

Ambulance Agency Assessment (Reporting Form)
(pursuant to 33 V.S.A. § 1959)

The reporting period is: July 1, 2016 to June 30, 2017. This form must be received by DVHA no later than November 15, 2017. Mail completed form to: DVHA 22, ATTN: Business Office, NOB 1 South, 280 State Drive, Waterbury, VT 05671-1010.

- 1. Name of Organization.....
- 2. VT Dept. of Health-issued Service Number...
- 3. Contact Person’s Name.....
- 4. Contact Person’s Telephone Number.....
- 5. Mailing Address.....

Please state the following information:

Line 1 – Patient Revenue..... \$ _____
Line 2 – Patient Revenue from Out of State services..... \$ _____
Line 3 – Paramedic Intercept Service Revenue.....\$ _____
Line 4 – (addition of Lines 2 and 3)\$ _____
Line 5 – Net Patient Revenue (subtract Line 4 from Line 1)... \$ _____
Anticipated Tax Liability (Line 5 multiplied by 3.3%) \$ _____

I, (printed name) _____, as a duly authorized agent or employee of the above named organization and authorized to submit this form on their behalf, do certify and attest to the information being reported to DVHA on this form as true and accurate to the best of my knowledge or ability. I acknowledge and understand that the State of Vermont or DVHA may audit, inspect, verify, or investigate the information that I have reported. I acknowledge and understand that the State of Vermont or DVHA may request any and all evidence, documents, forms, claims, and records from the organization, and the organization must make them available to the State of Vermont or DVHA. I acknowledge and understand that if any miscalculation, misrepresentation, error, omission, or fraud is found, the organization may be liable for any differences owed and any fines and/or penalties under 33 V.S.A. § 1959 or other state and federal laws.

Authorized Agent’s/Employee’s Signature
on Behalf of the Organization

Date

INSTRUCTIONS

All ambulance agencies must complete and submit the reporting form if applicable. Please review and fill in information as indicated. All information provided must be based upon the indicated reporting period on page one. The completed form must be submitted to DVHA by the date indicated on page one.

QUESTIONS: If you have any questions about filling out this form, please contact the DVHA Business Office at AHS.DVHAAccountsReceivable@vermont.gov or 802-241-0255.

Definitions

For purposes of the ambulance agency assessment, the following definitions shall apply:

1. “Patient revenue” shall mean the cash revenue received by an ambulance agency during the reporting period for delivering services to patients excluding any revenue from:
 - a. air ambulance services;
 - b. municipal appropriations;
 - c. donations from any source; or
 - d. any other funding unrelated to the delivery of health care services.
2. “Paramedic intercept services revenue” shall mean an ALS services provided by an entity that does not provide the ambulance transport and can be billed under codes like ALS code A0432 or HCPCS code S0208.
3. “Ambulance agency” shall mean an ambulance service licensed by the Vermont Department of Health. This term shall not apply to any ambulance agency conducted, maintained, or operated by the U.S. government.
4. “Patient Revenue from out of state services” shall mean:
 - a. Cash revenue received for transport when part of the transport is made outside of the geographic border of Vermont. This includes revenue received from a trip that originates or concludes in Vermont but part of the trip is made in New Hampshire or any other state.