MOORESTOWN FIRST AID AND EMERGENCY SQUAD INC.
PATIENT QUESTIONNAIRE FOR FINANCIAL HARDSHIP DETERMINATIONS

Instructions to Patient

Please complete this form in its entirely and return it to
Moorestown First Aid and Emergency Squad Inc.
892 New Castle Road
Slippery Rock, PA 16057

Patient Name: _____

Address: _____

City/State/Zip: _____

Responsible party (if different than patient): _____

Address of Responsible Party: _____

City/State/Zip of Responsible Party: _____

I am applying for a Hardship Determination 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).

I am supplying the following information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources including Social Security benefits, pensions, annuities, dividends, etc. Attached you will find verification of my employment/unemployment status and copies of my federal tax returns or W-2 forms for the previous 2 years.

My insurance information is:

Insurer Name: _____

Insurance Policy/ID Numbers: _____

Monthly Income	**Self**		**Spouse**		
Wage/salary	$_____		$_____		
Social security	$_____		$_____		
Pension	$_____		$_____		
Interest income	$_____		$_____		
Other	$_____		$_____		
Totals	$_____	+	$_____	=	$_____

Statement of Agreement: "I am supplying this information to request that Moorestown First Aid and Emergency Squad 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 Moorestown First Aid and Emergency Squad 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 Moorestown First Aid and Emergency Squad, if any."

Patient signature:_____ Date:_____

MOORESTOWN FIRST AID AND EMERGENCY SQUAD INC.
PATIENT NOTICE FOR FINANCIAL HARDSHIP DETERMINATIONS

Patient Name: _____ Date of Service: _____

Dear Patient:

The law requires that Moorestown First Aid and Emergency Squad attempt to collect any unpaid portion of the $203 annual Medicare (2021) Part B or insurance deductible and the applicable co-insurance amount from the beneficiary. However, two conditions may permit the emergency medical service provider to waive collection of these amounts. One of the conditions is that of financial hardship for the beneficiary to meet such payment amounts.

Based upon discussions with you, we have determined that, due to your current financial situation, you are unable to pay the unpaid portion of your deductible and/or the co-insurance amount. Due to these circumstances, we hereby waive your obligation for payment of the charges for the following service:

Date of Service: _____
Description of Service: _____
Amount Waived: _____
Balance Due: _____

However, if future discussion with you regarding your financial situation indicates that your situation has improved enough to enable you to pay, we will require payment of charges incurred for that date of service.

Sincerely,

Moorestown First Aid and Emergency Squad