Brownsburg Fire Territory Hardship Program

1) Patients must complete the Hardship application and supply support documents as requested.
2) Hardship application must be completed for each Brownsburg Fire Territory invoice for each patient.
3) Hardship applications must be completed and received by Brownsburg Fire Territory prior to the account submitted to collection agency. If account is placed with the collection agency, the patient is required to pay all collection fees. If hardship qualifications are met after the account has been placed with collections, the account will only be reduced to 50% of the original invoice minus any payments made on the account. Patient is required to pay any collection fees acquired.
4) Hardship qualification for 100% deduction after any payments received will based on the following:
    i. Income level for the number of dependants for patient is equal to or less than the poverty level. Poverty level is based on the income guidelines for determining township assistance eligibility which is based on 100% of the Federal Poverty Level. This information will be provided by the most recent year's tax returns or W-2's.
5) **Patients are encouraged to set up payment pays to pay off any balances. Continuation of timely payments will avoid account being placed with collection agency.**

Brownsburg Fire Territory Hardship Application

Instructions to Patient

Please complete this form in its entirety and return it, along with all of the required supporting documentation and /or forms to the Division Chief of Brownsburg Fire Territory, 470 E. Northfield Drive, Brownsburg, IN 46112. Your request will not be processed unless the application is **fully completed** and signed and all supporting documentation is received. The Territory reserves the right to request any additional information and/or documentation that may be determined necessary by it to make this determination.

All information provided as part of this financial hardship request will be kept confidential.

Patient Name: _____

Address: _____

City/State/Zip: _____

Responsible Party (if different than patient): _____

Address of Responsible Party: _____

City/State/Zip of Responsible Party: _____
Number of person in the household: _____

I am applying for hardship in order that you will consider waiving my co-pay/co-insurance/deductible (or total charges if uninsured) for service and care provided to me on _____ (date of service).

Reason for requesting hardship: _____
_____
_____
_____

I am supplying the following information so that you can make an accurate determination of my case. Attached you will find verification of my financial hardship circumstances and copies of the following documents. (Please check where applicable)

_____ Verification of current employment/unemployment status;
_____ W-2 withholding statements or unemployment check stubs for the past 90 days;
_____ Pay check stubs for the past 90 days for all persons employed in the home;
_____ Income tax return (most recently signed 1040 and/or W-2);
_____ Proof of all other income received in the past 90 days;
_____ Application forms from Medicaid or other State funded medical assistance program;
_____ Forms from employers or government agencies

Documentation indicating other circumstances outside of federal poverty guidelines financial hardship determination such as:

_____ Proof of all outstanding debts or bills (copies of bills, statement, late notices, etc.)
_____ Proof of bankruptcy settlement (if applicable); and/or
_____ Proof of other catastrophic situations (for example, death or disability in family) or other documentation which demonstrates patient would be unable to pay medical bills and Still be able to pay for other basic necessary expenses.

The monthly dollar amount provided below is from all sources including Social Security benefits, pensions, annuities, dividends, etc.

Monthly Income	Self	Spouse
Wage/Salary	$_____	$_____
Social Security	$_____	$_____
Pension	$_____	$_____
Interest Income	$_____	$_____
Other	$_____	$_____
Totals	$_____	$_____

Statement of Agreement: "I am supplying this information to request that the Brownsburg Fire Territory waive collection of all or part of the Medicare or other deductible/co-insurance amounts in my case due to financial hardship. I also understand that the Territory 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 by the Territory, if any."

I hereby acknowledge and affirm that the Information given herein is true and accurate. I authorize the Brownsburg Fire Territory to verify any information contained in this document for the purpose of assessing financial need and considering my application for financial assistance.

Patient Signature: _____
Date: _____
****

□ Approved □ Not Approved _____