Eligibility For Ambulance Supplemental Payment Program

Application Request Criteria

A governmental ambulance provider must submit a written request for a supplemental payment by regular mail or special mail delivery to the Texas Health and Human Services Commission Provider Finance Department (HHSC PFD). The request, if acceptable, will be effective the first day of the month after the request is approved. HHSC considers only requests from governmental ambulance providers as defined in RULE §355.8600. HHSC will respond to all written requests for consideration, indicating the requestor's eligibility to receive supplemental payments.

HHSC-PFD requires that all applicants submit a digital copy of the application request. Submit your application as one document containing all the required attachments in order of the documents and information outlined below as a PDF.

Send your digital application to the PFD Hospitals mailbox at pfd_hospitals@hhsc.state.tx.us.

An acceptable application request must include:

i. Overview of the governmental agency. Overview should clearly indicate that the provider operates as part of a governmental (taxing) authority.

ii. Complete the governmental agency's organizational chart. An acceptable chart will display how the provider fits into the agency as compared to other public entities under the same jurisdiction, e.g., public works, parks and recreation, police, etc.

iii. Complete the organizational chart of the ambulance department within the governmental agency providing ambulance services, including the total number of employees, both full-time and part-time positions, filled and vacant.

iv. Identification of the specific geographic service area covered by the ambulance department by ZIP code.

v. Copies of all job descriptions for staff types or job categories of staff who work for the ambulance department, as indicated in the entity's ambulance department organizational chart. The title of job descriptions should match what is listed on the ambulance department organizational chart.

vi. The primary contact person for the governmental agency is someone who can respond to questions about the ambulance department. Include Name, Address, Phone Number, E-mail Address, and Fax Number. All approvals, denials, and requests for additional documentation regarding your application will be sent via email. Please list one or two additional personnel as a backup for this type of communication.

vii. A signed and notarized letter documenting the governmental provider's voluntary contribution of non-federal funds (see attached). The original may be scanned and submitted digitally with the rest of the application materials.

viii. Estimated percentage of time each staff member spends working for each department, e.g., ambulance department, finance department, etc., including medical director, business manager, and chief financial officer.

ix. Public Ambulance Provider's National Provider Identifier (NPI) number.

x. Public Ambulance Provider's Texas Provider Identifier (TPI) number.

xi. Estimated total revenue this program will provide the organization over the course of one (12 months) fiscal year (using the most recent date on file). (See example below).

xii. Copy of the entity's Indirect Cost Rate and Cost Allocation Plan.

xiii. Completed Texas Identification Number (TIN) application. (For the ability to complete the TIN application contact pfd_uc_payments@hhs.texas.gov).

Estimated revenue reimbursed to your organization.

Provider Name	
City:	
Medicaid (FFS) - Charges	
Medicaid (FFS) - Paid Claims	
Medicaid (MCO) - Charges	
Medicaid (MCO) - Paid Claims	
Uninsured - Charges	
Uninsured - Paid Claims	
Total Billed Charges (Medicaid & Uninsured)	
Total Paid Claims (Medicaid & Uninsured)	
Total Computable (Total Billed Charges - Total Paid Claims)	

(Insert Date)

HHSC Hospitals

Texas Health and Human Services

HHSC Provider Finance Department

Mail Code H-400

4601 Guadalupe St

Austin, TX 78751

RE: Contributions of the Non-Federal Share of Supplemental Payments to Ambulance Providers

Dear HHSC Hospital Rates Department:

I am the (Representative) of the (Provider/Entity), and as such, I am personally knowledgeable of the facts in this letter, and I am authorized by (Governing Agency of Provider/Entity) to affirm these facts on behalf of (Provider/Entity) that is the provider of ambulance services.

(Provider/Entity) is a (department/agency/etc.) within the governmental structure of the (Governing Agency of the Provider/Entity) organized under the laws of the State of Texas. The (Local Government) is legally authorized to levy and collect ad valorem taxes, generate public revenue, or receive and expend appropriated public funds.

(Governing Agency of Provider/Entity) has voluntarily agreed to certify public expenditures for use as the non-federal share of Medicaid payments for this program to the provider identified in this letter. (Governing Agency of Provider/Entity) is not required by the State of Texas to make this certification of public expenditures.

(Governing Agency of Provider/Entity) will certify the non-federal share of their payments annually by submitting the approval cost report for the Emergency Medical Services/Ambulance Services program (described on page 1 b of Attachment 4.19 B of the Texas Medicaid Plan). (Governing Agency of Provider/Entity) will continue to provide funding described indefinitely, pending the continued annual appropriation of (Governing Agency of Provider/Entity) general fund expenditures to the (Provider/Entity) in support of this program. (Governing Agency of Provider/Entity) will notify you annually, through the annual cost report, of the amount of local governmental expenditures associated with this program.

Contact (Provider/Entity Primary Contact Person) at (Provider/Entity Primary Contact Email Address) or (Provider/Entity Primary Contact Telephone Number) should you have any questions regarding this matter.