Town of Vinalhaven, Maine
Ambulance Service Write-Off Policy

Purpose:
The purpose of this policy is to allow ambulance transport fees to be waived, based on financial hardship as defined by the Department of Health and Human Service (DHHS) Poverty Guidelines, and to specify when an ambulance transport fee becomes non-collectable.

Procedures:
After the appropriate health insurance carrier has been billed, and has paid their portion, the appropriate secondary health insurance carrier will be billed for co-pays and deductibles, if applicable. A patient who does not have secondary insurance and is unable to pay their co-pays, deductibles or make payments, may complete a "Request for Transport Fee Hardship Waiver Form" TOA 2011. The form is available at Town Office, or may be requested by calling the billing company at 207-223-5733.

The form, along with proof of income, which includes a current W-2, three (3) most current pay stubs or other documentation from the patient or patient's legal guardian, must be forwarded to: Town of Vinalhaven Ambulance, Post Office Box 815, Vinalhaven, ME 04863. The form will be forwarded to the billing agent to determine if the person meets the poverty guidelines set forth by the DHHS. The waiver application will then be forwarded to the Vinalhaven Board of Selectmen for review and approval or disapproval. Final decisions will be noted on the form. Decisions regarding ability to pay will be made on a case by case basis. If approved, a copy of the waiver will be kept on file for 5 years and the original will be sent to the billing company to authorize elimination of the patient's ambulance charges. The billing agent will notify the patient of the decision by U. S. Mail.

If the patient does not meet the established poverty guidelines but still requests a waiver, the request may be forwarded to the Vinalhaven Board of Selectmen for review. The Ambulance Director may recommend to the Board of Selectmen that the request be approved for a reduction of the invoice outside the income guidelines, or recommend against the waiver. Invoices and payment plans will be set up by the billing agent. No interest or finance charges will be levied.

Remaining account balances of Medicare patients that have no supplemental insurance will be documented and written off with the Board of Selectmen approval.

Any time a charge is waived, documentation will be kept on file with the Town of Vinalhaven Ambulance for five (5) years. The billing agent will keep the original.

Collections:
Payments are due 30 days after the billing date. Any patient who has not called the billing agent to discuss insurance or payment arrangements will be sent a final notice after ninety
(90) days and if there is no response from the patient, forwarded on to Town of Vinalhaven collections agency.

Accounts will be immediately forwarded to the Town of Vinalhaven collections agency when the mail is returned from the post office as undeliverable and due diligence has been done to locate the patient.

Town of Vinalhaven Ambulance
Request for Transport Fee Hardship Reduction/Waiver

Patient Name:_____SSN:_____Date of Service:_____

Patient Address:_____

Patient Phone:_____ Date of Birth:_____

Monthly Household Gross Income:_____Number of Dependents Living in Household:_____

List of attached documentation (i.e. W-2, 3 most current paystubs, or other documentation_____

Responsible party (if different from patient):
Name:_____Relationship:_____

Address (if different from
patient):_____

I do hereby request that I, as the party who is financially responsible for the applicant, be considered for a reduction in the payment responsibilities as they relate to this EMS transport 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 and I may be held liable for any false statements pertaining to this waiver request. I agree to notify Vinalhaven Ambulance of any change in the financial status of the responsible party which may affect the ability to pay the EMS Transport Fee.

_____ _____
Signature Date

_____
Print Name

For questions regarding this form call 877-233-5775
Mail this application and documentation to
Town of Vinalhaven
Vinalhaven Ambulance Service
PO Box 815, Vinalhaven, ME ~~0000~~ 04363

Administrative Use Only

Incident #:_____ Invoice #:_____

Date of Service:_____Date Received:_____

Request (circle one): Approved Denied
Reason_____
Date Billing Agent Notified: _____

Signature:_____

VHA 2012 January 2012