## WESTERN BERKS AMBULANCE ASSOCIATION

### Application Process for Financial Hardship

**An application for a financial hardship waiver of ambulance charges and fees must be made in accordance with Western Berks Ambulance Association's, hereinafter referred to as WBAA, policy entitled "Financial Hardship".**

**Applicants can request and complete a Financial Hardship Application Form. The form can be obtained by calling (610) 678-1545 or by visiting the WBAA Business Office at 2506 Belmont Avenue, West Lawn, PA, during normal business hours. Forms can also be requested, through submission of a written request, to the above listed address for the WBAA Business Office.**

**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 WBAA at (610) 678-1545. Applicants are required to return the completed forms and submit all required documentation to WBAA.**

**Required Information:**

**WBAA 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 WBAA administrative staff involved in processing requests for waiver of ambulance charges.**

**Time Frame:**

**After an application and verification information is received, WBAA will consider the overall financial situation of the applicant and then render a decision. WBAA has designated the authority to grant or reject requests for financial hardship waivers to the Administrative Director. All decisions will be made within 10 working days from the time that WBAA receives and reviews all required information.**

**Applicants will receive a notification letter outlining whether the application has been approved or rejected. If your request for waiver of the charges is rejected, WBAA will provide the applicant with a written summary and explanation of its decision.**

**WBAA administrative staff will maintain all documentation related to the financial hardship waiver process. This documentation will include all supporting documentation including the waiver request and all documents provided in support of the request.**

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

**In applying these guidelines, WBAA will consider and take into account all 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.**

**Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient or their designee. This annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.**

**Any denial of "financial hardship" discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.**

**PLEASE COMPLETE ATTACHED APPLICATION AND FINANCIAL STATEMENT.**

**YOUR REQUEST CANNOT BE PROCESSED UNLESS THE APPLICATION AND FINANCIAL STATEMENT IS COMPLETED FULLY AND SIGNED!**

## WESTERN BERKS AMBULANCE ASSOCIATION

### Financial Hardship Application

**Please complete the application and attached financial statement. Please return all forms and required documentation (in person or by mail) to Western Berks Ambulance, 2506 Belmont Avenue, West Lawn, PA 19609, (telephone 610-678-1545 or by fax to 610-670-3783)**

***All information relating to financial hardship requests will be kept confidential.***

**Patient Name:** _____

**Address 1:** _____

**Address 2:** _____

**Telephone #:** _____

**DOB:** _____/_____/_____ **SS #:** _____

**Date of Service:** _____/_____/_____

**Name of Person completing this Application (if different than patient listed above)**

_____ **Telephone #:** _____

**Relationship to Patient:** _____

**NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):** _____

**PLEASE LIST ALL CURRENT EMPLOYERS:**

_____ **Check Here if UNEMPLOYED.** **HOW LONG?** _____

**Employer 1:** _____

**Address:** _____

**Contact Person:** _____ **Telephone:** _____

**Employer 2:** _____

**Address:** _____

**Contact Person:** _____ **Telephone:** _____

**WESTERN BERKS AMBULANCE ASSOCIATION**

***Financial Hardship Application – Attachment A***

**Please provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:**

1) **Documented proof that patient is at or below 135% of the current federal poverty guidelines (see attachment A for current federal HHS guidelines). Documents may include but not limited to:**
   - o **W-2 withholding statements or unemployment check stubs for the past 90 days**
   - o **Paycheck stubs for the past 90 days for all persons employed in the home**
   - o **Income tax return (most recent signed 1040 and/or W-2)**
   - o **Proof of all other income received in the past 90 days**
   - o **Application Forms from Medicaid or other State-funded medical assistance program**
   - o **Forms from employers or welfare agencies.**
2) **Patient has other circumstances that indicate financial hardship. These can be situations such as:**
   - o **Proof of all outstanding debts or bills (copies of bills, statements, late notices, etc.)**
   - o **Proof of bankruptcy settlement (if applicable)**
   - o **Catastrophic situations (death or disability in family, divorce) or other documentation which demonstrates the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses.**
3) **Please describe patient indigent circumstances:** _____

_____

## MONTHLY FAMILY INCOME & SOURCE

| | Patient | Spouse | Dependents |
|---|---|---|---|
| **Monthly Salary (Gross)** | $_____ | $ _____ | $ _____ |
| **Public Assistance Benefits** | $ _____ | $ _____ | $ _____ |
| **Unemployment Benefits** | $ _____ | $ _____ | $ _____ |
| **Social Security Benefits** | $ _____ | $ _____ | $ _____ |
| **Workman's Compensation** | $ _____ | $ _____ | $ _____ |
| **Child Support** | $ _____ | $ _____ | $ _____ |
| **Other (Alimony, Etc.)** | $ _____ | $ _____ | $ _____ |

**TOTAL FAMILY INCOME:** $ _____

**I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE WBAA TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.**

_____ ____/____/____

**Signature of Person Making Request** **Date**

_____

**Printed Name of Person Making Request**

# WESTERN BERKS AMBULANCE ASSOCIATION

***Financial Hardship Application – Attachment B***

**2013 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA**

| Persons in family/household | Poverty guideline | |
|---|---|---|
| For families/households with more than 8 persons, add $4,020 for each additional person. | | 135% Threshold Established by WBAA |
| 1 | $ 11,490 | $ 15,511.50 |
| 2 | 15,510 | 20,938.50 |
| 3 | 19,530 | 26,365.50 |
| 4 | 23,550 | 31,792.50 |
| 5 | 27,570 | 37,219.50 |
| 6 | 31,590 | 42,646.50 |
| 7 | 35,610 | 48,073.50 |
| 8 | 39,630 | 53,500.50 |
| For each additional personal, in Families exceeding eight Members, add >>>> | 3,740 | 14,621.00 |