South Cove Community Health Center, Inc.
Effective 01/12/2024

Title: Charity Care and Sliding Fee Discount Schedule – (SFDS)

Purpose:

- To provide and facilitate access to health care services for patients who do not have the ability to pay for those services
- To establish a system for discounting the cost of health services for patients who do not have the ability to pay full charges
- To ensure that the patient or responsible party understands the sliding fee scale program

Policy:

South Cove Community Health Center's (SCCHC) sliding fee discount schedule (SFDS) is based on the Federal Department of Health and Human Services Poverty Income Guidelines. Reduced charges will be established for health services provided to individuals with annual incomes at or below 200% of poverty level as outlined in the HHS guidelines. Individuals with incomes at or below 100% of poverty will be charged a nominal fee. The difference between the actual charges incurred and the approved fees paid by patients under this policy will be immediately written off as sliding fee discounts. No discounts are available to patients with incomes above 200% of the poverty level.

EMPLOYEES OF SOUTH COVE COMMUNITY HEALTH CENTER ARE NOT ELIGIBLE FOR CHARITY CARE OR SLIDING FEE DISCOUNTS SCHEDULE UNLESS QUALIFIED BY THE STANDARD SCREENING AND REGISTRATION PROCEDURES.

Scope: This policy applies to patient charges, co-pays or deductibles for medical and dental services at all SCCHC locations. It does not apply to amounts billed to third party payers.

Definition of Income: Income includes salary or employment income and certain other income. The most common items that should be included when calculating an individual's income include salary or wages (including tips), dividends or interest received, alimony, pension, capital gains and rental income.

Definition of Family Size: The number of Household Members determines family size.

Definition of Household Member: A household member is a person living within the household that is solely dependent on the applicant's income.

No denial of services for inability to pay: Regardless of whether a patient qualifies for a discount, if a patient would be denied services due to inability to pay, then charges will be waived or reduced to the extent necessary to ensure that such patient receives health care services.

Procedures:

<u>Application of the Sliding Fee Discount</u>

Registration Staff/Benefits Staff

1. Determine if the patient or responsible person is eligible for sliding fee schedule application by:

a. Establishing proof of income. Patient is charged based on head of household information and is responsible for all charges.
b. Verifying whether the patient has current medical assistance or health insurance to cover outpatient and/or physician services.
c. If patient does not have supporting documentation at the time of services a self-declaration form must be completed to support application for applicant. If patient claims to be self-employed, a separate form must be completed at the time of service.
d. Some patients may choose not to provide information that the health center requires for assessing income and family size, even after being informed that they may qualify for sliding fee discounts. These patients are declining to be assessed for eligibility for sliding fee discounts. If the health center has followed its policies and supporting operating procedures and the patient declines to be considered for SFDS, the health center may consider the patient ineligible for such discounts.

2. Explain that payment is expected at the time of service, and explain the sliding fee discount program to the patient. Establish if the patient is interested in applying.

3. If the patient or responsible party elects to apply for the sliding fee discount, s/he is asked to complete the Sliding Fee Discount Application, and provide the following documents;

    a. Unemployment stub
    b. W-2 form for the most recent year
    c. Pay check stub not more than 30 days prior to visit
    d. Most recent tax return

4. Assign the appropriate discount code as shown on application:

5. Explain to the applicant the amount of fee reduction that they are qualified to received and have them sign the Sliding Fee Discount Application (Fee described on application).

6. For patients with third party insurance that does not cover or only partially covers fees certain health center services, these patients may also be eligible for the SFDS based on income and family size. In such cases, subject to potential legal and contractual obligations, the charge for each SFDS pay class is the maximum amount an eligible patient in that pay class is required to pay for certain services, regardless of insurance status.

<u>Benefits Staff</u>

7. After the patient has completed the visit (check out), billing staff will enter the charges immediately, apply the appropriate discount, and inform the patient of any amount due.

8. Review all sliding fee applications on a daily basis to:
    - Verify the payment code with income data (if necessary).
    - Ensure that support documents were obtained and reviewed.
    - Verify that the application is complete and accurate, initial the form documenting that it has been reviewed.

9. Forward the application to the COO for filing.

10. **Collections.**
    The Health Center shall make a reasonable effort to collect all charges for health care services rendered, regardless of whether discounted charges or standard charges are applied. A reasonable

effort includes issuance of a bill to the patient or responsible party and follow-up with subsequent billing, collection letters, and telephone calls. A patient's refusal to pay does not equate to an inability to pay. Refusal to Pay to be defined as a patient making no good faith effort to make a payment, at least 120 days in arrears, on an outstanding balance. Patient will receive 4 statements and a final notice.

See the Credit and Collection Policies and Procedures for further guidance.

Revisions:

This policy is scheduled for review annually in coordination with changes to the Federal Poverty Guidelines, changes to the fee (charge) schedule or at any other time deemed necessary by South Cove Community Health Center management and Board of Directors.

SCCHC Medical Record #_____

SOUTH COVE COMMUNITY HEALTH CENTER
Sliding Fee Discount Application

Name:_____ Date: _____

DOB:_____ # of Household Members: _____

HOUSEHOLD INFORMATION MUST BE COMPLETED FOR ALL APPLICANTS
List all members of household and date of birth

1. Name: _____ DOB: _____

2. Name: _____ DOB: _____

3. Name: _____ DOB: _____

4. Name: _____ DOB: _____

HOUSEHOLD INCOME (Proof of income must be copied and attached)

Wages: Employer Name or Self Employed: _____ Annual Wages: $ _____

OTHER INCOME: Annual Other: $ _____

Total Income: $ _____

Circle all sources of other income which may include: Self-employment Wages, Tips, Unemployment Benefits, Social Security, SST, Child Support, Public Assistance, Housing Allowance, Military Family Allotment, Pension Benefits, VA Benefits, Trust Fund Disbursement, Training Stipends, Scholarships, Grants, Food Stamps and any other forms of financial support.

Self-Declaration Form will be accepted on the <u>first</u> visit only. All subsequent visits will be charged at the full fee unless proof of income is provided. All prior balances must be paid prior to your next appointment.

AFFIDAVIT: By signing, I attest that, as of the date of my signature, the income sources listed constitute all of my household income, the household members listed are all solely dependent on that income and the explanation provided to verify my income level is true.

APPLICANT SIGNATURE: _____

SCCHC Staff Signature: _____ Review Date: _____

Office Manager Signature: _____ VAILD UNTIL: _____

SCCHC Sliding Fee Discount

Service Type	Income <100% FPIG	Income 100%-125% FPIG	Income 126%-150% FPIG	Income 151%-175% FPIG	Income 176%-200% FPIG	Income Over 200% FPIG
Medical	$0 Fixed Fee per visit	45.00 Fixed Fee per visit	65.00 Fixed Fee per visit	85.00 Fixed Fee per visit	105.00 Fixed Fee per visit	No Discount
Behavioral Health	$0.00 Fixed Fee per visit	45.00 Fixed Fee per visit	65.00 Fixed Fee per visit	85.00 Fixed Fee per visit	105.00 Fixed Fee per visit	No Discount
Optometry	$0.00 Fixed Fee per visit	35.00 Fixed Fee per visit	45.00 Fixed Fee per visit	55.00 Fixed Fee per visit	65.00 Fixed Fee per visit	No Discount
Dental Preventive Including fillings	0.00 Fixed Fee per Procedure	45.00 Fixed Fee per Procedure	55.00 Fixed Fee per Procedure	65.00 Fixed Fee per Procedure	75.00 Fixed Fee per Procedure	No Discount
Cosmetic Dental Fixed, Including Endodontic, Crown, Bridge, Denture	$300 per Procedure + material cost	$350.00 per Procedure + material cost	400.00 per Procedure + material cost	450.00 per Procedure + material cost	500.00 per Procedure + material cost	No Discount
340B Pharmaceuticals	$0.00 per script + drug cost	$3.00 per prescription + cost	$4.00 per prescription + cost	$5.00 per prescription + cost	$5.00 per prescription + cost	No Discount

SCCHC Staff: Circle Income Sliding Fee Eligibility

SCCHC Medical Record #_____

SOUTH COVE COMMUNITY HEALTH CENTER
Self-Declaration of Household Income
Sliding Fee Discount

Patient Name (First, Middle, Last)	**Date of Birth**
Address	**Telephone #**
City/State/Zip Code	**Cell Phone #**

To Whom It May Concern:

I, _____ the undersigned, residing at
(name)

_____ certify that at this time
(address)

_____ is residing with me at the above address and
(patient name)

that at this time I am financially supporting them. Based on the attached income documentation, I attest that my annual household income is $_____ (ie. Income tax returns, pay stubs, social services award, etc.) which supports myself and _____ dependant(s) (including patient applicant).

Signature: _____ Date: _____

Print Name: _____

SCCHC Medical Record #_____

SOUTH COVE COMMUNITY HEALTH CENTER
Self-Employment Form
Sliding Fee Discount

Patient Name (First, Middle, Last)	**Date of Birth**
Address	**Telephone #**
City/State/Zip Code	**Cell Phone #**

To Whom It May Concern:

I, _____ the undersigned, residing at
(name)

_____ certify that I am myself self employed at the
(address)

Following job(s) _____

_____.

I attest that (based upon the attached documentation, i.e. receipts for services rendered, income tax returns, etc.) the following is the approximate amount of income that I receive monthly $_____, or annually $_____.

Signature: _____ Date: _____

Print Name: _____