



## EMS Cost Recovery Program FINANCIAL WAIVER POLICY

**1. Policy.** Fluvanna County may reduce or eliminate the patient’s financial responsibility for EMS transport services on a case-by-case basis where the patient qualifies under our financial hardship guidelines. Determination of financial hardship is based upon a percentage of established Federal Poverty Income Guidelines in relation to household income and household assets. (NOTE: Insured patients who choose not to have their claim filed with their insurance company are not eligible for our financial hardship assistance program.)

a. To apply for financial hardship assistance, the patient or responsible party will need to complete an **Ambulance Fee Waiver Request** and submit the completed worksheet for verification of your financial information.

b. Fluvanna County will use the most current National Poverty guidelines (as below and updated periodically by the reporting agency) in assessing possible partial or full waiver of charges.

**2016 Poverty Level Guidelines**

Persons in Family or Household	48 Contiguous States and D.C.
1	\$11,880
2	16,020
3	20,160
4	24,300
5	28,440
6	32,580
7	36,730
8	40,890
For each additional person, add:	\$4,160

**SOURCE:** Federal Poverty Income Guidelines (<http://aspe.hhs.gov/poverty/index.cfm>)

c. Upon verification of a patient’s financial hardship, the County uses the structure (Chart B) to determine the level of charges waiver warranted.

When Family Income is:	Waiver of Charges
0.0 – 0.99 x poverty level	100%
1.0 – 1.75 x poverty level	75%
1.76 – 2.25 x poverty level	50%
2.26 – 3.00 x poverty level	25%
Over 3.00 x poverty level	No discount

**Chart B:** Warranted Waiver Guidelines

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

e. Elderly or disabled residents, or disabled veterans, who apply for financial hardship assistance and qualify for real estate tax relief pursuant to the County ordinance or other applicable law, will not be billed for any charges not covered by insurance.

**2. Payment Plans.** Payment plans may be arranged for charges due based on a review of circumstances and approval by the County Administrator or designee. We generally do not extend payment plans to patients who have failed to make timely payments in the past. Fluvanna County may authorize monthly installment payments based on the following minimum payment guidelines chart (Chart C).

Account Balance	Minimum Monthly Payment
\$250 or less	\$25.00
\$251 - \$500	\$45.00
\$501 - \$750	\$65.00
\$751 - \$1000	\$85.00
Over \$1,000	10%

**Chart C:** Minimum Payment Guidelines

## County of Fluvanna, Virginia

# Ambulance Fee Waiver Request

Please **complete all boxes (1-24)** on this form and return it to:  
 Finance Department, County of Fluvanna, P.O. Box 540, 132 Main Street, Palmyra, VA 22963 – Ph: (434) 591-1930

PATIENT INFORMATION			
1. Name	2. Date of Birth	3. Social Security Number	
4. Home Address	5. City	6. Zip Code	
7. Home Phone	8. Work Phone	9. Cell Phone	
10. Date(s) of Ambulance Service?			
11. Household member who is Fire, Rescue, or Law Enforcement person currently volunteering in or employed by Fluvanna County? (Name: _____)		Yes <input type="checkbox"/>	No <input type="checkbox"/>
<i>If YES, go to Box 22 and please sign Waiver Request</i>			
12. Employment Information: Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/>	13. Gross Household Income?	14. Source(s) of Income?	
15. Health Insurance: Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> None <input type="checkbox"/>			
16. Number of Family Members Living in Household:	___ Adults	___ Children	
17. Are you currently eligible for Elderly, Disabled, or Disabled Veteran Tax Relief?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. Name of Person Completing Form (if not patient)	19. Relationship to Patient	20. Telephone	
21. Briefly describe why you are requesting a waiver or reduction of fees.			
SIGNATURE			
I hereby request that I, as either the applicant or responsible party for the above-named applicant, be considered for a reduction in my payment responsibilities for ambulance transport services. I understand that I will be held liable for any false statements made herein. I also understand that the County reserves the right to require proof of income in consideration of this request and to verify any information contained in this document for the sole purpose of assessing financial need.			
22. Signature of Patient or Legal Representative	23. Date	24. Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Other _____	

FLUVANNA COUNTY STAFF USE ONLY			
Date Received:	Date of Service:	Incident #:	EMS MC Invoice #:
Reviewer Comments			
Financial Hardship Verified? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, percent reduction of charges: _____	
EMS MC Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature		Date