CAMILLUS HEALTH
CONCERN PATIENT SERVICES
SLIDING FEE SCALE POLICY NUMBER: PSP-008
REVISION DATE: 02/2017, 02/2020

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. During registration, patient income and family size are documented by the PSR in CHC's EHR system. 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. The Sliding Fee Discount Schedule is structured in such a way that

charges are adjusted based on ability to pay. Flat fee amounts differ across different discount pay classes, or sliding fee levels. The Sliding Fee Discount Schedule also differs based on services type, which includes medical, behavioral health, and dental.

C. Once the Federal Poverty Guidelines are published each year, the health center will update the Sliding Fee Discount Schedule within 45 days to present to the board for approval.

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

E. 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 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.

F. 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.

G. 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

H. 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 subsequentvisit.

I. 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.

J. If a patient refuses to provide information on income and family size, they will be considered ineligible for CHC's SFDP. These patients will be given a Refusal to Provide Income and Family Size Information Notice form to sign during registration. These patients will not receive a discount on services.

K. 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.

L. Determination of patient eligibility for the Sliding Fee Discounts Program will be performed annually per Federally Poverty Guidelines updated within the center's EHR system.

M. 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.

N. 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.

O. Requests for additional discounts on services for patients that do not qualify for Level A on Sliding Fee Scale can be requested by patients. Documentation will be reviewed by the Medical Billing Manager and submitted to CFO for approval.

P. 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.

Q. Unpaid self-pay balances will be reviewed by the Medical Billing Manager and written-off after 90 days once approved by CFO or designee, according to Write-Off policy.

R. Annually, CHC evaluates the effectiveness of the SFDP in reducing barriers to care. The 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 annually within 45 days of the current Federal Poverty Guidelines being published. In order to evaluate the effectiveness of the SFDP in reducing barriers to care, CHC will conduct an analysis on the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPG accessed services in the previous year. This analysis will be conducted before the SFDP is updated annually. At this time, CHC will also collect utilization data through patient surveys that will include questions related to CHC's current SFDP in order to evaluate the effectiveness of the SFDP in reducing financial barriers to care. If CHC identifies changes are needed, changes will be made and presented to the board for approval.

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	12,760	15,950	19,140	22,330	25,520	25,521
2	17,240	21,550	25,860	30,170	34,480	34,481
3	21,720	27,150	32,580	38,010	43,440	43,441
4	26,200	32,750	39,300	45,850	52,400	52,401
5	30,680	38,350	46,020	53,690	61,360	61,361
6	35,160	43,950	52,740	61,530	70,320	70,321
7	39,640	49,550	59,460	69,370	79,280	79,281
8	44,120	55,150	66,180	77,210	88,240	88,241
9	53,080	66,350	79,620	92,890	106,160	106,161
10	57,560	71,950	86,340	100,730	115,120	115,121
Add	Add $4,480 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

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»**

Income $_____(***monthly/biweekly/weekly***) ☐ 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	12,760	15,950	19,140	22,330	25,520	25,521
2	17,240	21,550	25,860	30,170	34,480	34,481
3	21,720	27,150	32,580	38,010	43,440	43,441
4	26,200	32,750	39,300	45,850	52,400	52,401
5	30,680	38,350	46,020	53,690	61,360	61,361
6	35,160	43,950	52,740	61,530	70,320	70,321
7	39,640	49,550	59,460	69,370	79,280	79,281
8	44,120	55,150	66,180	77,210	88,240	88,241
9	53,080	66,350	79,620	92,890	106,160	106,161
10	57,560	71,950	86,340	100,730	115,120	115,121
Add	Add $4,480 per person for families above 8					

Monthly Gross Income Calculations					
A	B	C	D	E	F
1,063	1,329	1,595	1,861	2,127	2,128
1,437	1,796	2,155	2,514	2,873	2,874
1,810	2,263	2,715	3,168	3,620	3,621
2,183	2,729	3,275	3,821	4,367	4,368
2,557	3,196	3,835	4,474	5,113	5,114
2,930	3,663	4,395	5,128	5,860	5,861
3,303	4,129	4,955	5,781	6,607	6,608
3,677	4,596	5,515	6,434	7,353	7,354
4,423	5,529	6,635	7,741	8,847	8,848
4,797	5,996	7,195	8,394	9,593	9,594

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