Last Update: June 2021; Approved by the Hooksett Town Council

HOOKSETT AMBULANCE SERVICE BILLING & COLLECTION POLICY

1. The Town of Hooksett / Hooksett Fire-Rescue Department intends to charge for all transported users or responsible parties that receive emergency ambulance services.

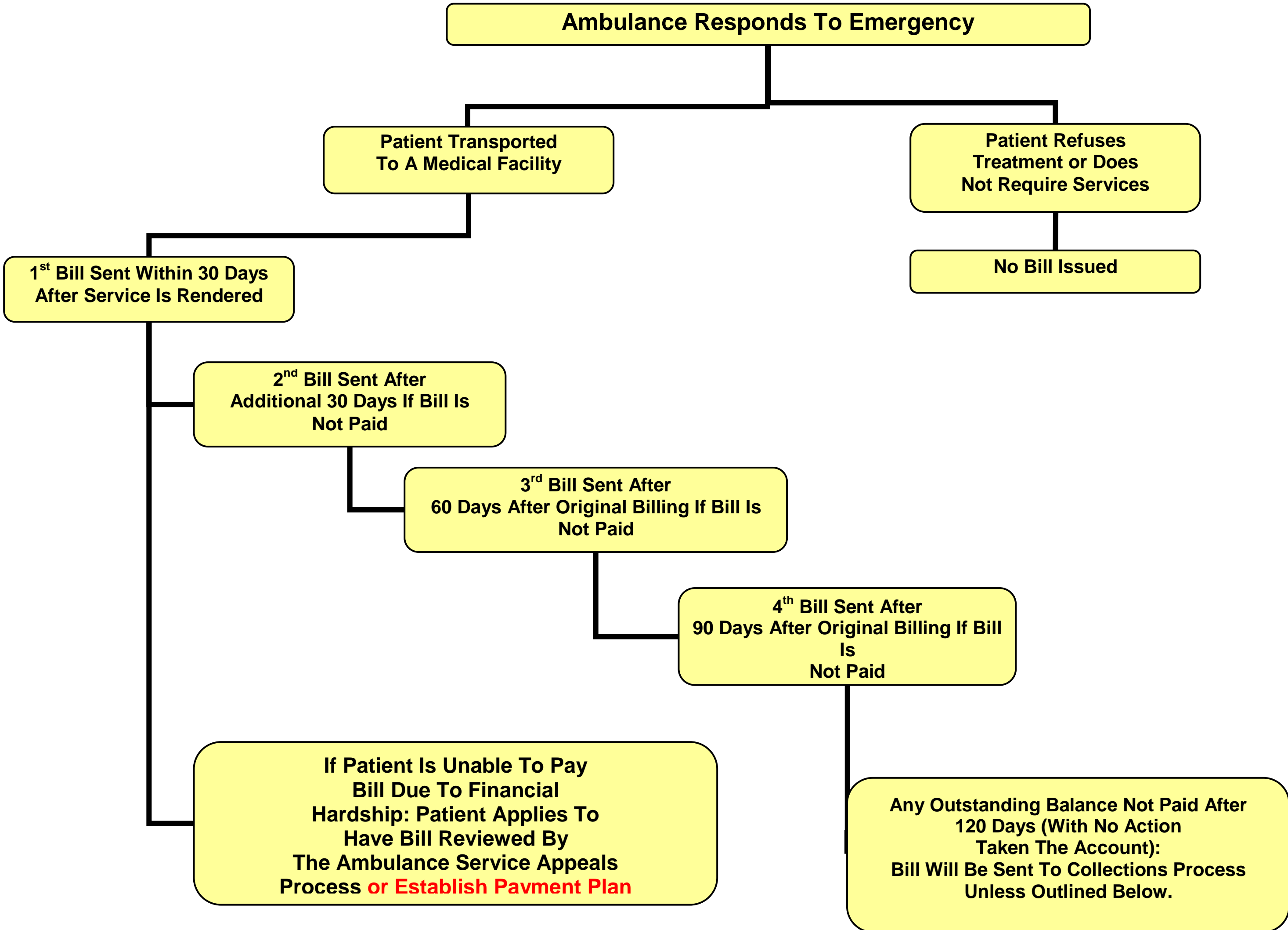
2. The Town of Hooksett Town Council and Hooksett Fire-Rescue will address patient concerns related to patient payment of ambulance service billable fees.

    a. An Ambulance Service Appeals Review (aka Hardship Review) shall be maintained for those patients who feel the fee for the ambulance service causes an undue financial hardship. The review process will consist of a review and final approval by the Town Administrator and the Town Council in non-public session.

    b. Any patient transported by the department who believes that the fees cause an undue hardship shall be informed by the Town's Ambulance Billing Agency that the Ambulance Service Appeals Review exists and that they may make application for consideration for a waiver of the fees or a payment plan for the fees. The patient shall have one hundred and twenty (120) calendar days to make application to the Town from the date of service, excluding any hospitalization days.

c. The Ambulance Service Appeals Review shall occur during non-public session of the town council meetings to discuss and decide on these hardships. A majority vote of the council shall decide all cases. If the patient is absolved of any or all parts of the obligation to pay the fee, Hooksett shall consider the outstanding debt as a loss. If the group and the town council rule that the patient should pay the fees, the Town of Hooksett shall be permitted to collect all fees by all means allowed by law.

PATIENT BILLING / COLLECTION PROCESS:



WRITE OFF CRITERIA / POLICY

Ambulance service hardship applications (see Attachment A) can be requested by any patient that has been transported by the Hooksett Fire-Rescue Department and feels he/she cannot financially cover the costs for ambulance services rendered. The person(s) requesting the Town of Hooksett to cancel any ambulance charges must show proof of income (i.e. financial statements, copy of latest tax return, payroll stubs) or special circumstances making it impossible to pay for any charges. The Town of Hooksett / Hooksett Fire-Rescue Department utilizes the current published United States – Dept Health and Human Services (DHHS) poverty income levels as criteria to determine eligibility to cancel any or all ambulance charges.

The Town of Hooksett / Hooksett Fire-Rescue Department may exercise its right to reduce the ambulance charges based on the information submitted through the hardship process or establish a monthly payment plan (see Attachment B) to resolve any charges due the Town of Hooksett by the patient(s).

The Town of Hooksett / Hooksett Fire-Rescue Department may also negotiate with payers a settlement charge to resolve any or all debts owed the Town of Hooksett / Hooksett Fire-Rescue Department due from ambulance charges.

The Hooksett Fire Chief shall forward all write off / settlement recommendations to the Town Administrator / Town Council for final approval. The Hooksett Town Council reserves the right to reduce or write-off ambulances charges as deemed appropriate by the Hooksett Town Council.

COLLECTION PROCESS:

The Town of Hooksett will send all delinquent patient accounts that have not been paid in full 120 days from the time of service to a contracted collection agency, unless they have applied for a financial hardship write-off. Once application has been made, the write-off policy will apply. All other accounts will be sent to the contracted agency for processing.

Collection Agency actions may include the following:

- Telephone and written notification to the patient (or responsible party) of the collection activity on the account.
- Reporting to the Credit Bureau (Equifax and Trans Union), after written 2nd written notification and a 35-day opportunity to pay the account.
- If all efforts fail to collect on any delinquent accounts, a decision will be made whether further action is necessary (i.e. legal action, additional written action) through dialogue between the collection agency and the Town.

Paramedic Intercept Billing

When the Hooksett Fire Rescue Department (HFRD) performs a paramedic intercept with an outside agency, the HFRD shall send an invoice to the requesting department/service for the amount of $516.38. When a paramedic intercept is performed, the department will not bill the patient and/or their insurance.

Ambulance Billing Rates

(See attachment for current rates.)

APPLICATION FOR AMBULANCE SERVICE FINANCIAL HARDSHIP

(ATTATCHMENT A)

I, __________________________ am requesting assistance with the ambulance service bill for (patient's name) ______________________, date of service __________, run number ________________ for the amount of $ ____________. I am requesting: (please check one)

- ☐ Write-off of the entire amount.
- ☐ To pay the bill using a monthly payment plan. (Complete the next page only)

If requesting write-off of the ambulance bill, please complete the form below and mail to the above address within 30 days:

I understand that this application is made so that the fire department ambulance service can determine my eligibility for uncompensated services based on the established criteria on file at the fire department. If any information I have given proves to be untrue, I understand that the Fire Department and the Town of Hooksett may re-evaluate my financial status and take whatever action is deemed to be appropriate to recoup the ambulances charges owed.

I certify that the current information given is true and accurate to the best of my knowledge. I further attest that payment would create a hardship for me and I request a waiver of the ambulance service fee. Further, I will make application for any assistance (Medicare, Medical Assistance, Etc.) which may be available for payment of my ambulance service charges and I will assign or pay to the Fire Department the amount recovered toward the ambulance service charges.

Name:____ Phone # :________________________________

Address:____

Patient's Name:____________________________________ Relationship to you:______________________

Your household size:____________ Total annual household income: $___________________________

Employment: List current employer (or retirement information)

____

Insurance: List all medical insurance coverage

Insurance Company:_______________________________ Policy Holder:____________________________

Policy Number: ___________________________________ Group Number:___________________________

Reason for request: ☐ Financial Hardship ☐ Other (Explain):

____

** Attach copies of past 2 pay stubs or show proof of income along with proof of you basic monthly expenses (utility bills, rent, or routine medications) you would like to consider to determine eligibility.

_______________________________________ ________________________

(Signature of Applicant) (Date)

EXTENDED PAYMENT PLAN FORM

(ATTACHMENT B)

Use this form to agree to an extended payment program arrangement with the Town of Hooksett in order to pay your ambulance bill(s). Please complete every field on this form, sign it and mail the form to the address above within 30 days.

_______________________________ _______________________________

Run Number From Bill Patient Social Security Number

_______________________________ ________ _______________________________

Patient's First Name M.I. Last Name

_______________________________ __________________ ________ __________

Patient's Address City/Town State ZIP

(_____)_________________ (_____)_________________ _____________________

Home Phone Work Phone email address

I authorize the Town of Hooksett ambulance-billing agency to bill me once a month as indicated below. The Town of Hooksett will not charge you interest on this payment plan.

- ☐ Check this box to pay $50 per month until your bill is paid in full.
- ☐ Check this box to pay $25 per month until your bill is paid in full.
- ☐ Check this box to pay $10 per month until your bill is paid in full.

Or, you can check the box below and indicate how much you desire to pay per month (Minimum $10.00 per month).

- ☐ How much will you pay per month? Enter the amount here: $____________

You signature below affirms that you need an extended payment arrangement and authorizes the Town of Hooksett and its ambulance-billing agency to bill you once per month for the amount indicated above until your bill is paid in full.

_____________________________________ _______________________

(Signature) (Date)