

Livingston County EMS

Financial Hardship Policy

Purpose:

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

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

Financial Hardship Criteria:

LCEMS 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, LCEMS 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.

LCEMS 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, LCEMS 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.

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Application Process for Financial Hardship

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

Applicants can request and complete a **Financial Hardship Application Form**. The form can be obtained by calling (517) 546-6220 or by visiting the LCEMS Business office at 3950 W Grand River Howell, MI 48855, during normal business hours.

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 LCEMS at (517) 546-6220. Applicants are required to return the completed forms and submit all required documentation to LCEMS.

Required Information:

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

Time Frame:

After an application and verification information is received, LCEMS will consider the overall financial situation of the applicant and then render a decision. LCEMS has designated the authority to grant or reject requests for financial hardship waivers to the Finance Manager/and or Director. All decisions will be made within 10 working days from the time that LCEMS 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, LCEMS will provide the applicant with a written summary and explanation of its decision.

LCEMS 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, LCEMS 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.

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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!

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Financial Hardship Application

Please complete the application and attached financial statement. Please return all forms and required documentation (in person or by mail) to Livingston County EMS 3950 W Grand River Howell MI 48855, telephone 517-546-6220 or by fax to 517-546-6788

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: _____

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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 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 Livingston County EMS 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:

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Financial Hardship Application - Attachment B

2013 HHS Poverty Guidelines			
Persons in Family	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$11,490	\$14,350	\$13,230
2	15,510	19,380	17,850
3	19,530	24,410	22,470
4	23,350	29,440	27,090
5	27,570	34,470	31,710
6	31,590	39,500	36,330
7	35,610	44,530	40,950
8	39,630	49,560	45,570
For each additional person, add	4,020	5,030	4,620

SOURCE: *Federal Register*, 78 FR 5182, document number 2013-01422
<https://www.federalregister.gov/articles/2013/01/24/2013-01422>