


Policy #: 2402	Policy Title: Federal Sliding Fee Scale
Department: Finance	Author/Editor: S. Burke, D. Huffman, J. Lefebvre, K. Cournoyer Revision date(s) : 11/04, 3/05, 5/07, 4/08, 4/09, 3/10, 4/10, 02/11, 4/12, 04/13, 2/14, 06/14, 3/16, 4/3/17, 4/9/18, 2/25/19, 6/10/19, 5/27/20, 4/26/21, 4/04/2022 Review Date(s): 8/10
Original Author: S. Burke Effective Date: 11/03	Accreditation Standard(s):
Reference(s): (optional – if included, listed at end document)	
Approvals:  Louis Brady, President/CEO	

POLICY STATEMENT

The provision of high quality primary care services to underserved populations is the mission of the Family Health Center of Worcester, Inc. (FHCW). FHCW is committed to providing high-quality, integrated care to all patients through the Patient Centered Medical Home Model. FHCW Policies and Procedures will be consistent with the goals, mission and clinical guidelines of the organization.

PURPOSE

This policy is to ensure that all Family Health Center of Worcester, Inc. (FHCW) patients have access to services for which there is a health center charge regardless of ability to pay so that the costs to the patient do not present a barrier to care. This policy outlines the principles governing the Sliding Fee Scale discounts (SFSD). This policy is in compliance with Section 330(k)(3)(G) of the Public Health Service Act, 42 C.F.R. § 51c.303(f) and applicable Health Resources and Services Administration (HRSA) policy regarding providing a schedule of fees for services and a corresponding schedule of discounts for eligible patients that is adjusted based on the patient's ability to pay. The SFSD is available to patients whose documented income does not exceed 200% of the current Federal Poverty Level (FPL) Guidelines which are updated each year by the federal government (see Attachment A-1). Individuals whose income is between 200-400% of the FPL may be eligible for the Health Safety Net program offered through the Commonwealth of Massachusetts. Individuals who are visiting the United States, including those who are visiting for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, do not meet the residency requirements for the federal sliding fee discount.

SCOPE

This policy applies to all sites of FHCW, all services in the health center's federal scope of project, and all services for which the health center has established a charge for reimbursement from patients and payers.

RESPONSIBILITY

Implementation and application of this policy is overseen by the CFO, COO, and the managers responsible for the overall operations of all health center sites. The Board of Directors is responsible for approving the FHCW Sliding Fee Scale discount policy annually, as well as the supporting policies. The SFSD will be evaluated at least annually for its effectiveness in addressing financial barriers to care and updated, as necessary. All amendments to the SFSD must be approved by FHCW's Board of Directors.

SCHEDULE OF FEES

FHCW will maintain a Board-approved schedule of fees for the provision of services. The schedule of fees will be used as the basis for seeking payment from patients as well as third party payers. The schedule of fees will be (i) designed to cover reasonable costs of providing services included in the approved scope of project, and (ii) consistent with locally prevailing rates or charges.

To assure that fees are set to cover reasonable costs and are consistent with locally prevailing rates or charges for the services, FHCW establishes its schedule of fees through the following process:

- A. Services. FHCW determines the schedule of health center services that will have distinct fees. For example, the fee for a medical visit may differ from the fee for a dental visit.
- B. Reasonable costs. FHCW determines the actual costs for providing the services for which there will be a distinct fee.
- C. Locally prevailing rates or charges. FHCW researches, reviews and determines charges used by other health care providers in the community for the same or similar services.

FHCW will adjust the schedule of fees, as appropriate, based on regular costs analyses and changes in the local market. All adjustments to the schedule of fees must be approved by FHCW's Board of Directors.

PROCEDURES

Patients who present as "self-pay" or who complete an application for SFSD, which may include patients with third party coverage, will be referred to a Health Benefit Advisor (HBA) or Patient Accounts representative for assistance. The HBAs/PA reps will screen patients for eligibility, process applications, monitor usage, and report findings. Proof of identification and income is required to receive a discount under the SFSD. If the patient is unable to furnish any of the accepted documents listed (Attachment A-5), he/she will be required to sign a report of self-declaration. (Attachment A-4).

Screening Process

- 1. Health Benefit Advisors will assist patients in determining eligibility for MassHealth, state subsidized products or the Health Safety Net program.
- 2. If it seems likely that the patient is ineligible for state programs, or if the patient opts not to enroll in the state program, and patients' income does not exceed 200% of the FPL as outlined in the sliding fee scale (see Attachment A-2), the patient may apply for the SFSD (see Attachment A-3).

Eligibility for Discounts

- 1. Eligibility for discounts will be based solely on income and family size under the Department of Health and Human Services' annual Poverty Guidelines.

Income shall include the following: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' 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.

Family size shall include the following: the head of household, spouse and dependents.

Sliding Fee Scale Application Process

- 1. Patients complete an application for SFSD (see Attachment A-3) providing their Name, Date of Birth, Address, Family Size and proof of income; providing requested documentation to support data submitted (see list in Attachment A-5).
- 2. HBA enters family size and income level in the Uniform Data System (UDS) tab within NextGen and verifies eligibility for SFSD.
- 3. Eligibility level is determined and classified into the following categories:
Medical, Behavioral Health, Radiology and Vision Services:

- a. 0-100% of FPL \$10.00 nominal fee
- b. 101-133% of FPL 20% of full charge
- c. 134-166% of FPL 40% of full charge
- d. 167-200% of FPL 60% of full charge

Dental Services:

- | | |
|--------------------|--|
| a. 0-100% | \$40.00 nominal fee per visit plus the cost of supplies and labs |
| b. 101-133% | 20% of full charge |
| c. 134-166% | 40% of full charge |
| d. 167-200% of FPL | 60% of full charge |

Dental Exclusions: Patients will be responsible for the cost of supplies and labs; a payment plan will be offered for patient responsibility.

Optical:

- | | |
|-------------|--|
| a. 0-100% | no charge for Tier I Basic; additional cost for upgrades |
| b. 101-133% | \$10.00 for Basic Glasses, cost all others |
| c. 134-166% | \$25.00 for Basic Glasses, cost all others |
| d. 151-200% | \$40.00 for Basic Glasses, cost all others |

Pharmacy:

- | | |
|-------------|-------------|
| a. 0-100% | no charge |
| b. 101-133% | \$10.00 fee |
| c. 134-166% | \$20.00 fee |
| d. 167-200% | \$25.00 fee |

A list of sliding fee patients with the appropriate sliding fee classification will be generated by the Pharmacy on a weekly basis. The patient will pay the cost of the prescription if it is less than the SFSD fee. HBA updates the sliding fee scale page and insurance screen in NextGen to reflect the type of scale the patient falls under and the effective/expiration dates as determined by the application process.

4. Application, signed consent form and supporting documentation are retained by HBA and filed for future reference.
5. Patients are reminded that if there are any changes in their family status including family size, income changes, and health insurance coverage, they must notify us.
6. A patient's eligibility for the SFSD is valid for one year from the date of application.

Check-in Process

1. Check-in staff in each location will verify insurance coverage via MMIS, NehenNet, or payer websites at each visit.
2. If active insurance coverage is not found and the Federal Sliding Payer is not active in the patient's chart, the patient can apply for the SFSD and is referred to an HBA or to patient accounting.
3. If the patient is eligible for the SFSD the appropriate type of Sliding Fee Payer class will be chosen within NextGen and attached to the visit. The appropriate sliding fee discount will be applied before any statement is sent to the patient. Applicable co-payments, if any, will be collected.
4. If patient has become ineligible for a discount, staff will refer the patient to an HBA for reapplication. The visit is entered as "self-pay" and patient is reminded that they may receive a bill if reapplication is not completed with an HBA following the appointment.

MISCELLANEOUS:

1. The FHCW HBAs shall inform all patients about the availability of the SFSD during the new patient registration process. The FHCW will post signage to inform patients of the sliding fee scale (see Attachment A-2) and the availability of discounts off of charges through the sliding fee scale as well as state agencies. Additional collateral (e.g., brochures) will be used to supplement the information outlined in the signage.
2. A copy of the FHCW's fee schedule and corresponding discounted patient amounts for the sliding fee scale and the Commonwealth of Massachusetts Health Safety Net assistance is maintained in our administrative offices for patient reference.

Attachment A-1

The 2022 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family	Poverty guideline
1	\$13,590
2	\$18,310
3	\$23,030
4	\$27,750
5	\$32,470
6	\$37,190
7	\$41,910
8	\$46,630
For families/households with more than 8 persons, add \$4,720 for each additional person.	

Source: U.S. Department of Health and Human Services, available at:
<https://www.federalregister.gov/documents/2022/01/21/2022-01166/annual-update-of-the-hhs-poverty-guidelines> accessed on April 4, 2022

Section 330 of the Public Health Service (PHS) Act (42 U.S.C. §254b) available at:
<http://uscode.house.gov/view.xhtml?edition=prelim&req=42+usc+254b&f=treesort&fq=true&num=20&hl=true>,
 accessed on April 4, 2022 via <http://bphc.hrsa.gov/programrequirements/>

Attachment A-2



Federal Sliding Fee Scale

Effective: January 01, 2022

WHO CAN QUALIFY

The sliding fee scale is a discount of charges for those who either have no insurance or who have insurance but have a high deductible or co-payment. It is also for people whose insurance does not cover services that may be necessary. Regardless of whether the patient has insurance or not, they must still meet the income guidelines to receive a discount. The sliding fee is a formula used to determine the availability of reduced charges to patients who qualify according to the number of individuals in the family and the average yearly income of the family.

HOW TO READ THE SLIDING FEE SCALE

Step 1: Locate the column corresponding to the number of individuals in your family or household.

Step 2: Move from the top to the bottom of the column to find the range containing your combined average annual income.

Step 3: Go to the item under the column to find the copayment amount you will need to pay per visit.

Family Size	0-100% of FPL		101-133% of FPL		134-166% of FPL		167-200% of FPL		201+% of FPL	
	Income level between:		Income level between:		Income level between:		Income level between:		Income level between:	
1	\$0	\$13,590	\$13,591	\$18,075	\$18,076	\$22,559	\$22,560	\$27,180	\$27,181	or more
2	\$0	\$18,310	\$18,311	\$24,352	\$24,353	\$30,395	\$30,396	\$36,620	\$36,621	or more
3	\$0	\$23,030	\$23,031	\$30,630	\$30,631	\$38,230	\$38,231	\$46,060	\$46,061	or more
4	\$0	\$27,750	\$27,751	\$36,908	\$36,909	\$46,065	\$46,066	\$55,500	\$55,501	or more
5	\$0	\$32,470	\$32,471	\$43,185	\$43,186	\$53,900	\$53,901	\$64,940	\$64,941	or more
6	\$0	\$37,190	\$37,191	\$49,463	\$49,464	\$61,735	\$61,736	\$74,380	\$74,381	or more
7	\$0	\$41,910	\$41,911	\$55,740	\$55,741	\$69,571	\$69,572	\$83,820	\$83,821	or more
8	\$0	\$46,630	\$46,631	\$62,018	\$62,019	\$77,406	\$77,407	\$93,260	\$93,261	or more



	You Pay	You Pay	You Pay	You Pay	You Pay
Medical, BH & Vision	\$10 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge †
Dental*	\$40 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge †
Optical	\$0 Basic, cost all others	\$10 Basic, cost all others	\$25 Basic, cost all others	\$40 Basic, cost all others	Full Charge †
Pharmacy	No Charge	\$10	\$20	\$25	Full Charge †

*Dental Exclusions: Patients will be responsible for the cost of supplies and labs; a payment plan will be offered for patient responsibility.

†Individuals with income levels over two-hundred percent (200%+) may be eligible for financial assistance through the Health Safety Net for Office Visits and Dental Services.

Attachment A-3

SLIDING FEE SCALE DISCOUNT APPLICATION

If you wish to qualify for the sliding fee scale discount, you **MUST** show proof of income for all family members/individuals living in your household or individuals for whom you are financially responsible. If you do not have any source of income, please speak with a staff member. Applicants should provide a copy of either:

- Two consecutive pay stubs for each employed adult age 18 and over living in the household, or living outside the household but for whom the household is financially responsible, OR
- Previous year's tax return or W-2 for each adult living in the household or for whom the household is financially responsible (Income will come from Adjusted Gross Income line on respective tax return).

_____/_____/_____
 Name Phone Number Date of Birth

_____/_____/_____/_____
 Address City State ZIP Code

List name(s) and date(s) of birth of family members/individuals living in your household or individuals for whom you are financially responsible.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 2. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

DISCLAIMER: I hereby certify under the pains and penalties of perjury that the above information is, to the best of my knowledge, true and correct. I further agree to notify Family Health Center of Worcester of any changes in this information. I understand that I must re-qualify annually to maintain my eligibility. I am also aware that this information is reviewed and based upon Federal Poverty Guidelines, published annually by the Federal Government. Sliding Fee payment is due and payable at the time of service. To maintain a discount, fees must be paid promptly. If you are unable to make payment at the time of service, please speak with the receptionist to make other arrangements.

_____/_____/_____
 Signature Date

DETERMINING ELIGIBILITY: Family Health Center of Worcester, Inc. is a Federally Qualified Health Center. We are able to offer a discount on some services based on a household's income and size. Sliding fee calculations are determined by using Federal Income Tax forms, W-2's, or last two consecutive pay stubs. The staff at FHCW then uses the table below to determine your eligibility. Your household discount will be assessed on a yearly basis. Individuals who are visiting the United States, including those who are visiting for personal pleasure or for the purposes of receiving medical care in a setting other than a nursing facility, do not meet the residency requirements for the federal sliding fee discount.

PLEASE NOTE: There is a minimum charge for some procedures and glasses.

***Exclusions:** Exclusions to the sliding fee discounts include the cost of certain supplies, Dental labs fees and hospital/nursing home services.

Financial Assistance may be available: Depending upon your income level and family size, you may qualify for financial assistance with your healthcare services.

Family Size	0-100% of FPL Income level between:	101-133% of FPL Income level between:	134-166% of FPL Income level between:	167-200% of FPL Income level between:	201+% of FPL Income level between:
1	\$0 \$13,590	\$13,591 \$18,075	\$18,076 \$22,559	\$22,560 \$27,180	\$27,181 or more
2	\$0 \$18,310	\$18,311 \$24,352	\$24,353 \$30,395	\$30,396 \$36,620	\$36,621 or more
3	\$0 \$23,030	\$23,031 \$30,630	\$30,631 \$38,230	\$38,231 \$46,060	\$46,061 or more
4	\$0 \$27,750	\$27,751 \$36,908	\$36,909 \$46,065	\$46,066 \$55,500	\$55,501 or more
5	\$0 \$32,470	\$32,471 \$43,185	\$43,186 \$53,900	\$53,901 \$64,940	\$64,941 or more
6	\$0 \$37,190	\$37,191 \$49,463	\$49,464 \$61,735	\$61,736 \$74,380	\$74,381 or more
7	\$0 \$41,910	\$41,911 \$55,740	\$55,741 \$69,571	\$69,572 \$83,820	\$83,821 or more
8	\$0 \$46,630	\$46,631 \$62,018	\$62,019 \$77,406	\$77,407 \$93,260	\$93,261 or more



	You Pay	You Pay	You Pay	You Pay	You Pay
Medical, BH & Vision	\$10 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge†
Dental*	\$40 Nominal Fee	20% of full charge	40% of full charge	60% of full charge	Full Charge†
Optical	\$0 Basic, cost all others	\$10 Basic, cost all others	\$25 Basic, cost all others	\$40 Basic, cost all others	Full Charge†
Pharmacy	No Charge	\$10	\$20	\$25	Full Charge†

*Dental Exclusions: Patients will be responsible for the cost of supplies and labs; a payment plan will be offered for patient responsibility.

Return completed application to: 26 Queen Street, Worcester, MA 01610

For more information please see a Health Benefit Advisor at the Family Health Center of Worcester (1st Floor Main Lobby) or call 508-860-7700.

FOR OFFICE USE ONLY				
Eligibility Date: _____		Renewal/Termination Date: _____		
Attach income documentation: <input type="checkbox"/> Pay stub(s) <input type="checkbox"/> Tax Form(s) <input type="checkbox"/> Other _____				
Federal Sliding Fee Scale Category:				
	<u>Medical BH Vision</u>	<u>Dental</u>	<u>Optical</u>	<u>Pharmacy</u>
0-100% of FPL	<input type="checkbox"/> \$10.00 nominal fee	\$40 of full chg	\$0 Basic; cost all others	No Charge
101-133% of FPL	<input type="checkbox"/> 20% of full charge	20% of full chg	\$10 Basic; cost all others	\$10
134-166% of FPL	<input type="checkbox"/> 40% of full charge	40% of full chg	\$25 Basic; cost all others	\$20
167-200% of FPL	<input type="checkbox"/> 60% of full charge	60% of full chg	\$40 Basic; cost all others	\$25
*Exclusions to the sliding fee discounts include the cost of some dental supplies and hospital/nursing home services.				
Application processed/approved by: _____				Date: _____

Attachment A-4 ANNUAL SELF-DECLARATION OF INCOME REPORT

Federal regulations require that we obtain this information annually in order to document that we are serving low and moderate income households. The Participant/Guardian should complete this form including all persons residing in their household, regardless of whether or not they are related. The information in this report will be retained for the purposes of the aggregate reporting.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT HSARED WITHOUT YOUR PERMISSION EXCEPT AS REQUIRED BY LAW TO CONFIRM INCOME ELIGIBILITY OF PARTICIPANTS IN FUNDED PROGRAMS.

PARTICIPANT INFORMATION

PARTICIPANT STATUS: FAMILY INDIVIDUAL

Participant Name: _____

Residential Address: _____

ETHNICITY (please select only one) :

Hispanic or Latino Not Hispanic or Latino

RACE (please select only one) :

White American Indian/Alaskan Native *and* White
 Black/African American Asian *and* White
 Asian Black/African American *and* White
 American Indian/Alaskan Native American Indian/Alaskan Native *and* Black/African American
 Native Hawaiian/Other Pacific Islander Other Multi-Racial: _____

HOUSEHOLD INFORMATION

- 1) **Circle the number of family and non-family members living in your household below.**
- 2) **Circle the corresponding annual household income level.**

Family Size	0-100% of FPL Income level between:		101-133% of FPL Income level between:		134-166% of FPL Income level between:		167-200% of FPL Income level between:		201+% of FPL Income level between:	
1	\$0	\$13,590	\$13,591	\$18,075	\$18,076	\$22,559	\$22,560	\$27,180	\$27,181	or more
2	\$0	\$18,310	\$18,311	\$24,352	\$24,353	\$30,395	\$30,396	\$36,620	\$36,621	or more
3	\$0	\$23,030	\$23,031	\$30,630	\$30,631	\$38,230	\$38,231	\$46,060	\$46,061	or more
4	\$0	\$27,750	\$27,751	\$36,908	\$36,909	\$46,065	\$46,066	\$55,500	\$55,501	or more
5	\$0	\$32,470	\$32,471	\$43,185	\$43,186	\$53,900	\$53,901	\$64,940	\$64,941	or more
6	\$0	\$37,190	\$37,191	\$49,463	\$49,464	\$61,735	\$61,736	\$74,380	\$74,381	or more
7	\$0	\$41,910	\$41,911	\$55,740	\$55,741	\$69,571	\$69,572	\$83,820	\$83,821	or more
8	\$0	\$46,630	\$46,631	\$62,018	\$62,019	\$77,406	\$77,407	\$93,260	\$93,261	or more

By signing this application, I certify that the submissions and statements I have made in this application are true and complete to the best of my knowledge,

Participant/Guardian: _____ **Date:** _____

Attachment A-5 ID Proofing and Income Verification Accepted Documents

ID Proofing Accepted Documents

- Driver's license issued by state or territory
- School identification card
- Voter Identification card
- military draft card or draft record
- Identification card issued by the federal, state, or local government
- U.S. passport or U.S. passport card
- Certificate of Naturalization (Form N-550 or N-570) or Certificate of U.S. Citizenship (Form N-560 or N-561)
- U.S. Customs I-94 Arrival/Departure Record; Nonimmigrant Visa Waiver/Immigration Travel Documents
- Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
- Employment Authorization Document that contains a photograph (Form I-766)
- Military dependent's identification card
- Native American Tribal document
- Coast Guard Merchant Mariner card
- Foreign passport, or identification card issued by a US-Based foreign embassy or consulate that contains a photograph

Or two of the following documents instead:

- Birth certificate
- Social Security card
- Marriage certificate
- Divorce decree
- Employer identification card
- High school or college diploma (including high school equivalency diplomas)
- Property deed or title

Income

- Your most recent Form 1040 (U.S. Individual Income Tax Return) with all attachments including W2s
- Recent pay stubs, at least 2 consecutive
- A signed earnings statement from your employer
- If you are seasonally employed, any of the proofs above including information about the duration of your employment
- Self-employment ledger
- 1099-MISC and your most recent Form 1040 (U.S. Individual Income Tax Return) with all attachments
- Military Leave and Earnings statement
- Agricultural income certificate
- 1040 SE with Schedule C, F, or SE (for self-employment income)
- Bookkeeping records
- Signed and dated most recent quarterly or year-to-date profit and loss statement
- Proof of residuals
- Cost of living adjustment letter and other benefit verification notices
- Document or letter from Social Security Administration (SSA)
- Form SSA 1099 Social Security benefits statement
- Recent court records for alimony and records of agency through which alimony is paid
- Recent legal documents that establish amount and frequency of alimony
- Letter from government agency for unemployment benefits
- Proof of tribal income
- 1099-G and your most recent Form 1040 (U.S. Individual Income Tax Return) with all attachments