Fitch-Rona EMS District Financial Hardship Application

The Fitch Rona EMS District may reduce or eliminate the patient's financial responsibility for EMS transport services, when requested, on a case-by-case where the patient qualifies under our financial hardship guidelines. The determination of financial hardship is based upon a percentage of established Federal Poverty Guidelines in relation to household income.

a. To apply for financial assistance, the patient or responsible party will need to complete a Financial Hardship Application and submit the completed information to Fitch Rona EMS for verification of financial information.

b. Fitch Rona will use 200% of the most current National Poverty Guidelines in assessing possible waiver of charges. (https://aspe.hhs.gov/)

c. Patients who fall at, or below the above guidelines may have up to 100% of their ambulance fees waived.

d. Payment plans may be arranged for charges due based on a review of circumstances and approval by the EMS Chief or designee.

e. The determination of financial hardship applies to the current EMS transport only. To waive or reduce future payments, the patient must again prove hardship.

f. Reductions cannot be applied to deductibles or co-pays as determined by a patient's health insurance plan.

g. Insured patients who choose not to have their claim filed with their insurance company are not eligible for our financial hardship assistance program.

Completed applications can be returned to the main Fitch-Rona EMS office at the address below, or via email to the EMS Chief at Patricka@fitchronaems.com

Fitch-Rona EMS District
ATTN: EMS Chief
101 Lincoln Street
Verona, WI 53593

All information relating to financial hardship will be kept confidential to the greatest extent possible.

Patient Name: _____

Address: _____

Account Number (if known): _____

Incident Number (if known): _____

Date(s) of Service: _____

Name and Relationship of Person Completing this Application (if different than the patient listed above)

_____

Please describe patient hardship circumstances: _____

_____

Number of Family Members Living in the Household? _____

Annual Household Income from all sources? _____

Please list current employers:

Employer: _____

Address: _____

Contact Person: _____

Employer: _____

Address: _____

Contact Person: _____

□ **Check Here if Unemployed**. How long? _____

By signing below, I am confirming that the information above is true.

_____ _____

Signature Date

Please provide any other document supporting document you may have to verify income such as tax returns, pay stubs, or confirmation of other state assistance.