TOWN OF ULYSSES
10 Elm Street, Trumansburg, NY 14886
townofulyssesny.gov

Town Supervisor (607) 387-5767, Ext 232 • supervisor@townofulyssesny.gov
Town Clerk (607) 387-5767, Ext 221 • clerk@townofulyssesny.gov

TOWN OF ULYSSES AMBULANCE BILLING FINANCIAL ASSISTANCE POLICY

Adopted 3/12/19

Purpose
The purpose of the Financial Assistance Policy is to assure that the Ulysses Ambulance Billing Policy shall not create a barrier that deters those needing emergency medical services from calling for help and to further assure that payment for billable emergency medical services shall not become a financial hardship for those with limited incomes or resources.

Policy
It is the policy of the Town of Ulysses to offer financial assistance to patients in the Ulysses Ambulance District who are billed for their share of ambulance transport and treatment and have household income less than 300% of the Federal Poverty Income Guidelines.

Eligibility
Patients with household incomes less than 300% of the Federal Poverty Income Guideline are eligible to have up to 100% of their share of the ambulance bill waived. The Chart in ***Appendix 1*** shall be updated annually to reflect the Federal Poverty Income Guideline.

For patients who are able to pay for their care, no-interest payment plans can be arranged.

Procedures
1. The Billing Contractor will include a cover letter written by the Town to explain the billing policy and procedures for requesting financial assistance with ambulance bills.
2. The Application for Ambulance Billing Financial Assistance is attached to this policy as Appendix 2. Significant changes must be made by resolution of the Town Board.
3. Patients who believe they may be eligible to have their share of the cost reduced or waived after reviewing the financial eligibility guidelines sent with the Ambulance Bill's cover letter, are encouraged to contact the billing contractor and may submit an Application for Ambulance Billing Financial Assistance along with Appendix 3 Income Verification Form to the Town Clerk's office.
4. Completed Applications for Financial Assistance shall be submitted to the Town Clerk 10 Elm Street, Trumansburg, NY ATTN: EMS Liaisons.
5. The Town of Ulysses authorizes the Town Board's EMS liaison(s) to review Applications for Assistance. The EMS liaisons are authorized to waive up to 100% of the patient's share of ambulance charges for those who document their household income at below 300% of the Federal Poverty Income Guideline or demonstrate other financial hardships.
6. The Town of Ulysses authorizes the Town Board EMS liaison(s) to arrange reasonable no- interest payment plans between patients who can pay their fees and the Billing Contractor.
7. The Town's EMS liaison(s) shall communicate their decisions in writing to the patient and the billing contractor and the Town Clerk shall file Applications in a confidential file. The EMS Coordinator may refer

any complex request, with personal information redacted, to the Town's EMS Committee, to be comprised of two Town Board members, for decisions.

8. Once the account is settled any confidential information shared as part of verifying household income will be shredded.
9. The Town's EMS liaison(s) shall prepare an annual report for the Town Board that includes the actions taken on all applications for assistance.

Date Adopted: 12/18/14
Effective Date: 1/1/15
Date Modified: 3/12/19
Date Effective: 4/1/19

APPENDIX 1

Town of Ulysses Ambulance Billing Financial Assistance
2024 Income Guidelines

	Financial Assistance Eligibility								
	Based on the number of people in your household and your total income, the Town of Ulysses may reduce your share of ambulance bill. Do not hesitate to ask for assistance.								
	1	2	3	4	5	6	7	8	Each Extra Add
Federal Poverty Guideline*	$14,580	$19,720	$24,860	$30,000	$35,140	$40,280	$45,420	$50,560	$5,140
Ulysses Allowance (300% of above)	$43,740	$59,160	$74,580	$90,000	$105,420	$120,840	$136,260	$151,680	$15,420

*Federal Poverty Guideline data from https://obamacarefacts.com/federal-poverty-levels-for-aca-coverage/#:~:text=The%20federal%20poverty%20level%20is,of%204)%20for%202023%20coverage.

For questions about your bill, please contact MedEx at **(800) 716-8015.**

APPENDIX 2

APPLICATION FOR AMBULANCE BILLING FINANCIAL ASSISTANCE

1. Name of patient: Current Date:

2. Name of person responsible for payment:

3. Contact Information for person responsible for payment

   Phone: Email:

   Mailing address:

4. Date of ambulance service:

5. Amount of fee billed:

6. If you can pay the full amount but need a payment plan, please propose installments and final payment date:

7. Amount of the bill you are asking to be waived:

8. Do you have insurance? Yes No

   a) If yes, please provide Insurer Name, Address, and Phone Number:

   b) Insurance Policy and ID Number:
   c) If yes, have you received a check from your insurance company for this claim?

9. Annual household income. Enter the Total from attached worksheet Appendix 3: _____

10. Family size:

11. Is your annual income less than the amount listed for your size household on the Appendix 3 Income Verification Form? Yes No

12. If "No", and you still need financial assistance, briefly describe why paying this bill would be a financial hardship:

Statement of Agreement: I am supplying this information to request that the Town of Ulysses waive collection of all or part of the bill for services in my case due to financial hardship. I also understand that MedEx Billing Inc. can and will begin to attempt to collect charges should my financial situation improve.

I agree to be responsible for any balance remaining after the application of any waiver or financial assistance.

Name:

Patient Signature:

For information or assistance, contact MedEx at (800) 716-8015.

Return this completed form with income verification to:
Town of Ulysses
c/o Town Clerk
10 Elm Street
Trumansburg, NY 14886

Town of Ulysses Ambulance Financial Assistance

Appendix 3

Financial Assistance Application Income Verification Form

I am supplying the following information so that the provider can make an accurate determination of my case. The monthly dollar amount provided on this document is from all sources including Social Security Benefits, pensions, annuities, dividends, etc,

I am attaching:

____My federal tax return for the previous year **OR** Documentation of eligibility for any (1) one of the following assistance programs:

____ Public Assistance, SSI, or Medicaid, Food Stamps OR

____ Free/Reduced School Breakfast and Lunch Program OR

____ Section 8 Housing Subsidy OR Home Energy Assistance Program (HEAP)

	Patient Income	Spouse/Partner Income	Other Household Income
Gross Wage/Salary	$	$	$
Social Security	$	$	$
Pension	$	$	$
Social Security	$	$	$
Interest Income	$	$	$
Other income	$	$	$
Totals	$	$	$
Combined Total Household Income	$_____		