KANAWHA COUNTY EMERGENCY AMBULANCE AUTHORITY (KCEAA)
PATIENT REQUEST FOR FINANCIAL HARDSHIP DETERMINATION

Instructions to Patient:
Please complete this form and return it to KCEAA by mailing it to P. O. Box 292, Charleston, WV 25301.

Patient Name:_____

Patient/Account Number:_____

Trip/Call Number: _____

Address: _____

City/State/Zip:_____

Telephone Number: _____

Responsible party (if different than patient): _____

Address of Responsible Party: _____

City/State/Zip of Responsible Party: _____

Telephone Number of Responsible Party: _____

I hereby confirm that I am applying for a Hardship Determination, requesting KCEAA to consider reducing and/or waiving my financial responsibility (e.g., my co-pay, co-insurance, and/or deductible (if I have health insured) or all or some portion of my total charges (if I have no health insurance)) for services and care provided to me on the following date:

_____(date of service).

In support of my request, I am supplying the following information to assist KCEAA in making a decision regarding my request for a Hardship Determination. The monthly income amount that I have provided includes income from **all** sources, including wages, Social Security benefits, pensions, annuities, dividends, etc. I have attached a verification of my employment or unemployment status and copies of my federal tax returns or W-2 forms for the previous two (2) years. If applicable, a letter of approval from Medicaid, stating that my Social Security benefits are being paid directly to a nursing home, less those dollars paid to me each month for my personal expenses. (This form shall be obtained from the nursing facility.)

I understand that if I fail to provide the requested information to KCEAA with this request, this request for Hardship Determination will not be processed and may be denied.

My insurance information is:

Insurer Name: _____

Insurance Policy/ID Numbers: _____

Monthly Income	**Self**		**Spouse**		
Wages/Salary	$_____		$_____		
Social Security	$_____		$_____		
Pension Income	$_____		$_____		
Interest income	$_____		$_____		
Other Income	$_____		$_____		
Totals:	$_____	+	$_____	=	$_____

Number of dependents that you claim on your Federal and State Income Tax Return: _____

Agreement:

By submitting this Patient Request for Financial Hardship Determination, I hereby *agree* to the following terms:

- I am supplying this application and supporting information to request that KCEAA waive collection of all or part of my financial responsibility for services rendered by KCEAA because of financial hardship.

- The information I have provided is complete, true, and accurate to the best of my information and belief.

- I understand that KCEAA may deny this request in its sole discretion and, further, that KCEAA will be entitled to make reasonable efforts to collect any debt owed by me should my financial situation change or improve.

- I understand that I am legally responsible for the balance, if any, remaining after KCEAA issues its decision on my application for Hardship Determination.

Patient Signature: _____ Date:_____

KANAWHA COUNTY EMERGENCY AMBULANCE AUTHORITY (KCEAA)
PATIENT NOTICE FOR FINANCIAL HARDSHIP DETERMINATIONS

Patient Name: _____ Date of Service: _____

Dear Patient:

The law requires that KCEAA attempt to collect any unpaid portion of the annual Medicare Part B or insurance deductible, and the applicable co-insurance amount from the beneficiary. However, there are situations in which KCEAA may be empowered to limit, or even waive, its collection of the amounts owed. One such situation is where the patient has established the existence of a significant financial hardship that would constitute a substantial barrier to the patient accessing essential medical services if the patient were required to pay the full amount owed for such services.

Based upon discussions with you and the verified documents you have provided in support of your request for Hardship Determination, KCEAA has determined that, as a result of your current financial condition, you are unable to pay some portion of the amount for which you are financially responsible (including but not necessarily limited to your deductible and/or co-insurance payment amount). Due to these circumstances, KCEAA has agreed to adjust your amount owed to KCEAA as set forth below:

Patient/Account Number: _____

Trip/Call Number: _____

Date of Service: _____

Description of Service: _____

Amount Waived: _____

Balance Due: _____

Please note that this decision to reduce and/or waive your payment obligations applies only to those services described above. Any adjustment of payments owed for other past or future services or transports provided to you shall require a separate request for Hardship Determination and re-evaluation of your financial status as of the date of service.

Sincerely,

_____ _____
Signature Date