Attachment B: Financial Hardship Adjustment Policy

Municipality of Anchorage
Anchorage Fire Department, EMS

FINANCIAL HARDSHIP ADJUSTMENT POLICY

Individuals transported by the Anchorage Fire Department, EMS Division whom are indigent and have no or inadequate means of paying for EMS provided care and transport under current methods of financing health care services, may apply for a Financial Hardship Adjustment. The Financial Hardship Adjustment only applies to costs of EMS care provided and transport under Anchorage Municipal Code chapter 16.95. For such applications, the following Financial Hardship Adjustment policy shall apply:

ELIGIBILITY CRITERIA:

A Financial Hardship Adjustment is **secondary** to all other financial resources available to the patient. Primary payment sources include, but are not limited to, group or individual medical plans, workers' compensation, Medicare, Medicaid or other medical assistance programs, other state federal or military programs, third party liability situations (e.g., auto accidents or personal injuries involving insured or otherwise covered third parties at fault), or any other situation in which another person or entity may have a legal obligation to pay for the cost of medical services.

In those instances where the patient can show proof that no primary payment sources are available and that attempts to obtain all forms of available assistance were made, patients may be considered for a Financial Hardship Adjustment under this policy based on the following criteria as calculated for the twelve (12) months prior to the date of the request:

1. The full amount of transport charges will be determined to be a Financial Hardship Adjustment for any patient whose gross family income is below 150% of the current federal poverty guidelines (as listed in Federal Register for current year).

2. A graduated fee adjustment will be made for any patient who qualifies with a gross family income between 150% and 200% of the current federal poverty guidelines (as listed in Federal Register for current year). Refer to the table below for the applicable graduated fee adjustment.

3. No Financial Hardship adjustment will be granted for any patient whose gross family income is over 200% of the current federal poverty guidelines (as listed in Federal Register for current year).

Persons in Household	Alaska Poverty Guidelines (2022)				
	100%	133%	138%	150%	200%
1	$16,990	$22,597	$23,446	$25,485	$33,980
2	$22,890	$30,444	$31,588	$34,335	$45,780
3	$28,790	$38,291	$39,730	$43,185	$57,580
4	$34,690	$46,138	$47,872	$52,035	$69,380
5	$40,590	$53,985	$56,014	$60,885	$81,180
6	$46,490	$61,832	$64,156	$69,735	$92,980
7	$52,390	$69,679	$72,298	$78,585	$104,780
8	$58,290	$77,526	$80,440	$87,435	$116,580
For each person over 8 add:	$5,900	$7,847	$8,142	$8,850	$11,800

ELIGIBILITY DETERMINATION:

Financial Hardship Adjustment forms and instructions shall be furnished to patients by the Billing Contractor when financial assistance is requested, if financial need or indigency is indicated, or if it is reasonably clear the patient is otherwise impoverished. All applications should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purposes of verifying income:

1. W-2 withholding statements for all employment during the relevant time period;
2. Pay stubs from all employment during the 12 months prior to the date of request;
3. An income tax return from the most recently filed calendar year;
4. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance;
5. Forms approving or denying unemployment compensation; or
6. Written statements from employers or welfare agencies.

Other documentation provided by the patient for purposes of verifying income or ineligibility for financial assistance from other sources will be considered.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

The Billing Contractor will evaluate applications received using the above stated guidelines. A written recommendation will be submitted to the AFD Contract Administrator for review. Once confirmation is received, the Billing Contractor will notify the patient in writing of the determination.

APPLICANT NOTIFICATION:

Approvals for Financial Hardship Adjustments will be in writing and will include the amount of the write-off to be performed, as well as a statement informing the patient of the balance remaining, if any.

Denials for Financial Hardship Adjustments will be in writing and will advise the patient that "This is a final agency decision. If you wish to appeal this decision, your appeal must be filed with the Alaska Superior Court within 30 days from the date this decision was mailed or otherwise distributed."

DOCUMENTATION & RECORDS:

All applicable federal, state and local laws relating to confidentiality and nondisclosure of medical related information shall be complied with, including the Health Insurance Portability and Accountability Act, P.L.104-191, August 21, 1996. All information gathered is considered confidential and exempt from public records disclosure laws under AS 40.20.120(a)(3)-(4), AMC 3.90.040B and AMC 3.90.040J. Copies of the documents that support the application will be kept with the application form.

Municipality of Anchorage
Anchorage Fire Department, EMS

FINANCIAL HARDSHIP ADJUSTMENT APPLICATION

Please provide following information so we may complete your application:

- MOST RECENT IRS TAX FORMS (1040 AND W-2) (MUST BE SIGNED)
- CHECK STUBS FOR THE PAST 30 DAYS FOR ALL PERSONS EMPLOYED IN THE HOME.
- UNEMPLOYMENT CHECK STUBS FOR THE PAST 30 DAYS.
- DRIVERS LICENSE OR IDENTIFICATION CARD FOR ADULTS.
- PROOF OF ALL OTHER INCOME RECEIVED IN THE PAST 30 DAYS.
- PROOF OF ALL OUTSTANDING BILLS (PAYMENT STUBS, CANCELLED CHECKS, ETC.)
- DEPARTMENT OF MEDICAL ASSISTANCE DENIAL LETTER.
- ATTACHED FINANCIAL STATEMENT (**COMPLETELY FILLED OUT AND SIGNED**)

OTHER DOCUMENTATION PROVIDED BY THE PATIENT FOR THE PURPOSES OF VERIFYING INCOME OR INELIGIBILITY FOR FINANCIAL ASSISTANCE FROM OTHER SOURCES WILL BE CONSIDERED.

PLEASE BE SURE TO SIGN THE ATTACHED FINANCIAL STATEMENT
YOUR REQUEST WILL NOT BE PROCESSED IF THIS IS NOT SIGNED!

PLEASE RETURN ALL ITEMS ON THIS CHECKLIST (IN PERSON OR BY MAIL) TO:

Anchorage Fire Department
(CONTRACTOR NAME & ADDRESS HERE)

All applicable federal, state and local laws relating to confidentiality and nondisclosure of medical related information shall be complied with, including the Health Insurance Portability and Accountability Act, P.L.104-191, August 21, 1996. All information gathered is considered confidential and exempt from public records disclosure laws under AS 40.20.120(a)(3)-(4), AMC 3.90.040B and AMC 3.90.040J. Copies of the documents that support the application will be kept with the application form.

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FINANCIAL HARDSHIP APPLICATION – FINANCIAL STATEMENT

Patient Name: _____ Phone #: _____

Address: _____ Other contact #:_____

Date(s) of EMS Service: _____

Name of Responsible Party: _____ Relationship to patient: _____

Responsible Party Contact #:_____

Spouse: _____ # Family Members living in Household: _____

Employer: _____ Address: _____

Spouse's Employer: _____ Address: _____

If Unemployed, how long? _____ If Spouse Unemployed, how long? _____

Other Family Member Employer(s): (Include Member Name, Employer and Address):

_____

_____

FAMILY INCOME & SOURCE

	Patient	Spouse	Responsible Party	Children Working
Monthly Salary (Gross)				
Public Assistance				
Unemployment				
Social Security				
Worker's Comp				
Child Support				
Other (Explain)				

Total Family Income: _____

I hereby acknowledge that the information given herein is true and correct. I authorize the Municipality of Anchorage, Anchorage Fire Department and/or their billing agent to verify any information contained in this document for the sole purpose of assessing financial need.

_____ _____

Signature of Person Making Request Signature of Spouse/ Other

Date: _____ Date: _____

This page for application evaluation:

This Application for Hardship Adjustment was received on (date) _____

By _____
Name/ Title
Reviewed by Contractor on (date): _____

Comments or calculations here:

Patient's Monthly Income: _____

Annualized: _____

RECOMMENDATIONS: _____

_____

REVIEWED BY AFD ON: _____

RECOMMENDATION ACCEPTED ☐ Initials _____

OTHER REQUESTED ACTION:

_____

_____

_____