# *Administrative Regulation* No. 67

# City of Cincinnati

Date: December 22, 2015

*Office of the City Manager*

*Approved:* H S Beck

***Subject:*** **Financial Aid Policy for City of Cincinnati Ambulance Transport Fees**

**Purpose:**

The purpose of this Administrative Regulation is to establish the financial aid policy for the City of Cincinnati Fire Department/EMS Billing for ambulance transports.

**Policy:**

This regulation pertains to individuals transported by the City of Cincinnati Fire/EMS Department who request a discount and complete a financial aid application.

The Cincinnati Fire Department/EMS Billing will apply discounts in accordance with the following guidelines:

1. The person must complete a financial aid application, and his or her financial situation will be assessed in accordance with the Health and Human Services (HHS) poverty guidelines outlined on the attached chart.

2. The person who requests a discount, and has a qualifying income, will be offered a discount pursuant to the HHS guidelines.

3. Persons who request a discount may have their bill adjusted to 150% above the current Medicare allowable rate, according to the chart below, regardless of whether they qualify for financial assistance. (These rates are adjusted annually by the Center for Medicare and Medicaid Services.)

| 2015 | MEDICARE ALLOWABLE RATE | PROPOSED DISCOUNT RATE |
|---|---|---|
| MILEAGE | $7.15 | $10.73 |
| BLS | $340.94 | $511.41 |
| ALS | $404.86 | 607.29 |
| ALS 2 | $585.99 | 878.99 |

4. Veterans may request a hardship reduction or waiver of their transports fees regardless of their income. They must present proof of service in form of a DD-214 or other documentation of service.

5. All persons may arrange a payment plan for the outstanding balance.

city of CINCINNATI FIRE & EMS

Dear Patient:

The City of Cincinnati understands that dealing with unexpected medical bills can be difficult. If you are unable to pay for all or part of your ambulance bill, and wish to apply for financial assistance, please print and fully complete the City of Cincinnati Financial Assistance Application. We provide full or partial financial assistance to persons whose family income is at or below the income guidelines outlined below.

**INCOME GUIDELINES**

| FAMILY SIZE | INCOME PER YEAR |
|---|---|
| 1 | $17,655 |
| 2 | $23,895 |
| 3 | $30,135 |
| 4 | $36,375 |
| 5 | $42,615 |
| 6 | $48,855 |
| 7 | $55,095 |
| 8 | $61,335 |

*For families greater than 8, add an additional $6240 for each member

To determine if you may be eligible for financial assistance, you must provide a completed City of Cincinnati Financial Assistance Application, along with a copy of at least one of the documents from the proof of income section on the back of this letter. Please complete and sign the attached application and send to the following address:

City of Cincinnati EMS
Attn: Financial Assistance
805 Central Av 4th Floor
Cincinnati, OH 45202

Upon receipt, we will process your application and notify you in writing of our determination.

If you have any questions, please call (513) 352-4895. If you believe you are not eligible for financial assistance under the income guidelines listed above please call to discuss other payment arrangements.

Thank you.

(PLEASE SEE REVERSE SIDE FOR IMPORTANT INFORMATION)

Please complete and sign the City of Cincinnati Financial Assistance Application and provide a copy of at least one of the following documents:

**Proof of Income:**

- Copy of benefit letter/check for Social Security or Disability.
- Check stubs for three months prior to the date of service (including payroll, Social Security, Worker's Compensation, Unemployment Compensation, Pensions, Public Assistance, etc.) or comparable payment record. If you are self-employed, please send a notarized statement of income and expenses for the three-month period prior to the date of service.
- A letter from your employer setting forth compensation detail on official employer letterhead with contact information.
- Copy of the prior year's tax return (if self-employed, Schedule C and a notarized income statement for the three month period prior to the date of service must be provided). Tax returns can only be accepted for dates of service through March 31 of the following year.
- Court support order.
- Letter from tenant setting forth rental income.
- Strike Pay.
- If you are claiming that you have no income, provide a sworn statement from the person providing you with basic financial support, validating your lack of income.

# APPLICATION FOR FINANCIAL ASSISTANCE

Patient/Guarantor Name: _____ Phone#: _____

Address: _____ City: _____ State: ____ Zip: _____

Patient Account Number: _____ Date of Service: _____

Patient Social Security Number: _____ Patient Date of Birth: _____

Email Address: _____

Were you a resident of the City of Cincinnati at the time of transport? (Circle Response) Yes No

Do you have health insurance? Yes No Are you on active Disability? Yes No

*If you answered "Yes" to either of the above two questions, please attach a copy of your insurance card (front and back), Medicaid or Disability Assistance card to this application and complete the following:

Name of Insurance Company: _____

Policy Number: _____ Group Number: _____

Insurance Phone Number: _____ Medicaid or Disability Assistance Number: _____

Are you a veteran of the Armed Services? Yes No

Please list all family members (including you). Family members include parents, spouses & children (natural or adoptive) under the age of 18 living in the home along with the patient. Income includes gross (pretax) wages, rental income, unemployment compensation, Social Security benefits, public assistance, etc. Income also includes rent or living expenses exchange for services provided. **Documentation must be included.**

| NAME | DATE OF BIRTH | RELATIONSHIP TO YOU SELF, SPOUSE,CHILD | SOURCE OF INCOME OR EMPLOYER NAME | INCOME FOR 3 MONTHS PRIOR TO DATE OF SERVICE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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(PLEASE SEE REVERSE SIDE)

If you reported $0.00 income, please have the Support Statement below completed by the person(s) helping to support you and/or your family.

**SUPPORT STATEMENT**

For applicants who stated zero income, the person(s) providing you with basic financial support must provide a brief explanation as to how you are being financially supported. List services, if any, that you are receiving from patient for providing this support.

_____

_____

_____

_____

I hereby certify and verify that all of the foregoing information given is true and correct to the best of my knowledge and belief. I understand that my signature does not obligate me to be financially responsible for charges rendered to the person for whom I am providing basic financial support.

_____ _____

**Signature of the person providing financial support to applicant** **Address**

_____

**City, State Zip**

By my signature below, I certify that I have carefully read this application and that everything I have stated or provided in any attachment is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

**Patient/Guarantor Signature:** _____ **Date Completed:** _____

If you have any questions or need assistance with this application, please call 513-352-4895.

(For Office Use Only)

Acct. Bal. _____

Approved

_____% Write-Off Amt. _____

Denial Reason _____

Admin. Initial _____

| Family Size | 2015 DHHS Poverty Guidelines |
|---|---|
| 1 | 11,770 |
| 2 | 15,930 |
| 3 | 20,090 |
| 4 | 24,250 |
| 5 | 28,410 |
| 6 | 32,570 |
| 7 | 36,730 |
| 8 | 40,890 |
| 9 | 45,050 |
| 10 | 49,210 |
| 11 | 53,370 |
| 12 | 57,530 |

http://aspe.hhs.gov/poverty/14poverty.cfm

*Source:* HHS website

The Schedule of Discounts is established by Board of Health Regulation 00073, Section 00073-7 "Criteria and Exceptions". The minimum pay class is 100% or less of the DHHS income poverty guidelines. The full pay class is 200% above the DHHS income poverty guidelines.

**2015 SCHEDULE OF DISCOUNTS** **Effective Date: 01/25/15**

Percentage of Maximum Charge Based on Family Income and Size

| SZ | MINIMUM | D or 75% | C or 50% | B or 25% | A or Full Pay |
|---|---|---|---|---|---|
| 1 | 0 - 11,770 | 11,771 - 17,655 | 17,656 - 20,598 | 20,599 - 23,540 | 23,541 & OVER |
| 2 | 0 - 15,930 | 15,931 - 23,895 | 23,896 - 27,878 | 27,879 - 31,860 | 31,861 & OVER |
| 3 | 0 - 20,090 | 20,091 - 30,135 | 30,136 - 35,158 | 35,159 - 40,180 | 40,181 & OVER |
| 4 | 0 - 24,250 | 24,251 - 36,375 | 36,376 - 42,438 | 42,439 - 48,500 | 48,501 & OVER |
| 5 | 0 - 28,410 | 28,411 - 42,615 | 42,616 - 49,718 | 49,719 - 56,820 | 56,821 & OVER |
| 6 | 0 - 32,570 | 32,571 - 48,855 | 48,856 - 56,998 | 56,999 - 65,140 | 65,141 & OVER |
| 7 | 0 - 36,730 | 36,731 - 55,095 | 55,096 - 64,278 | 64,279 - 73,460 | 73,461 & OVER |
| 8 | 0 - 40,890 | 40,891 - 61,335 | 61,336 - 71,558 | 71,559 - 81,780 | 81,781 & OVER |
| 9 | 0 - 45,050 | 45,051 - 67,575 | 67,576 - 78,838 | 78,839 - 90,100 | 90,101 & OVER |
| 10 | 0 - 49,210 | 49,211 - 73,815 | 73,816 - 86,118 | 86,119 - 98,420 | 98,421 & OVER |
| 11 | 0 - 53,370 | 53,371 - 80,055 | 80,056 - 93,398 | 93,399 - 106,740 | 106,741 & OVER |
| 12 | 0 - 57,530 | 57,531 - 86,295 | 86,296 - 100,678 | 100,679 - 115,060 | 115,061 & OVER |

No individual will be denied Health Services based on his/her inability to pay for such services.

Note to Information Systems:

The sheet's calculation is based on the first two entries of the DHHS Proverty Guidelines (E2 & E3)