Request for Financial Hardship Determination

South Seneca Community Volunteer Ambulance Corp, Inc., d.b.a South Seneca Ambulance (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 AdminisystEMS, 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. SAA 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 liabilities, 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 liabilities or 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 verification of information to support claims of financial hardship including verification of expenses and income, lack of insurance coverage, as well as assets and liabilities. 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
E-mail: info@ambulancebillingoffice.com

Financial Hardship Request:
South Seneca Community
Volunteer Ambulance Corp, Inc.
2011 State Route 96A
Ovid, NY 14521
Phone: 607-869-5313
Fax: 607-869-5314

South Seneca Ambulance

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 a portion up to the 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 request. The monthly dollar amount provided is from all sources including work, 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)	$_________ +	$___________	= $ ____________

Liabilities	Self	Spouse	
13) Mortgage (remaining principle)	$_________	$___________	
14) Outstanding principle from Line 8	$_________	$___________	
15) Outstanding principle from Line 9	$_________	$___________	
Describe: ____			
16) All other Liabilities	$_________	$___________	
Describe: ____			
17) Totals Liabilities (add lines 13-15)	$_________ +	$___________	= $ ____________

Other Assets	Self	Spouse	
18) Cash on hand	$_________	$___________	
19) Total Savings Accounts	$_________	$___________	
20) Total Checking Accounts	$_________	$___________	
21) IRA or Other Retirement	$_________	$___________	
22) Real Property (auto/home/other)	$_________	$___________	
Describe: ____			
22) Investment accounts (Stocks, bond)	$_________	$___________	
Describe: ____			
23) 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 my current financial hardship. I understand that SSA may request updated information for up to one (1) year after determination to verify that my financial situation and hardship status has not changed. I also understand that based on findings of my financial situation improving within that period, SSA may reverse this finding and begin to collect the original balance. I agree to be responsible for the remaining balance, if any, after the determination of hardship process has been completed by SSA.

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: ___________________________