAS 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.

ELY AREA AMBULANCE SERVICE

Application Process for Financial Hardship

An application for a financial hardship waiver of ambulance charges and fees must be made in accordance with **ELYAREA AMBULANCE SERVICE**, hereinafter referred to as ("**EAAS**"), policy entitled "**Financial Hardship**".

Applicants can request and complete a **Financial Hardship Application Form**. The form can be obtained by calling (218) 365-6322 or by visiting the **EAAS** website at **www.elyambulance.com**, during normal business hours. Forms can also be requested, through submission of a written request, to EAAS PO BOX 629, Ely, MN 55731.

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 EAAS at (218) 365-6322. Applicants are required to return the completed forms and submit all required documentation to EAAS.

Required Information:

EAAS 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 EAAS administrative staff involved in processing requests for waiver of ambulance charges.

Time Frame:

After an application and verification information is received, EAAS will consider the overall financial situation of the applicant and then render a decision. EAAS 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 EAAS 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, EAAS will provide the applicant with a written summary and explanation of its decision.

EAAS 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, EAAS 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.

ELY AREA AMBULANCE SERVICE

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 COMPLETED AND SIGNED!

ELY AREA AMBULANCE SERVICE

Financial Hardship Application

Please complete the application and attached financial statement. Please return all forms and required documentation (in person or by mail) to: EAAS

PO BOX 629
Ely, MN 55731

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: _____

ELY AREA AMBULANCE SERVICE

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 **Ely Area Ambulance Service** 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:

ELY AREA AMBULANCE SERVICE

Financial Hardship Application - Attachment B

| The 2016 Poverty Guidelines for the 48 Contiguous States and the District of Columbia | |
|--|--------------------------|
| Persons in family | Poverty guideline |
| 1 | \$11,880 |
| 2 | 16,020 |
| 3 | 20,160 |
| 4 | 24,300 |
| 5 | 28,440 |
| 6 | 32,580 |
| 7 | 36,730 |
| 8 | 40,890 |
| For families with more than 8 persons, add \$4,160 for each additional person. | |

<https://www.federalregister.gov/articles/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines>

Revised: 04/2016