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 - Rate Analysis Department (HHSC-RAD). 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-RAD requires that all applicants submit a digital copy of the application request. Submit your application as one document containing all of the required attachments in order of the documents/information outlined below as a PDF.

You may send your digital application to the UC Tools mailbox at uctools@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 organizational chart of the governmental agency. An acceptable chart will display the how the provider fits into the governmental agency as compared to other public entities under the same jurisdiction, like public works, parks and recreation, police, etc.
iii. Complete organizational chart of the ambulance department within the governmental agency providing ambulance services including a 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. Titles of job descriptions should match what is listed the ambulance department organizational chart.
vi. Primary contact person for the governmental agency 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 an email communication. Please list one or two additional personnel as back-up for this type of communication.

vii. 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, i.e., ambulance department, finance department, etc. (Including Medical Director, Business Manager, Chief Financial Officer, etc.)

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 month) fiscal year (using the most recent date on file); (See example below)

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

xiii. Completed Texas Identification Number (TIN) application. (Follow the below link to download the existing TIN application form.)

AP-152

(NOTE: If you would like to receive your payment via direct deposit, you may use the below link to download the Direct Deposit Authorization form to fill out and send with your enrollment application.)

74-176

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 Hospital Rates Department

Texas Health and Human Services Commission

HHSC Rate Analysis

Mail Code H-400

4900 North Lamar

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 provide the certification of the non-federal share of their payments annually through the submission of the approval cost report for the Emergency Medical Services/Ambulance Services program (described on page I b of Attachment 4.19 B of the Texas Medicaid Plan). (Governing Agency of Provider/Entity) will continue to provide funding described in this letter 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.

Please feel free to 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.