

Request for Financial Hardship Determination

South Seneca Community Volunteer Ambulance Corp, Inc. (SSA) has established this Financial Hardship Assistance policy to maintain consistency in assisting uninsured and impoverished patients who request a reduction or waiver of certain ambulance charges.

Cornerstone AdminisystemEMS, Inc. (CAS) will bill and ultimately manage all requests for financial hardship and/or payment plans for SSA, SSA will consider the overall financial circumstances of the applicant and apply this policy consistently.

If approved, SSA may elect to reduce or waive certain amounts which are due from our patients who can successfully demonstrate that paying ambulance fees would cause significant financial hardship. SSA may also elect to assist by establishing a payment plan managed by CAS.

Financial Hardship Criteria:

SSA will consider 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, SSA 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.

SSA uses a combination of the current year's federal poverty guidelines with information provided by the patient/guarantor to help in determining if an applicant qualifies for a financial hardship waiver.

In applying these guidelines, SSA will also consider any other income, expenses, Assets, and debts, including:

- 1) Money earned in the entire household. Income and employment status verification may be required, including tax returns, paycheck stubs, etc.
- 2) 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)
- 3) 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.
- 4) Whether the applicant has any debts.

Applicants may download and complete a **Patient Request for Financial Hardship Determination** form from ssaems.org. The form is a pdf document. The form can also be obtained by calling (607) 869-5313.

Required Information:

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

Billing Inquiries and Payments:

Cornerstone Adminisystems, Inc.
PO Box 726
New Cumberland, PA 17070
Toll-free: (800) 927-5845
Fax: (877) 215-1546

Financial Hardship Request:

South Seneca Community
Volunteer Ambulance Corp, Inc.
2011 State Route 96A
Ovid, NY 14521
Phone: 607-869-5313

E-mail: info@ambulancebillingoffice.com

Fax: 607-869-5314



South Seneca Community Volunteer Ambulance Corp, Inc.

2011 State Route 96A

Ovid, NY 14521

(p) 607-869-5313 (f) 607-869-5314

Patient Request for Financial Hardship Determination

Instruction to Patient

Please complete this form in its entirety and return it with all supporting documentation to:

Cornerstone Adminisystems, Inc.

PO Box 726

New Cumberland, PA 17070

Fax: (877) 215-1546

E-mail: info@ambulancebillingoffice.com

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Responsible Party (if different than patient): _____

Address of Responsible Party: _____

City: _____ State: _____ Zip: _____

Due to my current financial circumstances and/or lack of insurance coverage, I am requesting a determination be made in consideration of waiving my co-pay/co-insurance/deductible (or total charges if uninsured) for service and care provided to me on _____ (date of service).

I am supplying the following information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources including Social Security benefits, pensions, annuities, dividends, etc. Attached you will find verification of my employment or unemployment status and copies of my federal tax returns or W-2 forms for the previous two (2) years. I **Have** **Have Not** included additional information about my current hardship for consideration of my request for assistance.

My insurance information is:

Insurer Name: _____

Insurance Policy/ID Numbers: _____

Invoice Number on billing statement: _____

Request for Financial Hardship Determination

Household and Financial Disclosure Worksheet

Number of family members in household: _____

Monthly Income

	Self	Spouse
1) Wage/salary	\$ _____	\$ _____
2) Social security	\$ _____	\$ _____
3) Pension	\$ _____	\$ _____
4) Interest income	\$ _____	\$ _____
5) Other	\$ _____	\$ _____

Please describe: _____

6) Total Income (add lines 1-5) \$ _____ + \$ _____ = \$ _____

Monthly Expenses

	Self	Spouse
7) Rent/Mortgage	\$ _____	\$ _____
8) Installment accounts (auto, boat,...)	\$ _____	\$ _____
9) Installment accounts (credit card,...)	\$ _____	\$ _____
10) Total Utility Expenses	\$ _____	\$ _____

Please describe: _____

11) Other Liabilities \$ _____ \$ _____

Please describe: _____

12) Total Expenses (add lines 7-11) \$ _____ + \$ _____ = \$ _____

Debts

	Self	Spouse
13) Rent/Mortgage	\$ _____	\$ _____
14) Outstanding balance from Line 8	\$ _____	\$ _____
15) Outstanding balance from Line 9	\$ _____	\$ _____

Describe: _____

16) Totals Debts (add lines 13-15) \$ _____ + \$ _____ = \$ _____

Other Assets

	Self	Spouse
17) Cash on hand	\$ _____	\$ _____
18) Total of Savings Accounts	\$ _____	\$ _____
19) Total Checking Accounts	\$ _____	\$ _____
20) IRA or Other Retirement	\$ _____	\$ _____
21) Real Property (auto/home/other)	\$ _____	\$ _____

Describe: _____

22) Totals Assets (add lines 13-15) \$ _____ + \$ _____ = \$ _____

Request for Financial Hardship Determination

Statement of Agreement:

"I am supplying this information to request that South Seneca Community Volunteer Ambulance Corp, Inc. (SSA) waive collection of all or part of the amounts I currently owe, due to financial hardship. I understand that SSA may request updated information for up to one (1) year to verify that my financial situation and hardship status has not changed. I also understand that SSA can and will begin to attempt to collect charges should my financial situation improve. I agree to be responsible for any balance remaining after the application of any waiver by SSA, if any."

Patient signature: _____ Date: _____

Documentation attached:

- Patient Request for Financial Hardship Determination form
- Household and Financial Disclosure Worksheet
- Previous two (2) Years federal tax returns or W-2 forms
- Supporting documentation about my current financial situation
- Additional information about my current hardship **(not required)**

----- For office use only -----

Date Received: _____ Run Date: _____ Run #: _____

Date Reviewed: _____ Reviewed by: _____

Determination:

- Hardship is founded – total due is waived in the amount of \$ _____
- Hardship is founded – partial due is waived in the amount of \$ _____ with a remaining balance of \$ _____.
- Payment plan offered in the amount of \$ _____ per month for _____ months
- Hardship is unfounded – waiver is denied
- Payment plan offered

Date applicant contacted: _____ Contacted by: _____

Billing Service contacted: _____ Contacted by: _____