Policy Name:	Sliding Fee Discount Program	APPROVAL PROCESS	
Policy Administrator:	Senior Director, Revenue Cycle	Revenue Cycle Committee Reviewed:	3/6/2023
Revision Date:	3/6/2023	CFO Approval:	3/10/2023
Review Frequency:	Board - every 3 years, Policy Administrator - annually	CEO Approval:	3/15/2023
Next Revision Date:	3/2026	Board Approval Date:	3/15/2023

Distribution: Patient Service Center, Patient Accounts Staff, Compliance Officer, Program Managers and Directors

Purpose:
To provide affordable access to care by reducing financial barriers to Lowell Community Health Center's patients.

Policy Statement:
LCHC offers a sliding fee scale discount program to all community health center patients with income at or below 200% of the Federal Poverty Level (FPL). Patients with income at or below 100% of the FPL may be offered a nominal fee. No discounts are provided to patients with income over 200% of the FPL, with the exception of prompt payment incentives, if applicable. No patient will be denied access to care based on inability to pay.

Definition(s):

Family: A family includes one or more people living in the same household who are related by birth, marriage, or adoption.

Income: Gross income received on a regular basis (exclusive of certain money receipts such as capital gains and lump-sum payments) before payments for personal income taxes, social security, union dues, Medicare deductions, etc.

Federal Poverty Level Guidelines (FPLG): poverty guidelines published annually by the U.S. Department of Health and Human Services ("DHHS"). See Attachment A.

Sliding Fee Scale Discount (SFSD): A discount that is applied to patients who are 200% of the poverty level or below based on their family size and income. This discount is applied to the full fee schedule.

Procedure(s) and Guideline(s):

1. **Program Review and Approval**
    a. The Lowell Community Health Center (Lowell CHC) Board of Directors will:
        i. Approve all changes to this policy and related schedule of discounts, standard operating procedures (SOP) and/or workflow.

ii. Review discount schedule, policy and procedures every three years to ensure the program is patient centered, improves access to care, and assures that no patient will be denied health care services due to an inability to pay.

iii. Review that the nominal fee is nominal from the patient's perspective and would not reflect the actual cost of the service being provided. As part of the review, consumer board members provide input and confirm affordability of the nominal fees presented. Additionally, Lowell CHC conducts a patient experience survey which captures feedback on a patient's ability to pay.

2. Program Communications

a. LCHC will communicate the Sliding Fee Discount Program information to patients, including eligibility and income verification requirements.

i. Program communications will be multilingual and will be included in waiting area signage, patient handouts and the Lowell CHC public website.

3. Denial of Care

No patient will be denied care based on their inability to pay. No aspect of the Sliding Fee Scale Discount program (SFSD), including Lowell CHC's fees themselves, the procedures for assessing patient eligibility or the procedures for collection payments, will create a barrier for the patient to health care services.

4. Eligibility Determination

a. LCHC Health Benefit Advisor will make all efforts to assist uninsured and underinsured patients in obtaining insurance coverage. A patient's willingness to apply for insurance will not be a condition of eligibility for the SFSD program.

b. The patient must provide proof of income and declare their family size based on the definition within this policy. The Health Benefit Advisor will use the most recent FPLG in conjunction with the information the patient provided to compute the patient's federal poverty level. - See Attachment C

i. If a patient does not have access to the income documents on the day of their appointment, the Health Benefit Advisor will grant a one-time waiver and charge the patient the nominal fee. The Health Benefit Advisor will ask the patient to bring their income verification documents to their next visit.

ii. If a patient or the family members within their household do not have income, the Health Benefit Advisor will assist the patient in writing a letter of attestation stating there is currently no income within their household.

c. The sliding fee scale will be applicable for one year from the date of application. Patients must be re-certified annually, as needed. If the patient's income has changed within the approved year, they are required to contact the Health Benefit department.

d. It is the policy of Lowell CHC that sliding fee scale discounts shall be applied in a prospective manner. However retroactive coverage may be considered for provision of retroactive discounts, as long as documentation can be provided in support of eligibility during the period of time in question. Discounts may not be more than three (3) months retroactive.

5. Eligibility for insured and underinsured Patients

Discounts for insured and/or underinsured patients will be applied to the patient responsibility (co-pay, deductible or coinsurance) based on the same eligibility guidelines as the uninsured and/or underinsured. An insured patient will not have greater out-of-pocket responsibilities than

an uninsured and underinsured patient will be at the same FPL as long as it is not precluded or prohibited by the applicable insurance contract.

6. **Sliding Fee Discount**
    a. Patients at or below 100% of the FPL will receive a full discount on services for Medical, Behavioral Health and Vision Care. A nominal fee will apply for Dental, Acupuncture, and Massage Therapy. Full fee is required for contact, fitting and eyewear.
    b. Patients between 101% and 200% of the FPL will receive a sliding discount based on their FPL and services rendered.
    c. No discounts will be provided to any patients above 200% of the FPL.

7. **Third Parties Providing Care to LCHC Patients**
    a. For services within Lowell CHC's approved scope of project, which are provided by contract or referral agreement, the Director of Patient Accounts reviews and maintains documentation of third-party sliding fee discounts to ensure that they meet or exceed LCHC's sliding fee policy discounts and make certain that financial barriers to care are minimized.
    b. Lowell CHC makes every effort to ensure that contracts with third parties within Lowell CHC's scope of services are compliant with HRSA sliding fee scale requirements. When compliance cannot be attained through the contract, Lowell CHC will negotiate with the third party on a patient-by-patient basis to ensure the patient's financial responsibility does not exceed the responsibility outlined in LCHC's sliding fee scale policy.

8. **Vision Products**
    a. Patients will be notified of these out-of-pocket costs prior to visits.

References: HRSA Compliance Manual

Previous Revisions/Review Dates: 3/15/2017, 2/15/2018, 10/11/2019

Attachments: (A) 2023 Federal Poverty Guidelines, (B) Lowell CHC 2023 Sliding Fee Discount Scale, (C) Lowell CHC Sliding Fee Discount Program Application

Bruce Robinson (Jun 12, 2023 16:19 EDT)

Chair of the Board of Directors

CY2024 Poverty Levels and Sliding Fee Schedule

Sliding Fee Discount Program Policy Updated Attachments A & B (*March, 2024*)

Poverty Levels	0% - 100%	101% - 125%	126% - 150%	151% - 175%	176% - 200%	Over 200%
* Family Size	Annual Income-Less Than:					
1	15,060	18,825	22,590	26,355	30,120	>30,120
2	20,440	25,550	30,660	35,770	40,880	>40,880
3	25,820	32,275	38,730	45,185	51,640	>51,640
4	31,200	39,000	46,800	54,600	62,400	>62,400
5	36,580	45,725	54,870	64,015	73,160	>73,160
6	41,960	52,450	62,940	73,430	83,920	>83,920
7	47,340	59,175	71,010	82,845	94,680	>94,680
8	52,720	65,900	79,080	92,260	105,440	>105,440
Visit Type	Patient Responsibility					
Medical/Behavioral	$0	$10	$20	25	$30	Full Fee
Acupuncture/Massage Therapy visit	$16	$22	$26	32	$36	Full Fee
****Vision Care Visits**	$0	$10	$20	25	$30	Full Fee
Preventative and diagnostic dental visits	$5	$20	$25	30	$35	Full Fee
Emergency dental treatment visits	$15	$30	$35	40	$45	Full Fee
Routine dental treatment visits	$30	20% of full fee	40% of full fee	60% of full fee	80% of full fee	Full Fee
Root canal treatment dental visits	$40	20% of full fee	40% of full fee	60% of full fee	80% of full fee	Full Fee
Outside lab dental visits	Full lab fee +10% of difference between lab fee and full procedure fee	Full lab fee +20% of difference between lab fee and full procedure fee	Full lab fee +40% of difference between lab fee and full procedure fee	Full lab fee +60% of difference between lab fee and full procedure fee	Full lab fee +80% of difference between lab fee and full procedure fee	Full Fee

***For family units with more than 8 persons, add $5,380 for each additional person**

**Lowell CHC offers optional optical products, including contact lens and evaluation at full fee. Lowell CHC also offers a range of package pricing for eye wear and maintains a family fund that covers the charge of non-premium glasses for eligible applicants.

SLIDING FEE ELIGIBILITY FORM

This Sliding Fee Discount is for patients with or without insurance and is based only on family size and income. This information will be kept on file in our center in strict confidence. You will be required to provide proof of income and information about your household, your annual income will be used to calculate the level of your payment. This application will be valid for 12 months. This information will not affect your ability to receive care at Lowell CHC.
This Eligibility form will be used to determine discounts for Medical, Behavioral, Dental and Eye Care services.

Medical Record #

ATIENT INFORMATION

Last Name:	**First Name:**
Date of Birth:	**Gender:** ☐ F ☐ M

ADDITIONAL INFORMATION OF ALL INDIVIDUALS LIVING IN THE HOUSEHOLD
Please provide Names, DOB and SSN (if one has been issued) for all individuals living in the household:

Name	Relationship	Date of Birth	SSN (optional)	Patient at LCHC?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐

Is anyone in the household pregnant? Yes ☐ No ☐ #_____

INCOME INFORMATION

Number of people living in your home (Family size):

Wages/Salary income before deductions(gross):

You:	Your Spouse:
$ _____	$ _____
Weekly ☐ Biweekly ☐ Monthly ☐	Weekly ☐ Biweekly ☐ Monthly ☐

OFFICE USE ONLY

☐ **APPROVED** from _____to _____

☐ **DENIED** reason: _____

FPL % _____**Co-pay** _____**HB Staff** _____

Do you receive any income from any of the following sources? ☐ Yes ☐ No **If Yes, how much?** _____

Sources	You	Your Spouse	Your Children	Other person
Social Security				
DTA – Cash assistance				
Retirement Pension				
Rental Income				
Interest Income				
Child Support, Alimony				
Other (Specify)				

I do hereby affirm that the information provided on this application is true and correct to the best of my knowledge. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the sliding fee program and will subject me to penalties under Federal Laws. I further agree to inform Lowell 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 Lowell Community Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

Signature:	Date:

Revised: 06/2021

SLIDING FEE REQUIREMENTS

Lowell Community Health Center is committed to ensuring you and your family is able to receive the care that you need regardless of your financial status.

This is why we offer a discounted fee for patients and their families who are below 200% of the federal poverty guidelines. This is called a "sliding fee scale"; eligibility is based on family size and income.

Family/Household includes immediate family members such as: yourself, your spouse, unborn children and your children under the age of 18.

Our Sliding Fee Scale applies to the following services: *Medical, Dental, Vision and Behavioral Health services.*

Federal poverty levels change every year, it is your responsibility to apply on a yearly basis depending on your need or if your situation changes.

HOW TO APPLY FOR THE SLIDING FEE DISCOUNT

Please complete the sliding fee eligibility form and provide the required proofs:

1. Photo identification (ex: license, passport, state ID)
2. Information about the individuals in your immediate household: self, spouse, unborn children, and your children under the age of 18.
3. 2 weekly paystubs or 1 bi-weekly paystub, or a letter from employer stating number of hours, hourly wage, and how often paid.
4. Social security, disability, or pension benefit statements
5. Documentation of other governmental assistance
6. Self-employed individuals - copy of the most recent Federal Income Tax Form 1040, Schedule C
7. <u>If no income</u> – A written, self-declaration explaining financial situation.

If you have any questions, please feel free to ask to speak to a Health Benefits Advisor.