SLIDING FEE DISCOUNT POLICY

Policy: FourPoints Health Sliding Fee Discount policy is designed to provide discounted care to those who have no means, or limited means, to pay for their medical, dental, mental health and/ or vision services.

FourPoints Health will determine program eligibility on a person's ability to pay and will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, or national origin. The Federal Poverty Guidelines are used in developing and updating the sliding fee schedule (SFS) to determine eligibility.

A. Discount Application Process and Guidelines

1. **Notification:** FourPoints Health will notify patients of the Sliding Fee Discount Policy as follows:

    - Notification of the Sliding Fee Discount Program in the Health Center waiting area.
    - Explanation of the Sliding Fee Discount Program and an application form are available on our FourPoints Health website (fourpointshealth.org).
    - Notification of the Sliding Fee Discount Program will be offered to each patient upon admission.

2. **Application:** Sliding Fee Discount Applications are available at the FourPoints Health Clinic or can be obtained by visiting our FourPoints Health website. Patients requesting to receive a discount for services must complete the discount fee application (Attachment B) in full. Applications that are missing information and not signed by the patients are considered incomplete and the patient will not be eligible for the Sliding Fee Discount Program. The sliding fee scale is based on Family Size and Income only.

    A. **Family:** Family is defined as: a group of two or people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including subfamilies) are considered as members of one family. For instance, if an older married couple, their daughter and her husband and two children, and the

older couple's nephew all lived in the same house or apartment; they would all be considered members of a single family.

B. **Proof of Income:** In addition to the application, all patients applying to receive discounted services must provide the Health Center with Proof of Income at the time the application is submitted or within five (5) business days from the date the application was submitted. Any patient who fails to provide proof of income will be responsible for the full charge of any services provided by FourPoints Health. **A minimum of <u>one</u> form of income verification is required**. Once approved, the discount will be honored for one (1) year. Any change in family size and income during the year will require the patient to reapply for the Sliding Fee Discount. Acceptable forms for proof of income include one of the following:

- Last (current year) federal tax returns, quarterly tax statement if self-employed.
- The last 2 paycheck stubs for each adult working in the household.
- A statement from your employer (signed, dated on company letterhead) stating rate of pay, average number of hours worked weekly, and hire date.
- Unemployment benefit letter.
- Social Security benefit letter showing your monthly payment (for each person receiving benefits).
- Verification of Workers Compensation Insurance benefits.
- Military family allotment verification.
- Payment made from trusts or estates verification.
- Documentation of child support (divorce papers, letter from Recovery Services)
- Copy of pension/ retirement benefits.
- Documentation of State support (letter of approval for food stamps or other benefits).
- 1040 or W-2 statement due to loss of employment.
- Financial Support Document (Attachment D), only if a patient has no proof of income and relying on financial support of another individual or organization.

3. **Record Keeping:** The Sliding Fee Discount Program will be administered through FourPoints Health. Dignity and confidentiality will be respected for all who seek and/ or are provided discount services. All discounted applications will be compiled, scanned and attached to the patient's electronic medical records.

4. **Discounts and Nominal Fees**: Those with incomes at or below 100% of the Federal Poverty Level (FPL) will be responsible for a nominal fee. Patients eligible for the nominal fee (below 100% FPL) will be assessed a $20 nominal fee for medical, mental health and vision services. Dental services will also be assessed a $20 nominal fee for procedures that fall under

Preventative Dental Services or Basic Dental Services. The list of procedures included in the nominal fee is in Attachment A. Non covered procedures, although not included in the nominal fee, can be taken advantage of at a heavily discounted rate. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the approved annual sliding fee schedule (Attachment C.) Patient access will be taken into consideration for each sliding fee discount including the nominal fee on an annual basis and will ensure that ability to pay does not create a barrier to care. FourPoints Health will make reasonable efforts to secure and maximize payments from patients for services rendered. FourPoints Health will conduct billing and collections from patients in an efficient, respectful and culturally appropriate manner, assuring that procedures do not present a barrier to care and patient privacy and confidentiality are protected throughout the process.

PATIENTS RECEIVING DISCOUNTS WILL NOT BE TURNED AWAY FOR INABILITY TO PAY. NO ONE IS REFUSED SERVICES BECAUSE OF LACK OF FINANCIAL MEANS TO PAY

5. **Alternate Payment Resources**: All reasonable effort to obtain reimbursement from third party payers – either public (Medicaid, Medicare, Chip, etc.) or private health insurance(s) will be made. Third party payers are billed on the basis of full amount of fees and payments for such services without application of any discounts. FourPoints Health has Outreach and Enrollment Specialists to help patients apply for these alternate resources.

B. Scope of Service included with this policy are:

1. Medical Office visits for primary care (including in-house laboratory, injections, routine vaccinations and minor surgical procedures) are covered under the discount fee program.
2. Dental –Preventative Dental Services and Basic Dental Services are included in the nominal fee. We also have Non-covered Dental procedures that are provided at a significantly discounted rate (See Attachment A).
3. Behavior Health – mental health counseling and outpatient substance abuse counseling are covered under the discount fee program.
4. Optical – Optometry exams and glasses are covered under this discount fee program.

Tamra Borchardt-Slayton, Tribal Chairwoman

1/17/2019

Date

Attachment A

Patients who qualify for the sliding fee scale will pay a nominal fee if under 100% of the Federal Poverty Limit. Patients between 101%-200% of the FPL will receive discounted services as detailed on the sliding fee policy.

The following dental services are included under the nominal fee:

- Preventative Dental Services - dental screenings, oral hygiene instructions, oral prophylaxis, topical application of fluoride.
- Basic dental services used to diagnose and treat disease, injury, or impairment in teeth – X-Rays and imaging, fillings

NON-COVERED SERVICES

Services that are not covered under the nominal fee, but are provided to patients under 100% of FPL at a discounted rate of 35% of our usual and customary fees, examples of these fees not covered under the nominal fee include:

- Single Unit Crowns
- Extractions
- Root Canals
- Bridges
- Dentures
- As well as any other procedure not directly outlined as a covered service under the nominal fee.

Attachment B

SLIDING FEE DISCOUNT APPLICATION

Head of Family Information: _____

Number of people living at home: _____

Family Member Information – Family Includes Self, spouse/partner, and children under age 26

Name	Date of Birth	Relationship to patient	Employed
1.			Yes/No
2.			Yes/No
3.			Yes/No
4.			Yes/No
5.			Yes/No
6.			Yes/No
7.			Yes/No

I HAVE provided the following sources of income verification with the application (select one):

- o The last 2 paycheck stubs for each adult working in the household.
- o Unemployment benefit letter.
- o Social Security benefit letter showing your monthly payment
- o Last (current year) federal tax returns, quarterly tax statement if self-employed.
- o Verification of Workers Compensation Insurance benefits.
- o Military family allotment verification.
- o Payment made from trusts or estates verification.
- o Documentation of child support (divorce papers, letter from Recovery Services)
- o Copy of pension/ retirement benefits.
- o Documentation of State support
- o 1040 or W-2 statement due to loss of employment.
- o Attachment D – Family support document signed by individual/organization supporting you. Must be completed in full, which includes signature and date, if not submitted within (5) Five days of turning in sliding fee discount application, I will be billed for the full cost of services rendered.
- o **I HAVE NOT SUBMITTED ANY SOURCES OF INCOME VERIFICATION AND UNDERSTAND THAT I HAVE (5) FIVE BUSINESS DAYS TO BRING IN INCOME VERIFICATION OR I WILL BE BILLED FOR THE FULL COST OF SERVICES RENDERED.**

I understand if I qualify for the Sliding Fee Discount Plan, an office fee may be charged for each visit depending on the service rendered. I understand I must apply for the Sliding Fee Discount Plan every 12 months. I understand that I must list all family members and wage earners in my family and provide income verification to be eligible for the Sliding Fee Discount Plan. I give FourPoints Health staff permission to contact my employer or any other appropriate source to verify I authorize FourPoints Health (Paiute Indian Tribe of Utah) to bill my insurance carrier for services rendered by our providers. I also authorize FourPoints health to release all or part of my/patient's record to any person or organization I permit a copy of this authorization to be used in place of the original release of information form and request that the payment of medical insurance benefits be paid to FourPoints Health (Paiute Indian Tribe of Utah).

I agree to pay for all charges not paid by my insurance company. If my account is sent to a collection agency, I agree to pay all reasonable collection and attorney's fees.

I understand that if any of this information has been falsified to fraudulently receive services that my participation will be revoked, and I will be responsible for 100% of the usual and customary charges of FourPoints Health. I will notify FourPoints health of any changes in my health status or any of the above information.

_____ _____

Signature Date

OFFICE USE ONLY

I verify the patient completed the sliding fee discount application in full. I have verified the patients family size in income through Athena health and supporting documentation. Based on information provided, patient has income of $_____ which is calculated on a _____ basis (bi-weekly, monthly, annual).

Patient is eligible for the sliding fee discount which expires _____. (12 months from application)

Select Eligibility (Mark Box)	Discount Level	Medical/Behavioral Health Fee	Behavioral Health Group Fee	Dental Fee
	Level 1 - >100% FPL	$20.00	$10.00	$20.00/ 35% of Fee
	Level 2 – 101-133% FPL	$30.00	$15.00	40% of Fee
	Level 3 – 134-166% FPL	$40.00	$20.00	60% of Fee
	Level 4 – 167-200% FPL	$50.00	$25.00	80% of Fee
	Level 5 – 201%+ FPL	Patient does not qualify for discounted services – Full Fee		

I verify the patients sliding fee discount application and income verification has been scanned into the patients electronic medical record and updated sliding fee level within Athenahealth.

_____

Name of Employee

_____ _____

Signature of Employee Date

Attachment C

Fourpoints Health Sliding Fee Discount Schedule					
Monthly Income Limits - Based on 2019 Monthly Federal Poverty Level (FPL) Guidelines By Family Size					
	Level 1 (Nominal Fee)	Level 2	Level 3	Level 4	Level 5
Medical, Mental Health and Vision Fee	$20.00	$30.00	$40.00	$50.00	*Full Fee
Behavioral Health Group	$10.00	$15.00	$20.00	$25.00	*Full Fee
Dental Fee	$20.00	40% of Fee Schedule	60% of Fee Schedule	80% of Fee Schedule	*Full Fee
	0-100%	101-133%	134-166%	167-200%	201 and up%
Family Size	Up to	Up to	Up to	Up to	and over
1	$1,012.00	$1,346.00	$1,679.00	$2,023.00	$2,023.00
2	$1,372.00	$1,824.00	$2,277.00	$2,743.00	$2,743.00
3	$1,732.00	$2,303.00	$2,875.00	$3,463.00	$3,463.00
4	$2,092.00	$2,782.00	$3,472.00	$4,183.00	$4,183.00
5	$2,452.00	$3,261.00	$4,070.00	$4,903.00	$4,903.00
6	$2,789.00	$3,710.00	$4,630.00	$5,578.00	$5,578.00
7	$3,173.00	$4,219.00	$5,266.00	$6,345.00	$6,345.00
8	$3,532.00	$4,697.00	$5,863.00	$7,063.00	$7,063.00
* Fee Schedule is updated and approved annually based on Optum fee schedule for local charges					

Fourpoints Health Sliding Fee Discount Schedule					
Annual Income Limits - Based on 2019 Annual Federal Poverty Level (FPL) Guidelines By Family Size					
Medical, Mental Health and Vision Fee	$20.00	$30.00	$40.00	$50.00	*Full Fee
Behavioral Health Group	$10.00	$15.00	$20.00	$25.00	*Full Fee
Dental Fee	$20.00	40% of Fee Schedule	60% of Fee Schedule	80% of Fee Schedule	*Full Fee
Federal Poverty Range	0-100%	101-133%	134-166%	167-200%	201 and up%
Family Size	Up to	Up to	Up to	Up to	and over
1	$12,140.00	$16,146.00	$20,152.00	$24,280.00	$24,281.00
2	$16,460.00	$21,892.00	$27,324.00	$32,920.00	$32,921.00
3	$20,780.00	$27,637.00	$34,495.00	$41,560.00	$41,561.00
4	$25,100.00	$33,383.00	$41,666.00	$50,200.00	$50,201.00
5	$29,420.00	$39,129.00	$48,837.00	$58,840.00	$58,841.00
6	$33,470.00	$44,515.00	$55,560.00	$66,940.00	$66,941.00
7	$38,070.00	$50,633.00	$63,196.00	$76,140.00	$76,141.00
8	$42,380.00	$56,365.00	$70,351.00	$84,760.00	$84,761.00
Note: For families with more than 8 persons, add $4,180 for each additional person					
* Fee Schedule is updated and approved annually based on Optum fee schedule for local charges					

Attachment D

Financial Support Document

THIS FORM IS ONLY TO COMPLETED IF YOU ARE NOT WORKING AND RECEIVING FINANCIAL ASSISTANCE FROM A FAMILY MEMBER, CHURCH OR OTHER ORGANIZATION

Patient Name: _____

Who is supporting you financially? Who pays for rent, buys food, pay utilities, etc.?

Name: _____
Phone #: _____
Address: _____

WE NEED THE FOLLOWING STATEMENT TO BE FILLED OUT BY THE PERSON WHO IS SUPPORTING YOU

Patient fees are based on the type of service provided and the patient's income and family size. Our patient has listed you as the person who is financially supporting them.
Please answer the following questions:

1.) How long has the patient been living with you _____months/ years
2.) How much do you pay to provide support for them (rent, utilities, food) per month $_____?
3.) How long do you anticipate that you will be supporting them? _____Months/years

****PLEASE PROVIDE A BRIEF DESCRIPTION OF THE SITUATION BELOW****

_____

_____

_____

_____

_____

_____

_____

I certify this information is true and correct and give permission to be contacted

Signature: _____ Date:

Attachment E

NOTICE TO PATIENTS:

This practice serves all patients regardless of Inability to pay.
Discount for essential services are offered based on family size and Income.
For more Information, ask at the front desk or visit our website.
Thank you.

AVISO PARA PACIENTES:

Esta Practica sirve a todos los pacientes, Independientemente de la Incapacidad de pago.
Descuentos para los esenciales son ofrecidos dependiendo de tamano de la Familia y de los Ingresos.
Usted puede solicitar un descuento en la recepcion o vista nuestro sitio web.
Gracias.