Title: Sliding Fee Scale – 330 Grant	**Category**: Fiscal
Policy ID:	**Effective Date**: 01/96
Approved By: Board of Directors	**Review/Revision Dates**: 8/07, 11/09, 1/14, 9/15, 7/16
Reviewed By: Exec Team	**Pages**: 5

POLICY: Sliding Fee Scale – **330 Grant**

OBJECTIVE:

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Based on s mission, financial assistance in the form of sliding fee scale (SFS) discounts will be provided for persons who have healthcare needs and are uninsured or under-insured, ineligible for a government program and otherwise unable to pay for medically necessary care based on their individual financial situation. Employees of shall be knowledgeable regarding the poverty guidelines for discounting health care services and shall assist patients in applying for SFS discounts.

no discussion on the need to evaluate the SFD program every 3 years.

PROCEDURE

A. The SFS is applicable to patients who would fall into the category of Self-Pay and will not be applied to charges of individuals who qualify for third party coverage, except for any balance remaining after third party billing. Patients have a right to decline the SFS program if they are not interested or prefer to opt out of the screening process for SFS assistance.

B. Wherever possible, each clinic should attempt to determine a patient's financial status using Federal Poverty Guidelines (see Exhibit II- c) prior to the rendering of service; however, this policy should be implemented, when applicable, after billing if it is later determined that the Fee Scale should have been applied.

C. Income will be based on Household Income. As defined by the Bureau of the Census, a household "consists of all the persons who occupy a housing unit (house or apartment) whether they are related to each other or not." For example, if a mother of three children allows another adult to live in her home with her and her children, the income from both the mother and other adult should be considered in determining household income.

D. The primary test for SFS eligibility is household gross income. Patients are required to provide documentation of household gross income.
Examples include:

- Wages, including overtime and tips
- W-2 withholding forms
- Current pay stubs
- Previous years Income Tax Returns
- Last bank Statement
- Written verification from employer

- Written verification of income from public assistance agencies (All social Security income, churches, United Way, etc).
- Retirement/Pension Income/ Social Security
- Worker's Compensation
- Unemployment Benefits/SSI
- Veteran's Benefits
- Child Support
- Alimony

E. Income verification (Exhibit V) is required and should be obtained through check stubs or tax returns. In an effort to accurately reflect income, if check stubs are used, one month (or four weeks) of income must be verified. For example, if the applicant is paid every other Friday, two check stubs must be provided to arrive at a monthly income amount. A copy of the check stubs or tax return must be maintained along with a copy of the SFS application (Exhibit I).

F. Based on federal guidelines, the SFS discount is valid for 12 months. However, reserves the right to reevaluate the need for financial assistance at any time due to a change in income.

G. Returning patients who do not have income verification with them will be billed at the full rate of a Self-Pay patient. However, the patient will be given the SFS application to complete and a self-addressed envelope. It is then the patient's responsibility to return the completed application and income verification to the clinic within 8 weeks. Once the application and proof of income have been received, the SFS discount will be applied to the original visit. If the patient fails to return the required information within eight weeks, the charge will remain at the full Self-Pay rate and become the sole responsibility of the patient.

H. If a patient is new to our clinic and has no proof of income with them on the first clinic or hospital visit, the patient may self-declare income (Exhibit VI). Written proof of income is not required to receive the discount, but employees are required to ask for gross income and household size. The SFS discount will only apply for the first clinic visit and related hospital admission. The patient shall be given a SFS application and self-addressed envelope and it becomes the patient's responsibility to return the application within eight weeks from the first visit. "SFS Given" must be documented in practice management system. The patient may be seen for future visits but must pay for the entire visit up front prior to being seen by a provider.

I. As in the case of any counseling, every effort will be made to provide the patient with a private space for discussion of income status.

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J. Current income guidelines (Exhibit II) shall be made available to any patient and a copy shall be given to the patient during the SFS application process.

K. The Operations Managers will review all SFS Applications in a timely fashion. Upon receipt of a completed application, a financial assistance determination will be made within ten (10) business days.

L. After review of the application, an approval letter (Exhibit III) or denial letter (Exhibit IV) will be given/mailed to the applicant.

M. If the hospital case manager is unable or not allowed to visit a hospital patient new to our clinic, the patient may self declare income verbally. The case manager must document the conversation (Exhibit V), to obtain approval signature from the insurance manager, forward documentation to the appropriate clinic and document in notes "SFS verbal hospital". The patient must be given a SFS application on the first follow-up clinic visit. The initial hospital and clinic visits will be covered by the verbal self declaration but all future visits will be billed at the full rate of a Self-Pay patient until the completed SFS application is returned and approved.

N. With the addition of the 340B Drug Discount Program, patients that are eligible for the Sliding Fee Scale program will receive discounts at the contracted pharmacies of according to the guidelines in Exhibit V. Patients will not receive an eight week retro for medications at the pharmacy if they were Self-Pay and later qualified for the Sliding Fee Scale. The patient will receive the discount at the contracted pharmacy according to the date the Sliding Fee Scale was returned and approved by staff.

O. For Specialty Services (Dental, OBGYN and Podiatry), a Board approved Carve out Sliding Fee schedule is used to discount selected services at these clinics.

P. Managers (based on special circumstances) may waive fees and nominal charges. For example: A patient seen for behavioral may require multiple visits in one month. If a SFS" A" patient, has the ability to limit the nominal fee to $50 a month.

does not discuss how nominal is set. does not discuss how often nominal fee is evaluated from the patient's perspective, does not discuss BOD approval on setting nominal fee.

Exhibit I

SLIDING FEE SCALE APPLICATION

APPLICANT INFORMATION

Applicant Name: _____
last first middle

Mailing Address: _____
street city zip

Telephone: _____ Date of Birth: _____

Social Security Number: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated

RESPONSIBLE PARTY

Guarantor Name: _____
last first middle

Relationship to Applicant: _____

Social Security Number: _____

Employer: _____ Phone Number: _____

HOUSEHOLD MEMBERS

Please list other household members and relationship to the applicant:

Name/Relationship: _____ DOB: _____ ❑ Unemployed / Minor

Name/Relationship: _____ DOB: _____ ❑ Unemployed / Minor

Name/Relationship: _____ DOB: _____ ❑ Unemployed / Minor

Name/Relationship: _____ DOB: _____ ❑ Unemployed / Minor

Name/Relationship: _____ DOB: _____ ❑ Unemployed / Minor

Name/Relationship: _____ DOB: _____ ❑ Unemployed / Minor

Name/Relationship: _____ DOB: _____ ❑ Unemployed / Minor

(continued on next page)

Exhibit I

Are any other household members patients at this clinic or any other clinic? linics include

If so, please list patient names and clinic used:

Name: _____ Clinic: _____

Name: _____ Clinic: _____

Name: _____ Clinic: _____

Name: _____ Clinic: _____

Name: _____ Clinic: _____

INSURANCE INFORMATION

Do you have any type of medical insurance coverage? ☐ Yes ☐ No

If yes, please complete:

Insurance Name: _____ Subscriber Name: _____

Group Number: _____ Effective Date: _____

INCOME VERIFICATION

********** **Please attach copies of income verification**. **********

Please remember that you will remain as a self pay patient until this information is received. Unless income verification is provided, you will be held liable for the full amount of charges. The sliding fee scale discount only applies to charges incurred within clinics and not to any outside services.

I verify that this information presented is true and accurate to the best of my knowledge and hereby apply for the sliding fee scale discounts as applicable.

Signature: _____ Date: _____

Office Use Only:

Chart Number: _____ Sliding Scale Code: _____

Approved by: _____ Date: _____

Effective Date of SFS Discount: _____

EXHIBIT II

DEPARTMENT OF HEALTH & HUMAN SERVICES POVERTY GUIDELINES

Effective: March 1, 2017

Household income is:		≤ A	> A ≤ B	> B ≤ C	> C ≤ D	> D ≤ E	> E ≤ F	> F
Co-pay %:		-0-	25%	50%	75%	90%	100%	100%
% of poverty guideline:		≤100%	100%> x ≤125%	125%> x ≤150%	150%> x ≤175%	175%> x ≤200%	200%> x ≤300%	>300%
Household	Slide:	A	B	C	D	E	F	G
	YEAR	12,060	15,075	18,090	21,105	24,120	36,180	
1	MONTH	1,005	1,256	1,508	1,759	2,010	3,015	
	WEEK	232	290	348	406	464	696	
	YEAR	16,240	20,300	24,360	28,420	32,480	48,720	
2	MONTH	1,353	1,692	2,030	2,368	2,707	4,060	
	WEEK	312	390	468	547	625	937	
	YEAR	20,420	25,525	30,630	35,735	40,840	61,260	
3	MONTH	1,702	2,127	2,553	2,978	3,403	5,105	
	WEEK	393	491	589	687	785	1,178	
	YEAR	24,600	30,750	36,900	43,050	49,200	73,800	
4	MONTH	2,050	2,563	3,075	3,588	4,100	6,150	
	WEEK	473	591	710	828	946	1,419	
	YEAR	28,780	35,975	43,170	50,365	57,560	86,340	
5	MONTH	2,398	2,998	3,598	4,197	4,797	7,195	
	WEEK	553	692	830	969	1,107	1,660	
	YEAR	32,960	41,200	49,440	57,680	65,920	98,880	
6	MONTH	2,747	3,433	4,120	4,807	5,493	8,240	
	WEEK	634	792	951	1,109	1,268	1,902	
	YEAR	37,140	46,425	55,710	64,995	74,280	111,420	
7	MONTH	3,095	3,869	4,643	5,416	6,190	9,285	
	WEEK	714	893	1,071	1,250	1,428	2,143	
	YEAR	41,320	51,650	61,980	72,310	82,640	123,960	
8	MONTH	3,443	4,304	5,165	6,026	6,887	10,330	
	WEEK	795	993	1,192	1,391	1,589	2,384	

For each additional person add: 4,180 per YEAR ● 348 per MONTH ● 80 per Week

Office visit for Slide A patients are subject to a nominal fee of $25 per visit with a maximum out of pocket expense of $50 per month for Behavioral Health Services. Office visits for Slide B-D patients are subject to a nominal fee of $30 per visit with a maximum out of pocket expense of $60 per month for Behavioral Health Services. Office visits for Dental Patients are subject to a nominal fee of $35. Office visits for Slide A patients for Title X Services are exempt from nominal fee charges.

Household incomes exceeding 200% of the guidelines ("E" above) are responsible for 100% of charges. See Sliding Fee Scale Policy for the definition of "household" and "income". The Rural HIV Model (Ryan White Grant) co-pays are presented on a separate schedule and differ from those on this schedule.

reserves the right to waive fees and nominal charges for specific patient circumstances.

Sliding Fee Scale Charge per Prescription for 340B Drug Discount Program:

A =	**≤100% of the Poverty Guideline**	**Acquisition cost +**	
B =	**>100% & ≤125% Poverty Guideline**	**Acquisition cost + fees + $1.25**	**Admin Fee**
C =	**>125% & ≤150% Poverty Guideline**	**Acquisition cost + fees + $1.50**	**Admin Fee**
D =	**>150% & ≤175% Poverty Guideline**	**Acquisition cost + fees + $2.00**	**Admin Fee**
E =	**>175% & ≤200% Poverty Guideline**	**Acquisition cost + fees + $2.50**	**Admin Fee**
F/G =	**>200% of the Poverty Guideline SELF PAY**	**Acquisition cost + fees + $5.00**	**Admin Fee**

Charges for prescriptions include: Acquisition Cost which is the 340B Drug Cost + Fees (including pharmacy dispensing fee and program administration fee) +