Policies and Procedures # A7

Subject: HARDSHIP

Department: Administrative

Approved/Amended: 01/01/2014, 11/15/2017

Approved By: Riggs/Abney, Legal Counsel

Effective Date: 12/10/2012

This policy/procedure supersedes all other policies/procedures of the same subject.

Purpose

To develop guidelines to objectively evaluate the financial ability of patients to make payments for their emergency medical services.

Overview

EMSA provides emergency services to patients without regard to their ability to pay. We recognize that a patient's illness can create large medical bills that inhibit the patient's ability to make payment. Our billing procedures allow for billing of all possible insurance carriers to maximize recovery from these sources. A follow-up should be performed, which includes statements and phone calls to the patient to keep him or her informed as to the progress of payment for the emergency medical service rendered.

When a patient has Medicare, he or she is required to pay the deductible and co-payment. However, Medicare will allow the balance due by the patient to be written off if the patient is unable to pay due to financial or income restrictions. Indigent patients may be determined to be financially unable to pay their portions of the bill in advance. Hardship declaration is the exception, not the rule.

A patient with no insurance, or an unpaid balance after insurance options have been exhausted can seek eligibility for discounts under this policy. If a patient does not meet eligibility requirements, and he refuses to render payment, he will be turned over to a collection agency.

Procedures

Before any discounts for services are granted, the first option is to attempt to arrange for the patient to make regular monthly payments in a dollar amount no less than $75.00 a month, but allow the patient to provide first the amount they think they are able to pay monthly. Should this attempt fail, the following guidelines will be used:

Option 1:	Ensure that insurance benefits have been maximized,
Option 2:	Payment plan – Offer, no less than $75.00 a month,
Option 3:	Offer a 10% discount and payment is made that day, no discounts above this can be taken without management approval and is a case by case depending on circumstances. If the balance is for a Medicare or Medicaid

co-pay or deductible an offer cannot be made, they will have to qualify for financial assistance through a hardship in order to receive a discount.

Option 4: Financial Hardship consideration - guidelines listed below

Option 5: Collection Agency

Once the request for charitable assistance has been made, a Charity Care Letter will be mailed along with the application to the patient. The patient will need to fill out and return the application, along with requested documentation, to us within 15 business days.

Once the application has been sent to the patient, the account(s) will be placed on hold. A callback will be set for the "Charity Care letter sent" callback group. The date of the callback will be the date the application is due to be returned.

2017 Annual Federal Poverty Guidelines
48 Contiguous States and DC

Household Size	100%	133%	150%	200%	250%	300%	400%
1	$12,060	$16,040	$18,090	$24,120	$30,150	$36,180	$48,240
2	16,240	21,599	24,360	32,480	40,600	48,720	64,960
3	20,420	27,159	30,630	40,840	51,050	61,260	81,680
4	24,600	32,718	36,900	49,200	61,500	73,800	98,400
5	28,780	38,277	43,170	57,560	71,950	86,340	115,120
6	32,960	43,837	49,440	65,920	82,400	98,880	131,840
7	37,140	49,396	55,710	74,280	92,850	111,420	148,560
8	41,320	54,956	61,980	82,640	103,300	123,960	165,280

Level of reduction:

FPG 100%=	**100% Reduction**
FPG >100% to 150%=	**75% Reduction**
FPG >150% to 200%=	**50% Reduction**
FPG >200% to 250%=	**25% Reduction**
FPG >250%=	**0% Reduction**

EMSA Management will review the request and will use their discretion in granting all or partial discounts, based on total resources, obligations and the patient statement of need.

Only an authorized EMSA official may approve a financial hardship case. Under no circumstances may personnel disclose our hardship criteria to the patient. Personnel should gather as much

information as possible from the patient and present this information to the designated EMSA official for approval.

If the patient exceeds the income criteria, he or she will be billed in accordance with the direction of his insurance company, if any. Status can change at any time. Income status must be renewed each time a patient claims financial hardship.

EMSA

PATIENT QUESTIONNAIRE FOR FINANCIAL HARDSHIP DETERMINATIONS
Please complete and return within 15 business days

Patient Name	Patient Account Number		
Social Security Number	Birth Date (Month/Date/Year)	Telephone Number	
Patient Address	City	State	Zip Code

Employer (Name, Address and Telephone Number) (If unemployed, list previous employer information)

Spouse Name (or Father and Mother or Legal Guardian, if Patient is a Minor) Social Security Number

Spouse Employer (Name, Address and Telephone Number) (If unemployed, list previous employer information)

I am applying for a Hardship Determination in order that you will consider 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/unemployment status and copies of my federal tax return or W-2 forms for the previous year.**

My insurance information is:

Insurer Name: _____

Insurance Policy/ID Numbers: _____

Monthly Income	**Self**		**Spouse**	
Wage/salary	$_____		$_____	
Social security	$_____		$_____	
Pension	$_____		$_____	
Interest income	$_____		$_____	
Other	$_____		$_____	
Totals	$_____	+	$_____	= $_____

Statement of Agreement: "I am supplying this information to request that EMSA waive collection of all or part of the Medicare or other deductible/co-insurance amounts in my case due to financial hardship. I also understand that EMSA 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 EMSA, if any."

Patient Signature:_____ Date:_____

EMSA
PATIENT NOTICE FOR FINANCIAL HARDSHIP DETERMINATIONS
APPROVAL

Patient Name: _____ Date of Service: _____

Dear Patient:

The law requires that EMSA attempt to collect any unpaid portion of the Medicare Part B, Medicaid, or other third party insurance deductible and the applicable co-insurance amount from the beneficiary. However, a condition may permit the emergency medical service provider to waive collection of these amounts or a percent of these amounts if a financial hardship is met according to policy.

Based upon information provided by you, we have determined that, due to your current financial situation, you are unable to pay the unpaid portion of your deductible and/or the co-insurance amount. We will waive the full OR partial balance due, based on the Federal Poverty Guidelines:

Date of Service:_____

Amount Waived: _____

Balance Due: _____ *Balance must be paid in full within 90 days* _____

However, if future discussion with you regarding your financial situation indicates that your situation has improved enough to enable you to pay, we will require payment of charges incurred for that date of service.

Sincerely,

EMSA

EMSA
PATIENT NOTICE FOR FINANCIAL HARDSHIP DETERMINATIONS
DENIAL

EMSA
PATIENT NOTICE FOR FINANCIAL HARDSHIP DETERMINATIONS
DENIAL

Patient Name: _____ Date of Service: _____

Dear Patient:

The law requires that EMSA attempt to collect any unpaid portion of the Medicare Part B, Medicaid or third party insurance deductible and the applicable co-insurance amount from the beneficiary. However, a condition may permit the emergency medical service provider to waive collection of these amounts or a percent of these amounts if a financial hardship is met according to policy.

Based upon discussions with you and information provided, we have determined that, you do not meet the guidelines for hardship. Please contact our office to work out a payment arrangement.

Date of Service:_____

Balance Due:_____

However, if future discussion with you regarding your financial situation indicates that your situation has changed, we will be happy to address this matter again.

Sincerely,

EMSA

EMSA
PATIENT NOTICE FOR FINANCIAL HARDSHIP DETERMINATIONS
DENIAL

Patient Name: _____ Date of Service: _____

Dear Patient:

The law requires that EMSA attempt to collect any unpaid portion of the Medicare Part B, Medicaid or third party insurance deductible and the applicable co-insurance amount from the beneficiary. However, a condition may permit the emergency medical service provider to waive collection of these amounts or a percent of these amounts if a financial hardship is met according to policy.

Based upon the information provided by you, we have determined that, you do not meet the guidelines for hardship. Please contact the office to work out a payment arrangement. For reconsideration please submit additional information, such as a current W2 or most current tax forms.

Balance Due: _____

However, if future discussion with you regarding your financial situation indicates that your situation has changed, we will be happy to address this matter again.

Sincerely,

EMSA