

**Sharon Community Health Center
2023 Sliding Fee Policy and Scale**

Sharon Community Health Center Sliding Fee Discount Policy

Effective Date March 15,2023

Policy: It is the policy of Sharon Community Health Center (SCHC) to make healthcare affordable by offering a sliding fee discount program to patients who qualify based on Household Size and Household Income level in accordance with the Federal Poverty Guidelines (FPG) as published and updated annually in the Federal Register. Patients shall have access to all services in SCHC's scope-of-service regardless of their ability to pay. Patients are responsible for the payment of the fee after the discount has been taken.

SCHC has a sliding fee discount (SFD) program that includes establishing a schedule of charges for the provision of services that is consistent with locally prevailing charges; and a corresponding schedule of discounts for eligible patients that is adjusted based on the patient's ability to pay; and is designed to cover the reasonable costs of operations for services approved scope-of-project. Sliding fee discounts shall be provided for healthcare services which there is an established charge, regardless of the type (required or additional) or mode of delivery (direct, by contract, or by formal referral agreement, as indicated on Form 5A.

SCHC's governing Board of Directors shall review and approve these policies and supporting operating procedures, including those regarding the billing and collections of patient accounts on an annual basis. The most recent evaluation was conducted in April 2022 by the Board.

For all eligible patients, SCHC has prepared and shall apply a SFD in which charges for healthcare services are adjusted based on the patient's ability to pay. SCHC's SFD program includes the following elements:

The SFD is applicability to all individuals and families with annual incomes at or below 200 percent of the Federal Poverty Guidelines (FPG). SCHC's has one category below 100% FPG, four discount pay classes above 100 percent and at or below 200 percent of the FPG, and the last category is for those above 200% PFG, (six categories in total).

- Full discount for individuals and families with annual incomes at or below 100 percent of the Federal Poverty Guidelines with a nominal fee. A nominal fee may be charged if determined to not create a barrier to service.
- Adjustment of fees (partial discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the Federal Poverty Guidelines.
- No sliding fee discounts for individuals and families with annual incomes above 200 percent of the Federal Poverty Guidelines.

SCHC makes every reasonable effort to obtain reimbursement from third party payers, including either public health insurance Medicaid, Medicare, and any other public assistance program or private health insurance for patients who have such coverage. These third-party payers are billed based on the full amount of charges for such services as negotiated through their contracts without application of any discount.

SCHC shall make its best effort to ensure that all patients are made aware of the sliding fee discount program. SCHC shall establish multiple methods for informing patients of the sliding fee discount program including signs in the lobby of each site, and communication with SCHC's patient registration staff. SCHC will ensure that information regarding the sliding fee discount program is available in appropriate languages and literacy levels for our target populations. SCHC will take every effort to ensure that patient privacy and confidentiality is protected throughout the process.

SCHC's Board of Director's shall evaluate the sliding fee discount program annually to determine that from the perspective of the patient the SFS does not create a barrier to service. Annually, the Board will review patient satisfaction surveys and seek input from the Board of Director "users" concerning any potential barriers.

Purpose: To provide health care services to patients based on their ability to pay. To ensure the continued financial viability of Sharon Community Health Center. To continue the provision of affordable medical services to those in need, special populations, and especially under-served populations.

Procedure:

- 1) The eligibility determination process will be conducted in an efficient, respectful, and culturally appropriate manner to assure that administrative operating procedures for such determinations do not themselves present a barrier to care.
- 2) All patients, including those with third party insurance, shall be given the opportunity to complete a sliding fee discount application form and provide documentation regarding household income and household size. **SCHC defines Household Size as:** anyone living in a traditional or non-traditional family unit that are tied together financially. If the patient is likely to be eligible for the Medicaid program or other governmental program, a Medicaid application form and documentation will be recommended to be completed. The completion of the Medicaid application form is not mandatory for the patient to apply for the sliding fee discount program. Patients without the ability to pay for services will not be turned away or denied access to health care services. **Individuals with third party insurance, who qualify for the Center's SFD, will not be charged a co-pay fee that exceed the corresponding SFD category fee for non-insured patients.**
- 3) Patients who apply for the Sliding Fee Discount Program are required to complete all the information requested on the registration form including a Sliding Fee Discount Application. SCHC will compute the sliding fee discount based on the patient's information provided. Without this documentation, the patient will receive a bill for the full amount of the charges, which are due at the time of service. If the patient requires a return visit to our health center in the future, SCHC will require that documentation be on file to continue qualifying for the sliding fee discount. If the required documentation is not on file, the patient will be charged SCHC's usual charges for the health care services provided.
- 4) The patient will sign a Patient Statement of Financial Responsibility indicating that he/she understands and agrees to pay the patient portion of the discounted fee at the time of service. If unable to make payment at the time of service, patient will be asked to sign a payment plan

agreement.

5) Sliding fee Discounts are assessed in part based upon annual Household Income. **SCHC defines Household Income as:** gross income for all persons living in a traditional or non-traditional family unit supporting the family unit. Proof of annual income and an application (see attachment B) form is required to determine patient's eligibility. Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself). Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. DO NOT include non-cash assistance such as food stamps, housing allowance, or other government subsidies. Adults (except for your Spouse) with zero income must provide required documentation.

The following items may be used as proof of income:

- a. W-2 form
- b. Pay stubs from the previous two (2) pay periods
- c. Income tax returns
- d. Social Security or Unemployment benefit check stub
- e. Other income documentation (e.g. Letter from your employer stating your gross monthly income, certified letter of support from a benefactor)

Inability to provide income verification will not prevent patients from being treated in the health center. Income verification can be obtained by documentation mailed or delivered to SCHC following the patient visit. The application/registration form is completed and signed by the patient applying for the Sliding Fee Discount, and witnessed by the staff person assisting the patient in filling out the form. The proof of income documents is photo copied, attached to the registration/application form and filed/scanned into the patient record. Eligibility shall be determined once a year. No asset verification applies.

6) Administrative exceptions can be made for patients under certain circumstances. SCHC provides an alternative mechanism for determining patient eligibility for the SFD for circumstances in which documentation/verification is unavailable (self-declaration) or under hardship circumstances. The patient must complete the self-declaration statement to qualify for a sliding fee discount. Self-declaration should be a onetime use. Administrative exceptions may be made by SCHC's Executive Director or Office Manager.

7) The Registration or Billing Department staff shall review the sliding fee discount application and determine patient eligibility for level of discount. Level of discount and the patient portion will be noted in the patient billing record and the patient will be advised of the outcome of the review.

8) Discounts are effective for twelve months. At the end of the period of eligibility (twelve months), the patient will be requested to reapply including documentation regarding family size and income. A patient may reapply for sliding fee discount at any time their financial circumstances change.

9) After the patient has been approved (or re-approved) for sliding fee discount, the Billing

Department will discount services which occurred up to thirty (30) days before the sliding fee approval date.

10) The patient may make a request for a review of the discount. The Billing Department staff will conduct the review for appropriateness. A patient who disagrees with the requirements of this policy will have the ability to appeal the determination process.

11) Important attributes of income for check stubs would be to calculate the monthly salary by. Using the following formula: Pay stubs with a pay period of Bi-Weekly (two-week period), multiply the gross pay by 26 and divide the results by 12. Pay stubs with a pay period of Semi-Monthly (fifteen-day period), multiply the gross pay by 24 and divide the results by 12. Pay stubs with a pay period of weekly, multiply the gross pay by 52 and divide the results by 12.

For W-2: Locate the total wages and divide the amount by 12 to calculate the monthly salary. For Tax Return: Locate the gross income amount and divide the amount by 12 to calculate the Monthly salary.

APPEAL RIGHTS

The patient shall have thirty days from the date of this notice to appeal any charity determination. The patient may challenge the level of charity granted as well as complete denial. The patient must contact an SCHC Representative who will schedule the appeal with one of SCHC's management staff. The patient must be prepared to substantiate facts previously submitted that were excluded from the determination due to lack of verification. If the patient has new, updated information to support the patient's claim, bring it to the meeting.

The charity guidelines are straightforward, and determinations are made based upon the facts the patient submits. Special consideration may be granted when unusual circumstances of medical hardship exist. The patient should be prepared to explain and substantiate unusual circumstances. S C HC's staff will decide the appeal and notify the patient of the decision within seven (7) calendar days.

Sliding Fee Discount Schedule

Attachment A

2023	At or below 100% of FPG	At or below 125% of FPG	At or below 150% of FPG	At or below 175% of FPG	At or below 200% of FPG	At or above 201% of FPG
	Category A	Category B	Category C	Category D	Category E	Category F
Household Size	If you make no more than:	If you make no more than:	If you make no more than:	If you make no more than:	If you make no more than:	If you make more than:
1	\$14,580	\$18,225	\$21,870	\$25,515	\$29,160	\$29,306
2	\$19,720	\$24,650	\$29,580	\$34,510	\$39,440	\$39,637
3	\$24,860	\$31,075	\$37,290	\$43,505	\$49,720	\$49,968
4	\$30,000	\$37,500	\$45,000	\$52,500	\$60,000	\$60,300
5	\$35,140	\$43,925	\$52,710	\$61,495	\$70,280	\$70,631
6	\$40,280	\$50,350	\$60,420	\$70,490	\$80,560	\$80,963
7	\$45,420	\$56,775	\$68,130	\$79,485	\$90,840	\$91,294
8	\$50,560	\$63,200	\$75,840	\$88,480	\$101,120	\$101,626
Each additional person above 8	\$5,140	\$6,425	\$7,710	\$8,995	\$10,280	\$10,331

**This chart is the HHS Federal Poverty Level Guidelines for the 2022 (Source: Federal Register 1/19/23)
Effective 1/19/2023**

Attachment B

**SLIDING FEE DISCOUNT APPLICATION FORM
SECTION I**

Name: _____ Date: _____
(First) (Middle Initial) (Last)

Social Security Number: _____ Date of birth: ____/____/____
(MM) (DD) (YYYY)

Marital Status: Single Married Divorced Widow Spouse name: _____

Patient name: _____ Applicant relationship to patient: _____

**HOUSEHOLD SIZE &
HOUSEHOLD INCOME
SECTION II**

Household Size: SCHC defines Household Size as all children and adults living in a traditional or non- traditional family unit that are tied together financially.

Household Income: SCHC defines Household Income as gross income for all persons living in a traditional or non -traditional family unit supporting the family unit. Please list everyone living in your home (including yourself) or anyone you have financial responsibility for. Include anyone at least 18 years of age or older who reside in the household and contribute to the basic living expenses of the household (including yourself). Income includes gross (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, pensions and/or IRA distribution income or other retirement income, etc. DO NOT include non-cash assistance such as food stamps, housing allowance, or other government subsidies. In order to be considered a household member, the person must be listed below. Adults (except for your Spouse) listed below with zero income must provide required documentation.

Name (first and last)	Age	Source of income or Employer Name	Monthly Income
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please include income documentation for each ADULT listed above.

Household Income:

Total estimated gross income: \$ _____

Household Size:

Total # of adults (18 years of age and older): _____

Total # of children (under the age of 18): _____

Total # of household members: _____

Witnessed by CHC staff _____

COMMUNITY HEALTH CENTER

Attachment B

**HOUSEHOLD INFORMATION
SECTION II (continued)**

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee discount program and will subject me to penalties under Federal Laws which may include fines and imprisonment. I further agree to inform Community Health Center if there is a significant change in my income. If acceptance to the sliding fee program is obtained under this application, I will comply with all rules and regulations of Community Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

I consent to the release of any and all of my financial records including but not limited to: sliding fee scale application and supporting documentation, patient information, insurance information, and any other types of information contained within my electronic health and/or dental records that may be deemed necessary for review by any auditor, for participating in any assistance programs including but not limited to sliding fee scale, grant-funded programs and/or pharmacy assistance programs for which I may be eligible.

Date: _____

Name (Print): _____

Signature: _____

Witnessed by SCHC staff _____

Self-Declaration of Income

Attachment C

My annual household income is \$_____. Total # of household members:

I, _____, attest the income I have stated is complete and accurate information to the best of my knowledge. I, further understand, that during the verification process should my information be found lacking, I forfeit the discounts afforded to me and will be held liable for the patient charges associated with the patient visit.

I have been informed that the Self Declaration of Income is valid for 30 days and I must provide the required income documentation in order to complete a Sliding Fee application upon expiration of Self Declaration.

I understand that if I do not provide the required documentation, I can continue to receive my health care services at Community Health Center but I will have to pay 100% of my medical bill.

Signature

Date

Witnessed by SCHC staff