CAMILLUS HEALTH CONCERN
PATIENT SERVICES
SLIDING FEE SCALE POLICY NUMBER: PSP-008
REVISION DATE: 01/2019

Purpose

To ensure that Camillus Health Concern provides services to all patients/clients without regard to the patient's ability to pay. **No one is refused service because of lack of financial means to pay**.

Policy

It is the policy of Camillus Health Concern (CHC) that patients who are uninsured or underinsured will be offered a Sliding Fee discount for billable services based on the most recent federal poverty guidelines. The Sliding Fee Scale will be reviewed and approved annually by the board of directors to ensure that the fee structure is patient centered, does not create a barrier to care and is appropriate for the population served by CHC. No person will be denied health care services due to an inability to pay. The Federal Poverty Guidelines, https://aspe.hhs.gov/poverty-guidelines, are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility.

Procedure

A. Eligibility for the Sliding Fee Discount Program is based on income and family size and no other factors such as insurance status or population type. CHC places notification of the Sliding Fee Discount Program in the clinic's patient waiting areas. CHC uses the Census Bureau definitions for each.
   i. **Family** is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered members of one family.
   ii. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. *Noncash benefits such as food stamps and housing subsidies **do not** count*.

B. CHC Patient Service Representative (PSR) will inform new patients of the Sliding Fee Scale Program. To accommodate literacy levels, PSRs will assist all patients in completing the Patient Sliding Scale Assessment Form.

C. Patients with third party insurance coverage that do not cover, or only

partially cover fees for certain health services, will also qualify for the Sliding Fee Scale discount per their financial assessment and income documentation provided. The charge for each self-pay class, subject to insurance contractual limitations, is the maximum amount an eligible patient is required to pay. Insured patients who meet 100% Sliding Fee discount according to the guidelines will also qualify for the appropriate discount.

D. PSRs will determine patient's eligibility and pay category for the Sliding Fee Discount Program based on the following information on the Sliding Scale Form:
   i. The patient's household income must be at or below 200% of the Federal Poverty Level. Patients with income over 200% of poverty are not eligible for the sliding fee scale and must pay full fee for services.
   ii. The patient's family size.
   iii. Third party coverage.

E. To qualify for the Sliding Fee Discount Program, appropriate proof of income must be provided. Proof of income is valid for one year, unless otherwise specified:
   i. Last two recent pay stubs
   ii. Letter from employer, shelter, housing program, treatment program or Case Manager.
   iii. Statement from Social Security stating earned income for current year.
   iv. Social Security TPQY (Third Party Query System) form for current year.
   v. Completion of Sliding Scale form signed by patient or responsible party (ie. Case Manager/Clinician) at the location the patient is currently residing.
   vi. Other proof of income/no income received via notarized letter

F. New Patients without insurance, a self-declaration of income is acceptable at the time of their first appointment. Required documentation of income must be provided on a subsequent visit.

G. If patient states they have no income or staff reasonably interprets that they have no income (i.e. patient sleeps at a shelter, similar facility, or in another person's residence) then Sliding Scale Form will be completed with form marked as having no income. If patient is not residing in a shelter or does not have a responsible person to sign the Sliding Scale Form, self-declaration will be accepted as proof of income.

H. If the patient is found to be eligible for the Sliding Fee Discount Program, he/she will sign Sliding Scale Form (attached). This form will acknowledge the patient's Sliding Fee Discount level and payment responsibility for each visit based on their income level and family size.

I. Determination of eligibility for the Sliding Fee Discounts Program will be performed annually per Federally Poverty Guidelines updated within the

Center's electronic health system Intergy.

J. If patient is unable to provide required documentation for proof of income during patient registration, he/she will be allowed to sign a Self-Declaration Form. The income and family size noted in the Sliding Fee Scale Form will be used to determine eligibility for Sliding Fee Discount. The PSR will assure that patient understands that the discount is temporary and is aware of the discount's expiration date, which will be 90 days from the date of the appointment. The PSR will add note to patient's account for a 90-day follow-up to contact patient to notify him/her of the required documentation needed to reapply for the Sliding Fee Discount Program prior to expiration date.

K. Billing and Collection: the appropriate fee will be requested from patient at time of service. If the patient cannot make payment on such date, reasonable efforts will be made on subsequent visit to collect outstanding balances. In certain situations, patients may be unable to pay the fees owed for services rendered. Fees may be waived under special circumstances and must be approved by the CFO or designee. Any fees that are waived must be documented in the patient's account.

L. Request for additional discounted services for patient that do not qualify for Level A on Sliding Fee Scale can be requested by patients, family members, social services staff or others who are aware of existing financial hardship. Documentation will be reviewed by Director of the Business Office and submitted to CFO for approval.

M. Refusal to Pay: if a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the Sliding Fee Schedule, a copy of the Sliding Fee Discount Program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, CHC can explore options not limited, but including offering the patient a payment plan or waiving of charges if approved by CFO or designee.

N. Patients who meet Homelessness status – individuals without permanent housing who may live on the streets, shelter, transitional housing, doubling up, car – and patients who are part of Transitional Housing Program will be exempt from all fees if they do not qualify for 100% Sliding Fee discount due to SS, SSI or other income. However, patients must still provide their proof of income and Homeless Status Letter from Case Manager and/or Housing Program if available.

O. Unpaid self-pay balances will be reviewed by the Business Office Director and written-off after 90 days once approved by CFO or designee, according to Write-Off policy.

P. Annually, the amount of Sliding Fee Discount Program will be reviewed by the CFO and CEO and approved by CHC's Board of Directors. The

Sliding Fee Schedule will be updated with the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patient from having access to our community care provisions.

Good Shepherd Health Center
Camillus Health Concern
Sliding Scale Form

Patient Name **«PatientFullName»** Gender at Birth **«PatientSex»**

Patient Social Security **«PatientSSN»** Date of Birth **«PatientDOB»**

Monthly Income $_____________ ☐ No Income ☐ Homeless _______________

Source of Income (Check any that may apply)

☐ Employment ☐ Veteran's Benefits ☐ TPQY

☐ Social Security/SSI ☐ Other _____________

Size of Family

☐ Single

☐ Family Size Number ________

Family Size	0% - 100.00% A	101.00% - 125.00% B	126.00% - 150.00% C	151.00% - 175.00% D	176.00% - 200.00% E	Over 200.00% F
1	12,490	15,613	18,735	21,858	24,980	24,981
2	16,910	21,138	25,365	29,593	33,820	33,821
3	21,330	26,663	31,995	37,328	42,660	42,661
4	25,750	32,188	38,625	45,063	51,500	51,501
5	30,170	37,713	45,255	52,798	60,340	60,341
6	34,590	43,238	51,885	60,533	69,180	69,181
7	39,010	48,763	58,515	68,268	78,020	78,021
8	43,430	54,288	65,145	76,003	86,860	86,861
9	47,850	59,813	71,775	83,738	95,700	95,701
10	52,270	65,338	78,405	91,473	104,540	104,541
Add	Add $4,420 per person for families above 8					

Monthly Gross Income Calculations					
A	B	C	D	E	F
1,041	1,301	1,561	1,821	2,082	2,083
1,409	1,761	2,114	2,466	2,818	2,819
1,778	2,222	2,666	3,111	3,555	3,556
2,146	2,682	3,219	3,755	4,292	4,293
2,514	3,143	3,771	4,400	5,028	5,029
2,883	3,603	4,324	5,044	5,765	5,766
3,251	4,064	4,876	5,689	6,502	6,503
3,619	4,524	5,429	6,334	7,238	7,239
3,988	4,984	5,981	6,978	7,975	7,976
4,356	5,445	6,534	7,623	8,712	8,713

I understand that based on my current income my regular fee for office visits at Camillus Health Concern according to the qualified Level _________ will be $ _____ (medical/behavioral) and $ ______ (dental). Patient Initials ______

Statement of Verification

I **«PatientFullName»** declare that as of the following date the information declared in this form is true.

____ **«CurrentDate»**

Patient Signature Date

________________________________ **«CurrentDate»**

Witness Signature Date

Verification of Homeless status and income level by authorized person (landlord, caseworker, Shelter staff, street outreach worker, etc.)

_______________________________ _______________________ ______________

Printed Name/Title Signature Phone Number

Camillus Health Concern

Good Shepherd Health Center

SLIDING FEE POLICY FOR PATIENTS

It is the goal of Camillus Health Concern, Good Shepherd Health Center, to charge patients according to their ability to pay. Patients who have either no third party insurance or inadequate coverage will be placed on a sliding fee scale according to family size and proof of income.

This fee scale is based on the Department of Health and Human Services Poverty Guidelines, published yearly. Updated guidelines can be obtained from the Census Bureau or via the website https://aspe.hhs.gov/poverty-guidelines.

Income of all existing sliding scale patients are verified during the new patient registration process and annually thereafter. Changes in family size and income are noted in CHC's Financial Assessment form. **No one is refused service due to inability to pay.**

Family Size	0% - 100.00% A	101.00% - 125.00% B	126.00% - 150.00% C	151.00% - 175.00% D	176.00% - 200.00% E	Over 200.00% F
1	12,490	15,613	18,735	21,858	24,980	24,981
2	16,910	21,138	25,365	29,593	33,820	33,821
3	21,330	26,663	31,995	37,328	42,660	42,661
4	25,750	32,188	38,625	45,063	51,500	51,501
5	30,170	37,713	45,255	52,798	60,340	60,341
6	34,590	43,238	51,885	60,533	69,180	69,181
7	39,010	48,763	58,515	68,268	78,020	78,021
8	43,430	54,288	65,145	76,003	86,860	86,861
9	47,850	59,813	71,775	83,738	95,700	95,701
10	52,270	65,338	78,405	91,473	104,540	104,541
Add	Add $4,420 per person for families above 8					

Appt Class Patient Due Amount	0% - 100.00% A	101.00% - 125.00% B	126.00% - 150.00% C	151.00% - 175.00% D	176.00% - 200.00% E	Over 200.00% F
Medical	$ -	$ 5.00	$ 10.00	$ 15.00	$ 20.00	*No Discount*
Behavioral	$ -	$ 5.00	$ 10.00	$ 15.00	$ 20.00	*No Discount*
Dental	$ -	$ 10.00	$ 20.00	$ 30.00	$ 40.00	*No Discount*

Note: Amounts to be reviewed and approved by The Board of Directors yearly according to Federal Poverty Guidelines.