Sliding Fee Discount Policy (SFDP)

POLICY: Community Health Programs, Inc. (CHP) is committed to making health center services available to all, regardless of the ability to pay.
CHP will reduce patient financial responsibility for medically necessary and appropriate treatment in situations where the individual qualifies under the guidelines of this policy and cooperates with CHP in the administration of this policy and related procedures for CHP services.
CHP will evaluate its SFDP annually in synch with the updated federal poverty guidelines (FPGs) to ensure the program is not creating any financial barrier to care. CHP will utilize Uniform Data System (UDS), other patient income and family size information it gathers, as well as Patient Satisfaction Surveys to evaluate the utilization, effectiveness, and affordability of the SFDP. Annually, CHP will present the updated program to its Board of Directors which will incorporate the updated FPGs as well as findings from the annual evaluation and any recommendations.

DEFINITIONS:

1. For purposes of this policy, the terms "patient," "patients," and "applicant" refer to individuals and their families who are served by CHP.
2. Income is defined as employment and cash earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' benefits, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance (scholarships and grants used for living expenses), and alimony.
3. Gross Income means income before taxes are taken out.
4. Noncash benefits (such as child food stamps and housing subsidies) are not counted as income, as is child support.
5. The definition of "family unit size" used by CHP is: Mother, Father, Children, Domestic Partner, Husband, Wife, and any dependent minor who is supported by the family unit and benefits from the combined household income. *Roommates do not qualify as family*.

PROCEDURE:

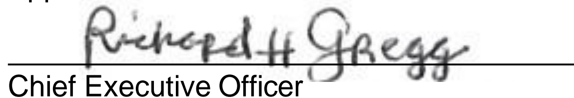
A. CHP sliding fee scale policy will be managed by the head of the revenue cycle department. In general, the following procedures will apply:
   1. The patient assistance coordinator/enrollment specialist will make a determination of eligibility for sliding fee scale. All approvals or denials of this reduced fee program will be provided in writing to the applicant. The patient's account will be documented with the result of the determination.
   2. If, as a result of the financial review, the patient does not qualify for sliding fee scale, the patient/guarantor will be advised to arrange payment according to CHP's self-pay policy.
   3. The level of assistance to be provided, **full or partial**, will be determined by an evaluation and analysis of the patient's income and family size. The latest Federal Poverty Income Guidelines (FPIG) issued by the Department of Health and Human Services will provide the basis for determining an individual's ability to pay.
   4. Any/all charges for patients at or below 100% of the FPIG will be charged a nominal fee.

5. In order to assure uniform application of this policy, all charges will be recorded in accordance with the normal procedure used for all patients. Charges will not be withheld. The sliding fee scale is to be applied equally to all patients who qualify for the program.
6. Quarterly, each applicant will be required to complete a confidential **sliding fee scale application** and provide such information as CHP deems necessary. At a minimum the patient will be required to provide as proof of income, copies of at least four recent weeks' worth of pay stubs, their federal income tax return from prior year or no more than 24 months, or a written statement by their employer documenting their employment status. Bank statements are not an acceptable form of income verification.
7. The completed application and supporting documents must be submitted directly to the CHP patient advocate/enrollment specialist or mailed to their attention at Community Health Programs, Inc., P.O. Box 30, Great Barrington, MA 01230. Upon receipt, the application will be reviewed and processed in accordance with the eligibility criteria.
8. Sliding fee discounts may be granted to patients on their initial visit based on self-reporting (documentation is not required). However, income documentation will be required for discounts after the initial visit.
9. Signs are to be prominently posted in all CHP locations in languages appropriate to the patient population explaining that the Sliding Fee Scale is available to eligible uninsured and underinsured patients.
10. Sliding fee discount program (SFDP) applies to all required and additional health services within the HRSA-approved scope of project for which there are distinct fees. For those situations in which CHP has a written referral agreement with a third-party provider and that third-party's charity care/discount policy is more favorable to the patient than CHP's sliding fee policy, a copy of that third-party's charity care/discount policy will be attached to this policy. CHP patients will receive the same or better discount from any formal referrals under written agreement. At present no such more-favorable agreements are in place.
11. Sliding fee discounts are not available for certain equipment or hardware such as dental hardware/dentures.

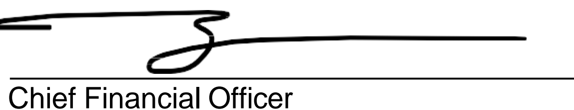
ATTACHMENTS:

1. Sliding Fee Scale 2023
2. Sliding Fee Scale Application

Approved By:



Chief Executive Officer — Date: 3/9/23



Chief Financial Officer — Date: 3/9/23

Chair, Board of Directors — Date: 3/9/23

COMMUNITY HEALTH PROGRAMS
healthy people • families • communities

SLIDING FEE SCALE 2023
(Annual income thresholds)

As a **HRSA-supported** federally funded health center, CHP is able to provide financial assistance to **<u>all patients that qualify</u>** using the sliding fee scale below:

Family Unit Size	$10.00 Nominal Fee	20% pay	40% pay	60% pay	80% pay	100% pay
Poverty	**100%**	**125%**	**150%**	**175%**	**200%**	**201%**
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	$49,969
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

Note: The income ceiling for the minimum fee pay class is equal to the federal poverty level. The 2023 federal poverty guideline increases by $5,140 for each additional family member.

- CHP will provide a **full discount** to patients and families with annual incomes at or below 100% of the federal poverty guidelines and only *a nominal fee of $10.00 will be charged.*

- CHP will provide a **partial discount** to patients and families with annual incomes between 100% and 200% of the federal poverty guidelines. Fees will be charged in accordance with the sliding fee scale table above.

- No discounts may be provided to patients with incomes over 200% of the federal poverty income guidelines.

- Eligibility must be verified prior to enrollment and once quarterly thereafter. Once verified by the Patient Assistance Coordinator/Enrollment Specialist, discount rates will be effective upon

- enrollment or, for those already enrolled, on the 1st day of the month following income verification. **Discount rates may be retroactive up to 6 months**.

- At the time of verification, the patient will receive notice of which bracket they qualify for on the sliding fee scale. CHP will draw up a “SLIDING FEE SCALE LETTER AND WAIVER” for the relevant services, including the reduced rate, for the patient to sign.

- Separate from this Sliding Fee Discount Program, CHP has a Waiver of Fees policy which is administered by the Director of Revenue Cycle or the Executive Vice President of Finance and Chief Financial Officer.

CHP SLIDING FEE SCALE APPLICATION

Dear Applicant(s):
Community Health Programs (CHP) offers a sliding fee scale to uninsured/underinsured patients and their families. Eligibility for the sliding fee scale is based on patient's family unit size and anual household income. Please complete this application as much as you can. **Eligibility must be verified prior to enrollment and once quarterly thereafter.** Once verified by the CHP Patient Assistance Coordinator/Enrollment Specialist, reduced fees will be effective upon enrollment or, for those already enrolled, on the 1st day of the month following income verification. In the event a family experiences a substantial drop in income, they have the option of going through the verification process again at any time. Thank you for your cooperation.

APPLICANT INFORMATION

First name_______________________________Last name__________________________________
SS# (optional)_______________________Date of birth__________________ Berkshire Co. resident? **YES / NO**
Home address: ____
____ Homeless? **YES / NO**
Mailing address if different: ____
Tel. (home/work)______________________________________(*Circle one*: Male / Female)

OTHER FAMILY MEMBERS (spouse or children under 19 living with you)

Name____Date of birth_____________
Name____Date of birth_____________
Name____Date of birth_____________
Name____Date of birth_____________

EMPLOYMENT STATUS

Are you **unemployed**? **YES / NO**
Do you get unemployment benefits? **YES / NO** How much a week? $__________________

Who is working in the family? *
1.____(*Circle one*: full time / part time)
Number of hours per week:_____________Amount paid per hour: $__________________
Employer name/address/tel.: ____
2.____(*Circle one*: full time / part time)
Number of hours per week:_____________Amount paid per hour: $__________________
Employer name/address/tel.: ____
IF SELF-EMPLOYED, annual income after deductions: $_________________________
**** Please provide 2 recent pay stubs, or federal income tax return, or signed statement by the employer.***

MISCELLANEOUS

- Do you or any family member have any other source of income (*Social Security, pension, worker's compensation, child support, etc.*)? **YES / NO** (if yes, how much? $_____________)
- Are you covered by any health insurance (*Medicare, MassHealth, CommCare*)? **YES / NO**

The above information is true to the best of my knowledge.

Applicant's signature: ______________________________________Date: ___________________________