

## Request for Financial Hardship Determination

South Seneca Community Volunteer Ambulance Corp, Inc. (SSA) has established this Financial Hardship Assistance policy in order to maintain consistency in assisting uninsured and indigent 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. SSA may also elect to assist by establishing a payment plan managed by MMBS.

### 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 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.

Applicants may download and complete a **Patient Request for Financial Hardship Determination** form from southsenecaambulance.org. The form is a pdf document. The form can also be obtained by calling (607) 869-5313.

### Required Information:

SSA 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 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

Request for Financial Hardship Determination



**South Seneca Community  
Volunteer Ambulance Corp, Inc.**

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 supporting documentation to:

**Cornerstone Adminisystems, Inc  
PO Box 726  
New Cumberland, PA  
17070**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Responsible Party (if different than patient): \_\_\_\_\_

Address of Responsible Party: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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 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: \_\_\_\_\_

<b>Monthly Income</b>	<b>Self</b>	<b>Spouse</b>
1) Wage/salary	\$ _____	\$ _____
2) Social security	\$ _____	\$ _____
3) Pension	\$ _____	\$ _____
4) Interest income	\$ _____	\$ _____
5) Other	\$ _____	\$ _____
Describe: _____		
6) Totals Income (add lines 1-5)	\$ _____ +	\$ _____ = \$ _____

<b>Monthly Expenses</b>	<b>Self</b>	<b>Spouse</b>
7) Rent/Mortgage	\$ _____	\$ _____
8) Installment accounts (auto)	\$ _____	\$ _____
9) Installment accounts (other)	\$ _____	\$ _____
10) Utility Expenses	\$ _____	\$ _____
Describe: _____		
11) Other Liabilities	\$ _____	\$ _____
Describe: _____		
12) Totals Expenses (add lines 7-11)	\$ _____ +	\$ _____ = \$ _____

<b>Debts</b>	<b>Self</b>	<b>Spouse</b>
13) Rent/Mortgage	\$ _____	\$ _____
14) Installment accounts (auto)	\$ _____	\$ _____
15) Installment accounts (other)	\$ _____	\$ _____
Describe: _____		
16) Totals Debts (add lines 13-15)	\$ _____ +	\$ _____ = \$ _____

<b>Other Assets</b>	<b>Self</b>	<b>Spouse</b>
17) Cash on hand	\$ _____	\$ _____
18) Total of Savings Accounts	\$ _____	\$ _____
19) Total Checking Accounts	\$ _____	\$ _____
20) IRA or Other Retirement	\$ _____	\$ _____
21) Real Property (auto/home/other)	\$ _____	\$ _____
Describe: _____		
22) 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 Medicare or other deductible/co-insurance amounts in my case due to financial hardship. I understand that SSA may request updated information for up to one (1) year to verify that my financial situation and hardship status has not changed. I also understand that SSA 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 SSA, if any."

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 amount due is waived \$ \_\_\_\_\_
- Hardship is founded – partial amount due is waived \$ \_\_\_\_\_
- Payment plan offered
- Hardship is unfounded – waiver is denied
- Payment plan offered

Date applicant contacted: \_\_\_\_\_ Contacted by: \_\_\_\_\_

Billing Service contacted: \_\_\_\_\_ Contacted by: \_\_\_\_\_