STOREY COUNTY FIRE PROTECTION DISTRICT POLICIES AND PROCEDURES

NUMBER: 034A
EFFECTIVE DATE: 4/18/13
AUTHORITY: Fire Chief

SUBJECT: FINANCIAL HARDSHIP POLICY

I. PURPOSE: SCFPD has established this policy in order to maintain consistency in assisting uninsured, underinsured and indigent patients who request a payment plan for certain ambulance charges and/or copayment amounts.

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

If approved, SCFPD may elect to allow payments for certain amounts which are due from non-subscribers who can successfully demonstrate that paying ambulance fees would cause significant financial hardship.

II. POLICY: SCFPD 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 allow a payment plan, SCFPD will compare the amount earned, living expenses, assets and debts. Written verification is required to substantiate and verify information contained in the financial hardship application.

SCFPD uses the current year's federal poverty guidelines to help in determining if an applicant qualifies for a financial hardship payment plan. In applying these guidelines, SCFPD will also consider and take into account any other income and expenses including money earned in the entire household. Income and employment status verification is required including tax returns, check stubs, etc. SCFPD will also consider the following:

- Whether the 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)
- 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.
- Whether the applicant has any debts.

III. PROCEDURE: An application for a financial hardship payment plan for ambulance charges and fees must be made in accordance with SCFPD's Financial Hardship Policy.

Applicants can request and complete a Financial Hardship Application Form. The form can be obtained by calling (775) 847-0954 or by visiting the SCFPD business office at 145 North C Street, Virginia City, Nevada, during normal business hours. Forms can also be requested, through submission of a written request, to SCFPD, PO Box 603, Virginia City, Nevada 89440, or downloaded from the Storey County website at www.storeycounty.org/fire/.

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 SCFPD at (775) 847-0954. Applicants are required to return the completed forms and submit all required documentation to SCFPD within forty five (45) days of service.

Required Information

SCFPD 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 SCFPD administrative staff involved in processing requests for payment plans for ambulance charges.

IV. TIME FRAME: After an application and verification information is received, SCFPD will consider the overall financial situation of the applicant and then render a decision. All decisions will be made within ten (10) working days from the time that SCFPD 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 a payment plan for the charges is rejected, SCFPD will provide the applicant with a written summary and explanation of its decision.

SCFPD administrative staff will maintain all documentation related to the financial hardship process. This documentation will include all supporting documentation including the payment request and all documents provided in support of the request. This information shall be kept in the patient's billing file.

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

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.

PLEASE COMPLETE ATTACHED APPLICATION AND FINANCIAL STATEMENT.

YOUR REQUEST CANNOT BE PROCESSED UNLESS THE APPLICATION AND FINANCIAL STATEMENT IS FULLY COMPLETED AND SIGNED AND ALL SUPPORTING DOCUMENTATION IS RECEIVED.

STOREY COUNTY FIRE PROTECTION DISTRICT
Post Office Box 603
Virginia City, NV 89440
(775) 847-0954 Phone • (775) 847-0987 Fax
www.storeycounty.org
"Be Nice • Solve Problems • Serve Community"

FINANCIAL HARDSHIP APPLICATION FORM

THIS HARDSHIP APPLICATION MUST BE SUBMITTED FOR EACH EMS TRANSPORT FEE PAYMENT PLAN REQUEST

Financial assistance shall be limited to medically necessary care and shall not be given if Ambulance service is given resulting from the commission of a crime. The Financial Hardship Policy does not cover services to patients that qualify for county, state, federal, or other assistance programs.

Responsible Party Name _____

Responsible Party Address _____

Social Security Number _____ Contact Phone _____

Invoice # _____ Date of Service _____

Patient Name
(If different from applicant) _____ Relationship _____

List the people in your household *including all dependants*. Please list the dollar amount of the total **monthly** income that supports the household. Include money that is earned (paychecks, profits, interest) as well as income that is not earned (welfare, unemployment, child support, gifts, grants)

	Name	Birth Date	Relationship	Monthly Income
1				
2				
3				
4				
5				
6				
7				
8				

Please make copies of this page and complete one for EACH employed member of the household

*Name*_____

Monthly Gross Income: $_____

☐ Check Here if UNEMPLOYED. SINCE WHAT DATE? _____/_____/_____

Employer 1:_____ Address: _____

Telephone: _____

Employer 2:_____ Address: _____

Telephone _____

Please list additional employers on the back of this page.

Monthly Expenses: Please indicate your average MONTHLY expenses for the following items:

☐Rent ☐Mortgage	$_____
Auto Insurance	$_____
Insurance (other) _____	$_____
Food:	$_____
Utilities:	$_____
Auto/Gas:	$_____
Telephone:	$_____
Childcare:	$_____
Other: _____	$_____
Other: _____	$_____
Other: _____	$_____
Other: _____	$_____
TotalMonthly Expenses:	**$**_____

Have you applied for Medical Assistance? ☐Yes ☐No If yes, date you applied _____

Determination (eligible, not eligible, disabled, other, etc.) _____

If you have applied for Medicaid and have not received a final determination, please contact your case worker to determine your eligibility. The financial assistance application will be processed once a final determination is received.

Attached documentation: (*Copies Only*)

Required:

☐Income tax return (most recent – signed)

☐Proof of all other income received in the past ninety (90) days (including child support, food stamps, public assistance, disability, workers compensation, unemployment, payday advances and other loans)

☐Proof of all outstanding debts or bills (copies of bills, statements, late notices, etc.)

☐Paycheck stubs, W-2 withholding statements, or unemployment check stubs for the past 90 days

If applicable:

☐Medical Assistance (Medicaid or other) determination

☐Proof of bankruptcy settlement (if applicable)

☐Catastrophic situations (death, or disability in family, divorce) or other documentation which demonstrates the patient would have difficulty paying medical bills and still be able to pay for other basic necessary expenses.

☐Other information or documentation you wish to provide that will help in our decision making process

In your own words, please explain why you are requesting a Hardship Payment Plan:

_____
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PAYMENT PLAN: MONTHLY PAYMENT AMOUNT REQUESTED $_____

Monthly payment amount will be determined with your requested amount and application information taken into consideration.

I do herby request that I, as the financially responsible party for the patient, be considered for a payment plan for the payment responsibilities as they relate to this EMS transport service fee. **By signing this form I certify that I have no insurance that can be billed for this charge. I declare that all of the information contained in this document and the attachments are true and accurate. Further, I understand that I may be held liable for any false statements pertaining to this payment plan request. I understand that a credit report may be run to verify my eligibility for the program.** I understand that information supplied will be verified by Storey County Fire Protection District and reviewed by state and/or federal enforcement agencies and others as required. I herby agree to notify the Storey County Fire District of any change in the financial status of the patient or responsible party that may affect the ability to pay the Ambulance Fee.

Signature of Responsible Party: _____ Date: _____

Printed Name: _____

For questions regarding the hardship application process call 775-847-0954 or email arussell@storeycounty.org

Mail this application and all attachments to:

Storey County Ambulance
PO Box 603
Virginia City, NV 89440