TOWNSEND FIRE – EMS AMBULANCE BILLING HARDSHIP POLICY

Purpose:

To establish a policy that allows the modifying of ambulance transport fees based on current year Department of Public Health and Human Service poverty Guidelines.

Scope:

This policy pertains to all patient transported by the Townsend Fire – EMS Ambulance Service. Transported individuals must NOT have been injured while involved in the commission of a felony criminal activity. Each patient as defined above may request one (1) hardship modification per consecutive twelve (12) month period.

Preface:

The charges for transport billing may be modified, based upon financial hardship, as determined by the Townsend Fire – EMS Ambulance Service. These procedures will ensure just and fair evaluation of a hardship waiver request as well as establish an audit trailer for future use.

Procedures

1. **No one will EVER be denied necessary medical treatment or transport service due to their inability to pay or lack of insurance.**
2. The Townsend Board of Selectmen will address cases of financial hardship on an individual basis.
3. Patients who are unable to pay their co-pays, deductibles, or who are uninsured, unemployed, homeless, or for other reasons unable to make payments may request a financial hardship review of their transport charges. Patients, or their designee, shall be complete the "Request for Transport Fee Hardship Form". The form is available on the Townsend Fire Department website (www.townsendfire-ems.org) or can be requested by calling coastal Ambulance Billing office at 1-866-268-5200.
4. The Townsend Fire-EMS Chief will make the final decision. The Chief may waive all charges, reduce the charges, establish a payment plan or deny the request. All final resolutions will be noted on the form.
5. If approved for modification, a copy of all documentation will be made and it will be held in the ambulance service files for a period of seven years. The original form will be submitted to the billing company authorizing changes to the patient's charges. Coastal Ambulance Billing will notify the patient in writing as to the final disposition of the hardship waiver.

TOWNSEND FIRE – EMS AMBULANCE BILLING HARDSHIP PROGRAM APPLICATION

THIS APPLICATION MUST BE SUBMITTED FOR EACH AMBULANCE FEE ADJUSTMENT REQUESTED.

Patients Name: ____

Address: ____

Telephone # ____________________ Date of Birth _____/_____/_____

SS# _____-_____-_____ Date of Service _____/_____/_____ Invoice # ______________

Monthly Household Income ________________ Number of Dependents living in Household _______

Responsible party completing this application (if different than patient listed above).

______________________________________ Telephone # ____________________

Relationship to Patient ____

Attached documentation:

_____ W-2 withholding statements or unemployment check stubs for past 90 days.

_____ Paycheck stubs for the past 90 days for all persons employed in the home.

_____ Income Tax Return (most recent and signed)

_____ Any other information you wish to provide that will help in our decision making process.

In your own Words explain why you are requesting a hardship waiver.

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Adopted by the Townsend Board of Selectmen on ________________ 2015

Chair ______________________________

Selectmen ______________________________

Selectmen ______________________________