Crossing
HEALTHCARE

320 East Central Ave. Decatur, Illinois 62521, (217) 877-9117

SUBJECT: Sliding Fee Discount Policy

EFFECTIVE: 03/2015, 8/2015, 12/2015, 02/2016, 03/2017

POLICY STATEMENT:

It is the policy of the Community Health Improvement Center d/b/a Crossing Healthcare to provide free or discounted medical services to all patients regardless of their ability to pay. A sliding fee discount program is established to assist patients at or below the 200% poverty line. Patients above 200% poverty do not qualify for the sliding fee program. The program eligibility is based upon a person's financial means and household size. The program will not discriminate on the basis of age, gender, race, creed, disability or national origin. The Federal Poverty Guidelines, http://aspe.hhs.gov/poverty/16poverty.cfm, are used to annually update the center's sliding fee discount schedule.

IMPLEMENTATION/PROCEDURE:

- Crossing Healthcare will notify all patients of the sliding fee policy upon registration. The center will also provide notification in the waiting area and website. The notification and schedule are offered in English and Spanish. **No one is refused service because of lack of financial means to pay**.

- Individuals seeking healthcare at Crossing Healthcare will be served regardless of ability to pay. **No one is refused care due to ability to pay.**

- Information and applications regarding the sliding fee program are available in the Registration and/or Billing Department. It is the patient's responsibility to complete the application in its entirety including documents validating income. Assistance is available to complete applications for patients when needed. By signing the application, the patient confirms the information is accurate and true. **Discount eligibility** will be based on **family size** and **income** only. The information provided on the application will determine the placement on the sliding fee schedule. Crossing Healthcare uses the Census Bureau

definitions of each:

- **Family Size:** A family consists of two or more people (one of whom is the householder) related by birth, marriage, or adoption residing in same housing unit.
- **Income:** Includes one or more of the following,
    - ✓ Earnings
    - ✓ Unemployment compensation
    - ✓ Worker's compensation
    - ✓ Social Security
    - ✓ Supplemental security income
    - ✓ Public Assistance
    - ✓ Veterans' payments
    - ✓ Survivor benefits
    - ✓ Disability benefits
    - ✓ Pension or retirement income
    - ✓ Interest and Dividends
    - ✓ Rents, Royalties, and estates and trusts
    - ✓ Educational assistance
    - ✓ Alimony, child support
    - ✓ Financial assistance from outside the household
    - ✓ Other Income

  Non-cash benefits that do not count as income: food stamps and housing subsidies.
- **Income verification:**
    - ✓ Two most recent pay stubs
    - ✓ Letter from employer
    - ✓ Letter from Social Security Administration
    - ✓ Self-employed: Most recent 3-month income statements of business.

➢ All eligible patients are required to make a nominal payment of $10.00 at the time of the visit. **No patient will be denied service for inability to make nominal payment.** For patients at the "A" level (incomes at or below 100% of poverty), this will be their nominal fee and there will be no additional charges billed. At no time will services be discounted below the nominal $10.00 fee. Application period is calendar year, January 1 to December 31. After January 1, the patient will need to reapply and provide documentation of income to receive sliding fee discount. If there are significant changes in income or family size within the 12 month period, the patient may submit the changes at any time for reevaluation.

- In certain situations, a patient may not be able to pay nominal fee and/or charges. If the case is approved by Executive Director, Finance Director, or Clinical Director, a waiver can be issued. Documentation of waiver will be placed in patient file under EPM notes by the billing department.

- If a patient refuses to complete paperwork for assessment, the remaining balance on the visit will be charged with no applicable discount.

- The sliding fee discount policy and scale will be reviewed annually by the Board of Director's Finance Committee. The Finance Committee consists of professional and user members of the Board of Directors. The policy will be updated based on current federal poverty guidelines. Information of budget vs. actual patient care will be reviewed to determine if changes in policy and procedure need to be improved to prevent eligible patients from having access to care. Results from biannual patient's satisfaction surveys will also be available for decision making by the board. Financial pertinent questions are:
    - Do you understand what we ask you to pay for your care?
    - Do you feel what you pay is reasonable?

  Any changes to the policy will be presented to and approved annually by the Board of Directors for operational development.

Sliding Scale for Office Visit Charges for Patients FY 2017

	A	B	C	D	E
Household Size	Household Income <100% FPG	Household Income 101% - 150% FPG	Household Income 151% - 175% FPG	Household Income 176% - 200% FPG	Household Income 200%> FPG
1	0 - 12060	12061 - 18090	18091 - 21105	21106 - 24119	24120 +
2	0 - 16240	16241 - 24360	24361 - 28420	28421 - 32479	32480 +
3	0 - 20420	20421 - 30630	30631 - 35735	35736 - 40839	40840 +
4	0 - 24600	24601 - 36900	36901 - 43050	43051 - 49199	49200 +
5	0 - 28780	28781 - 43170	43171 - 50365	50366 - 57559	57560 +
6	0 - 32960	32961 - 49440	49441 - 57680	57681 - 65919	65920 +
7	0 - 37140	37141 - 55710	55711 - 64995	64996 - 74279	74280 +
8	0 - 41320	41321 - 61980	61981 - 72310	72311 - 82639	82640 +
Each add'l member add:	$4,180	$6,270	$7,315	$8,360	$8,360
	Nominal Fee $10	25% Charges	50% Charges	75% Charges	100% Charges

FPG - Federal Poverty Guidelines

Household Size - Members of household supported by the reported income

Household Income - Gross income documented on federal tax return, pay stubs or unemployment award letter

Patient Income Information

Medical Record #_____ Name_____ Date of Birth _____

Address _____

Please Verify Your Monthly Household Gross (before taxes) Income:

Number of People Living in Your Household:

Monthly Earnings:

Salary/Wages	$_____
Unemployment Compensation	$_____
Social Security Income	$_____
Supplemental Security Income	$_____
Veteran's Payments	$_____
Disability Benefits	$_____
Pension/ Retirement Income	$_____
Alimony/Child Support	$_____
All Other Income	$_____
No Reportable Income (Enter $0.00)	$_____
TOTAL Monthly Household Income	$_____

Verification Documents:

Two Most Recent Pay Stubs.

Letter From Employer.

Unemployment Benefits Letter.

Social Security Letter.

3 Months of Income Statements if Self Employed.

Other Documentation.

Attention: ALL OTHER INCOME includes Workmen's Compensation, Public Assistance, Survivor Benefits, Interest, Dividends, Rents, Royalties, Estates, Trusts, Educational Assistance, Financial Assistance from Outside the Household, etc.

DO NOT INCLUDE food stamps and housing subsidies.

Please Note: Please provide income verification by submitting copies of the applicable verification documents listed above.

With my signature, I confirm that all above information is true and accurate and subject to determining my eligibility for special programs and possible billing reductions. Should any financial or demographical information change, I will report the correct updated information to Crossing Healthcare immediately.

Patient/ Guardian Signature: _____ Date: _____

Witness: _____

Patient Refusal to Provide Income

Crossing Healthcare offers to its patients a sliding fee discount based on Federal Poverty Guidelines for the year. The information provided on the Patient Income Information sheet and Income Verification Documents obtained, determine the patient's placement on the sliding fee scale, specifically family size and income.

The following patient has elected not to provide income information or verification to Crossing Healthcare.

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

With my signature, I confirm that I have been asked to fill out a patient income form and provide income verification documents for Crossing Healthcare. I understand that refusing to fill out these papers will render me ineligible for any billing discounts for my dates of service. I understand that this will result in me being responsible for all charges at full price as a self-pay patient or any remaining charges after my insurance has been submitted.

Patient/Guardian Signature: _____ Date: _____

Witnessed by (Crossing Healthcare Staff) _____

Patient Income Calculation

Patient income is figured using the family size and income of the patient. If either one of these items have not been filled out on the Patient Income Information sheet, the information for the sliding fee cannot be calculated.

Patient income includes, Salary/Wages, Unemployment Compensation, Social Security Income, Supplemental Security Income, Veteran's Payments, Disability Benefits, Pension/Retirement Income, Alimony/Child Support, Workmen's Compensation, Public Assistance, Survivor Benefits, Interest,
Dividends, Rents, Royalties, Estates, Trusts, Educational Assistance, and Financial Assistance from outside the household. Food Stamps and Housing subsidies are not included.

The registration desk will have a new patient or established patient that requires income validation or revalidation fill out the Patient Income Information form. Registration staff will witness their signature on the form. The form will then be put in the appropriate box to be sent to billing.

Members of the billing staff will collect these forms and after checking the correctness of the forms and their computations, a billing staff member will enter the appropriate family size and income information into the EPM system. If necessary, an alert will be created in the system as a reminder that income verification documents are still needed. The income forms will be passed along to a second billing staff member for double verification. After completion the forms will be given to the E H R support staff for scanning into the patients account.

Income should be put in the EPM as a monthly figure.

Figuring Salary/Wages from a patient/guardian paycheck:

Weekly Paycheck: Multiply the hourly rate by the number of hours worked on the paycheck, not to exceed 40 hours per week and not including overtime hours. If there are two paychecks, add the number of hours together, not to exceed 80 hours and not including overtime hours. Divide this number by 2 to get average hours per week. Multiply that figure by 52 weeks. Divide by 12 months. This is the gross income per month. Add to other monthly earnings for the Total Monthly Household Income.

Biweekly Paycheck: Multiply the hourly rate by the number of hours worked on the paycheck, not to exceed 80 hours per week and not including overtime hours. If there are two paychecks, add the number of hours together, not to exceed 160 hours and not including overtime hours. Divide this number by 2 to get the average hours per biweekly paycheck. Multiply that figure by 26 weeks. Divide by 12 months. This is the gross income per month. Add to other monthly earnings for the Total Monthly Household Income.

APPLICABLE TO:

All Employees

APPROVED BY:

Thomas R. West
Chief Financial Officer

5/8/17
Date

Chief Executive Officer

5/8/17
Date

Board Chairman

5/4/17
Date