# FINANCIAL ASSISTANCE FOR EMS PATIENTS POLICY

Charles County Government
Department of Emergency Services
Emergency Medical Services Division
P.O. Box 630354
Baltimore, Maryland 21263-0354

Please complete the Financial Assistance Request for EMS Services below by filling out all sections which apply to you. If some of the information is already on the form, please check to be sure that it is correct. Don't forget to sign the form. Please return this form to us as soon as possible. WE CANNOT PROCESS YOUR REQUEST UNTIL WE RECEIVE THIS SIGNED FORM. Thank you.

## FINANCIAL ASSISTANCE REQUEST for EMS SERVICES

PATIENT'S NAME: _____ S.S.#: _____

PATIENT'S ADDRESS: _____ ACCT #: _____

_____ PHONE: _____

NAME OF RESPONSIBLE
PARTY (if other than patient): _____ S.S.#: _____

MONTHLY HOUSEHOLD GROSS INCOME: $ _____ HOUSEHOLD SIZE: _____

**FOR FULL AND COMPLETE CONSIDERATION, I HAVE ATTACHED AT LEAST ONE OF THE FOLLOWING RECENT DOCUMENTS TO CERTIFY THAT THE ABOVE REFERENCED GROSS INCOME IS TRUE AND ACCURATE:** ***(Please check all of the following that are attached)***

☐ Paycheck Stub (dated within the last sixty (60) days.)

☐ Primary bank statement (dated within the last sixty (60) days.)

☐ Income Tax forms (most recent year.)

I hereby request of Charles County that I, as the applicant or responsible party for the above named applicant or account, be considered for a reduction in my payment responsibility. I certify that the patient has no insurance that can be billed for this charge, that the above information is true and accurate to the best of my knowledge and that I will be held responsible for any false statements made herein. I also agree to notify Charles County if my situation changes and the reduction is no longer necessary.

_____ _____

*Signature* *Date*

**If you have any questions or need further assistance,**
**please call Meridian Financial Management at (888)429-5380.**
**Please mail completed form and applicable documentation to:**
**CHARLES COUNTY COMMISSIONERS**
**P.O. BOX 630354**
**BALTIMORE, MARYLAND 21263-0354**

ADMINISTRATIVE USE ONLY

Annual Gross Income based on information provided: $ _____ Acct #: _____

☐ Approved Payment responsibility of: _____ % Revised Amount Due: $ _____

☐ Denied Reason: _____

Date MFM notified: _____ Contact Person : _____

Approved/Denied by: _____ Date: _____

# Charles County Department of Emergency Services
# Standard Operating Policy and Procedure

| | | |
|---|---|---|
| **Title:** | Financial Assistance for EMS Patients | **SOP #:** ES97.001 |
| **Division:** | Emergency Medical Services | **Effective Date:** 1/25/2005 |
| | | **Revision Date:** 7/31/2012 |
| | | **Page 1 of 3** |
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| **Purpose:** | To provide a systemic and equitable way to offer financial assistance to those persons or financially responsible party who received pre-hospital emergency medical services and transportation from the County's Emergency Medical Services (EMS) providers and lack adequate resources to pay for those services. | |
| **References:** | Charles County EMS Transport Fee for Service Policy | |
| **Policy:** | | |
| **Procedure:** | **BACKGROUND:**<br><br>It is part of Charles County's mission to provide pre-hospital emergency medical services to those who are unable to pay for services. This policy requires patients or financially responsible parties to cooperate with and avail themselves of all available programs (including Medicaid, workers compensation, and other state and local programs), which would appear to provide coverage for those services. Only services for which it is not possible to obtain any other program coverage will qualify for financial assistance.<br><br>All patients or financially responsible parties, regardless of race, creed, sex, age, national origin or financial status may apply for financial assistance. Each request for assistance will be reviewed based upon an assessment of the patient's and / or family's income as it compares to the current Federal Poverty Level.<br><br>**I. SCOPE:**<br><br>A. The financial assistance policy applies to charges for pre-hospital emergency medical services that are rendered by Charles County emergency medical personnel only.<br><br>B. Services not covered by this financial assistance policy:<br>1. EMS services not charged and billed by or on behalf of Charles County Government are not covered or affected by this policy; i.e., private physician services or charges from any hospital, emergency department or clinic.<br><br>2. Patients or financially responsible parties who qualify for County, State, Federal, or other assistance programs are excluded from this program to the extent that needed services would be provided under those programs. | |

3. Any transport by emergency medical personnel where the patient is not transported to a hospital's emergency department or labor and deliver unit.

C. Eligibility
Charles County provides scheduled discounting for patients or financially responsible parties that meet the following requirements:

1. The patient is uninsured and

2. The patient's household income is less than 300% of the current federal poverty level.

**II. PROCEDURE:**

A. All accounts receivable, collection staff and medical billing agents authorized by Charles County are to be thoroughly familiar with the availability of the financial assistance program and the criteria for such assistance. Material describing the financial assistance program is to be given or sent to all patients or financially responsible parties who request this information. Personnel are to be particularly alert to offer it to those who do not have insurance coverage. All EMS personnel are encouraged to refer patients or financially responsible parties needing financial assistance to cover services provided to the EMS Billing Coordinator or the billing vendor.

B. Whenever a patient or financially responsible party is approved for scheduled financial assistance, the billing vendor will create and maintain a code within their accounting system for that patient. This code will provide an automatic adjustment of up to 100% of covered charges for eligible services for the patient and their dependent for a period of six months. This code is to be entered or deleted only by credit-department personnel, and should expire six months from the effective date of a completed and approved application – at which time the patient or financially responsible party may re-apply for financial assistance if their situation continues to merit assistance. Patients or financially responsible parties whose financial situation improves or who become insured within that six-month period are encouraged to provide that information to the billing vendor.

C. The billing vendor will be responsible for evaluating requests for financial assistance. The billing vendor can approve or disapprove requests within the scheduled guidelines without approval from the Charles County Commissioners. The billing vendor will maintain statistical information on the applications received, those denied and those approved - along with the amount of assistance approved for each applicant.

D. Individual application processing will be handled as follows:

1. Requests for financial assistance must be documented with a completed Charles County EMS Financial Assistance Request Form, along with any supporting documents such as paycheck stub (dated within the last 60 days), primary bank statement (dated within the last 60 days) or tax forms (most recent year). A signature is required on all applications prior to the evaluation process. Financial assistance will not be granted if complete and accurate information and supporting documentation is not provided. Any assistance granted will be rescinded if information given on the application is inaccurate or untrue. The application and supporting documentation is to be retained by the billing vendor, in the patient's file for three years after period of eligibility and until all audit requirements have been fulfilled as stated in Charles County Government's Records Management Retention Policy.

2. The Charles County Commissioners may approve financial assistance that does not otherwise meet the program guidelines.

**III. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES POVERTY GUIDELINES**

| # Persons in family/household | 2013 Poverty guideline | 300% of Poverty Guideline |
|---|---|---|
| 1 | $11,490 | **$34,470** |
| 2 | 15,510 | **$46,530** |
| 3 | 19,530 | **$58,590** |
| 4 | 23,550 | **$70,650** |
| 5 | 27,570 | **$82,710** |
| 6 | 31,590 | **$94,770** |
| 7 | 35,610 | **$106,830** |
| 8 | 39,630 | **$118,890** |
| For families/households with more than 8 persons, add $4,020 for each additional person. | | |

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|---|---|---|
| Authorized: | Cordell L. Kelly | Date: 6-6-13 |