HRSA Policy 2014-02

Policy Information Notice (PIN) 2014-02 clarifies HRSA's policy regarding the sliding fee discount program (SFDP) at Federally Qualified Health Centers. The purpose of this document is to highlight specific areas from the PIN that have unique implications for special populations. "Special populations" include migrant and seasonal farmworkers, persons experiencing homelessness and residents of public housing. These populations face unique challenges to accessing needed services and warrant special attention when developing the health center's sliding fee discount policies "…so as not to overlook or create additional barriers to care."

HRSA is clear that health centers have the ability to exercise discretion to ensure services remain accessible, stating that "The unique characteristics of target populations (e.g., individuals experiencing homelessness) and service areas (e.g., areas with high cost of living) must be considered in developing policies and supporting operating procedures to ensure that these elements do not become a barrier to care. The PIN states, "Health centers retain flexibility in establishing the related operating procedures to minimize barriers to care."

Policies must be the same for all patients, regardless of population and there can be no discounts based on anything other than income and family size. Yet it remains important when developing these policies to consider some of the unique circumstances faced by special populations.

Verification of Income

Many agricultural workers and homeless individuals get paid in cash and therefore lack documentation such as pay stubs, tax returns, public benefit letters and bank statements. This makes it difficult to prove their income and qualify for discounted services. To overcome this, many health centers allow alternative documentation such as a letter from an employer or written self-attestation statement.

In cases where documentation such as a check stub is provided, consideration should be given to the fact that agricultural workers are generally not employed year round due to growing seasons, weather and other variables beyond their control. Health centers should make every attempt to determine the real annual income based on these factors, rather than automatically multiplying by twelve months the current amount being earned, which would likely disqualify many from receiving the discounts. It is up to the center to define what documentation is required and how it is annualized for income determination.

Definition of "Family"

Because of the mobile nature of their work and lifestyle, which is tied to crops and seasons, the living arrangements of many farmworkers don't fall within the typical definition of "family." For example, crews of men may travel and live together while their wives and families remain at home. Or multiple families may travel and live together under one roof. Or extended families may live and travel together, including grandparents, aunts, uncles and cousins, etc. Health centers should consider whether the definition they are using of "Family" adequately reflects the reality of their patient's living arrangements.

The PIN states, "It is important that the eligibility determination process be conducted in an efficient, respectful, and culturally appropriate manner to assure that administrative operating procedures for such determinations do not themselves present a barrier to care." In the Q&A posted on HRSA's web site after the release of the PIN, it states health centers "Can include as part of "family size" persons who are not living with the patient but who are largely dependent on the patient's income."

Eligibility Re-Determination

The PIN states, "Health centers may establish and implement streamlined SFDS patient eligibility renewal/review procedures that are separate from the initial sliding fee discount screening." This is particularly important for special populations for whom producing paperwork one time can be a challenge they may not be able repeat annually or more often.

Nominal Fees

Health centers must provide a full discount for individuals and families with annual incomes at or below 100 percent of the federal poverty line. The majority of patients that belong to special populations will fall into this category. Health centers can adopt a nominal charge for these patients as long as it does not impede access to their services due to inability to pay. The PIN states that, "nominal charges must be considered nominal from the perspective of the patient," in a footnote, suggesting health centers seek input from patient board members, survey, advisory committees and or copays associated with Medicare and Medicaid to assist in determining what patients would consider nominal.

In October 2014, The National Healthcare for the Homeless Council (NHCHC) issued a policy advisory discouraging health centers from charging patients below 100% of poverty a nominal fee so as not to create a disincentive to accessing needed services. It cites "severe disparities in morbidity and mortality that merit additional efforts to increase the frequency and intensity of services," going on to say that, "in a survey of homeless persons conducted by the National Consumer Advisory Board, those directly experiencing homelessness identified not being able to pay for health services as the largest barrier to obtaining health care." Furthermore, the advisory suggests that "attempts to collect nominal fees are likely to be cost ineffective for provider agencies."

Waiving Fees

The NHCHC advisory quotes The Code of Medical Ethics of the American Medical Association, which states that, "when a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment." If health centers opt to charge patients at or below poverty a nominal fee, policies should outline under what circumstances those fees will be waived.

Collections

PIN 2014-02 states, "The Health Center Program statute requires health centers to make every reasonable effort to secure from patients payment for services in accordance with such schedules. In balancing the statutory requirement of maximizing revenue with ensuring that no patient is denied

services based on inability to pay, the applicable definition of "reasonable" effort may vary depending on elements unique to the individual health center, such as the target population." It is up to the board to define what is "reasonable" for their particular target population and when it's acceptable to write off charges.

Board Authority

Responsibility for reviewing and approving policies around the sliding fee discount schedule annually rests with the health center board of directors. Board members need to take this responsibility very seriously since it can determine whether or not members of special populations and others below the poverty line are able to afford their services and maintain access to badly needed care. Vigilance around this issue is required in order to ensure that all policies around the sliding fee discount program are "Effective in addressing financial barriers to care."

For all these reasons it's important that health centers, especially those receiving special populations funding, have adequate representation from those populations on their board to ensure policies that are culturally appropriate and sensitive to the unique barriers they face.

The following pages provide examples of alternative forms used by community health centers to determine patient income.

APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

PATIENT NAME _____ **HOME/ CELL NUMBER** _____

☐ **I have been given the opportunity to apply for the BRCHS discount services sliding fee schedule, and I DO NOT WISH TO APPLY FOR THE BRCHS DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME.**

Patient Signature _____ Date _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health, and/or dental needs. **This information will not be used to withhold or deny services to you**.

1. Are you covered under Medicaid, Medicare and/or any other insurance? ☐ Yes ☐ No
2. If you have private insurance, what is your annual deductible, per family member? $_____
3. Have you or your dependents ever applied for or been denied for Medicaid or Medicare? ☐ Yes ☐ No
4. Would you like to apply or re-apply for Medicaid today? ☐ Yes ☐ No
5. Are you unemployed? ☐ Yes ☐ No
6. Are you too sick to work or are you disabled? ☐ Yes ☐ No

Please include yourself, your spouse/partner and all dependents living in the home below:

Name	Date of Birth	Relationship to Head of House	Insurance or Medicaid?
		Head of Household	**Yes or No**
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

INCOME VERIFICATION

Please enter your **gross income** (the $ amount received before taxes are taken out). Household income includes ***everyone*** in the home. Proof of income includes: most recent tax return, check stubs, bank verification, a letter from the employer stating wages earned or proof of unemployment.

If there is **no income to report, or if you do not want to comply with documentation requirements**, you must complete the reverse side of this application.

HOW ARE YOU PAID?	AMOUNT?	CIRCLE ONE?
Work Wages	**$**	**Weekly /Bi weekly /Other**
Cash Wages	**$**	**Weekly /Bi weekly /Other**
Disability	**$**	**Weekly /Bi weekly /Other**
Social Security	**$**	**Weekly /Bi weekly /Other**
Unemployment	**$**	**Weekly /Bi weekly /Other**
Worker's Comp	**$**	**Weekly /Bi weekly /Other**
Child Support	**$**	**Weekly /Bi weekly /Other**
Other Income	**$**	**Weekly /Bi weekly /Other**

Office Use Only

Staff Signature:_____

Verifies Wages are calculated in PM System

Date: _____

Patient Advised of Discount Rate: _____
Initials

Audit Stamp:

PLEASE REFER TO THE CURRENT BRCHS SLIDING FEE DISCOUNT SLIDE SCHEDULE

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I understand that I will be financially responsible for **all or a portion of my care** and that I will be asked to **submit payment at the time of service**. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled.

Patient Signature_____ Date_____

Declination Statement (for Patient's Who Do Not Want to Comply with Sliding Scale Requirements)

Because you do not wish to apply or comply with the requirements to apply for our sliding scale discount, you are choosing to be a self pay patient. This means that you will pay ***$75.00*** up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges are not applicable and you will not be allowed to receive a discount for these charges in the event that a future sliding scale application is completed.

Patient Signature _____ Date_____

COMPLETE BELOW FOR Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked and all the questions answered. Failure to complete this information will result in in denial of your application for a sliding scale discount.

- ☐ I get paid in cash.
- ☐ I do not get pay checks.
- ☐ I do not get pay stubs.
- ☐ I cannot get a letter from my employer. Explain why: _____

_____

My cash income is $ _____ How often?: ☐Weekly, ☐Bi-Weekly, ☐Monthly, ☐Other: _____

Current Employer: _____

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the BRCHS Sliding Fee Discount Schedule. I understand that BRCHS officials may verify information on this form.

Patient Signature _____ Date_____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other posible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature _____ Date _____

SLIDING FEE SCALE PROGRAM

SELF DECLARATION OF INCOME

I, _____ certify that I am self-employed or have worked odd jobs for cash, for the last _____ months/years.

My average monthly income is $_____. I have no records nor have I filed Income Taxes.

Generally, the type of work I do is _____. If you need to verify this information you may contact the following person for a reference:

Name: _____

Address: _____

City: _____

Phone Number: _____

I certify that the information listed above is true and correct to the best of my knowledge, I understand that in accordance with SECT.817.50, of the Florida State Statue, providing false information to defraud a health care provider for the purpose of obtaining goods or services is a MISDEMEANOR in the second degree.

_____ _____

Applicant's Signature Date

ATTESTATION/SELF DECLARATION FORM

Parent/Legal Guardian or Patient Name: **MR #**_____

_____

First **Middle** **Last**

Address _____

Street **City**

_____ **Gender** ___**M** ___**F** **DOB**_____

State **Zip**

Please place a check mark under the amount of your annual household income range.

$0 -	$11,491	$15,511	$19,531	$23,550	$27,571	$31,591	$35,611	$39,631	$43,651	$47,671	$51,691
$11,490	$15,510	$19,530	$23,550	$27,570	$31,590	$35,610	$39,630	$43,650	$47,670	$51,690	over
___	___	___	___	___	___	___	___	___	___	___	___

Number of people in your household: _____

Sliding Fee Schedule One Time Program Eligibility, please check what applies:

___ I am not interested in disclosing my financial information, therefore I acknowledge my family and I are not eligible for the sliding fee discount program.

I presently do not have any documentation to verify my income; the reasons are (mark all that apply):

____ I get paid in cash

____ I do not get paychecks or pay stubs

____ I did not file a tax return last year

____ I cannot get a letter from my employer

____ Other, Please explain_____

I certify that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for the Community Health Center's sliding fee discount program. I understand that the Health Center may verify information on this form and on my next visit I need to bring in valid documentation to substantiate the above information. I also understand that if I intentionally misrepresent my family's income, I will not be eligible to receive services at a discounted rate in the future.

Signature of Patient/Parent/Legal Guardian_____ **Date** _____

For Office Use ONLY:

Qualifies for_____% Discount Does not qualify because_____

Date of Determination_____ Employee Signature_____

SUPPORT FORM

Instructions: Please check the box(es) that apply and fill in name(s) and date(s), then sign form and give back to applicant.

To Whom It May Concern:

I, the undersigned, verify that I [☐ give ☐ loan] money to _____
(check one) (name of applicant)

to help with living expenses each month. In the month of _____, 20_____ I [☐ gave ☐ loaned]
(check one)

the amount of $_____.

Check all that apply:

☐ I [☐ gave ☐ loaned] this money directly to the named applicant to help pay household expenses.
(check one)

☐ I pay this money directly to the company(ies) to cover expenses for the named applicant's household.

☐ I will continue to do this each month.

☐ I will not continue to do this. I am only helping temporarily or until _____.

_____
Name of Person Helping Household **(PLEASE PRINT)**

_____
Signature of Person Helping Household Date

Address: _____
Number & Street/PO Box City State Zip

Contact Number: (_____) _____-_____

VERIFICATION OF EARNINGS FORM

Dear Employer:

An employee of your company has applied for the Access Assistance (Discount Program) at Access Family Health Services, Inc. Please complete this form and return it to the employee. Thank you for your cooperation.

Name of Employee: _____

Address: _____
Number & Street/PO Box City State Zip

Social Security Number: _____ - _____ - _____

It is hereby certified that the individual named above is employed by the undersigned, and that the following wages and hours represent a normal rate of this individual.

Number of hours worked per week (average) _____

Average Gross Weekly Income $_____

Signature of Employer Representative _____

Name of Employer: _____

Address: _____
Number & Street/PO Box City State Zip

Telephone Number: (_____) _____-_____

Does employee have health insurance coverage? Yes ☐ No ☐

PERMISSION TO RELEASE WAGE/INSURANCE INFORMATION:

_____
Signature Date

APPLICATION FOR DISCOUNT SERVICES SLIDING FEE SCHEDULE

PATIENT NAME _____ **HOME/ CELL NUMBER** _____

☐ **I have been given the opportunity to apply for the BRCHS discount services sliding fee schedule, and I DO NOT WISH TO APPLY FOR THE BRCHS DISCOUNT SERVICES SLIDING FEE PROGRAM AT THIS TIME.**

Patient Signature _____ Date _____

The data gathered on this form will only be used to get information about you and your family so that we can better meet your medical, behavioral health, and/or dental needs. **This information will not be used to withhold or deny services to you**.

1. Are you covered under Medicaid, Medicare and/or any other insurance? ☐ Yes ☐ No
2. If you have private insurance, what is your annual deductible, per family member? $_____
3. Have you or your dependents ever applied for or been denied for Medicaid or Medicare? ☐ Yes ☐ No
4. Would you like to apply or re-apply for Medicaid today? ☐ Yes ☐ No
5. Are you unemployed? ☐ Yes ☐ No
6. Are you too sick to work or are you disabled? ☐ Yes ☐ No

Please include yourself, your spouse/partner and all dependents living in the home below:

Name	Date of Birth	Relationship to Head of House	Insurance or Medicaid?
		Head of Household	**Yes or No**
			Yes or No
			Yes or No
			Yes or No
			Yes or No
			Yes or No

INCOME VERIFICATION

Please enter your **gross income** (the $ amount received before taxes are taken out). Household income includes ***everyone*** in the home. Proof of income includes: most recent tax return, check stubs, bank verification, a letter from the employer stating wages earned or proof of unemployment.

If there is **no income to report, or if you do not want to comply with documentation requirements**, you must complete the reverse side of this application.

HOW ARE YOU PAID?	AMOUNT?	CIRCLE ONE?
Work Wages	**$**	**Weekly /Bi weekly /Other**
Cash Wages	**$**	**Weekly /Bi weekly /Other**
Disability	**$**	**Weekly /Bi weekly /Other**
Social Security	**$**	**Weekly /Bi weekly /Other**
Unemployment	**$**	**Weekly /Bi weekly /Other**
Worker's Comp	**$**	**Weekly /Bi weekly /Other**
Child Support	**$**	**Weekly /Bi weekly /Other**
Other Income	**$**	**Weekly /Bi weekly /Other**

Office Use Only

Staff Signature:_____

Verifies Wages are calculated in PM System

Date: _____

Patient Advised of Discount Rate: _____
Initials

Audit Stamp:

PLEASE REFER TO THE CURRENT BRCHS SLIDING FEE DISCOUNT SLIDE SCHEDULE

PATIENT ACKNOWLEDGEMENT STATEMENT

I certify that the information provided is accurate and complete to the best of my knowledge and in the event of a change in income or insurance coverage, I will contact/notify the facility. I understand that I will be financially responsible for **all or a portion of my care** and that I will be asked to **submit payment at the time of service**. I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled.

Patient Signature_____ Date_____

Declination Statement (for Patient's Who Do Not Want to Comply with Sliding Scale Requirements)

Because you do not wish to apply or comply with the requirements to apply for our sliding scale discount, you are choosing to be a self pay patient. This means that you will pay ***$75.00*** up front at the time of service and you will be responsible for any and all balances due after the provider's charges for your visit are entered. You will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges are not applicable and you will not be allowed to receive a discount for these charges in the event that a future sliding scale application is completed.

Patient Signature _____ Date_____

COMPLETE BELOW FOR Self-Declaration of Income

Please complete the information below only ***if you have no other way to document your income***. All of the boxes below must be checked and all the questions answered. Failure to complete this information will result in in denial of your application for a sliding scale discount.

- ☐ I get paid in cash.
- ☐ I do not get pay checks.
- ☐ I do not get pay stubs.
- ☐ I cannot get a letter from my employer. Explain why: _____

_____

My cash income is $ _____ How often?: ☐Weekly, ☐Bi-Weekly, ☐Monthly, ☐Other: _____

Current Employer: _____

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the BRCHS Sliding Fee Discount Schedule. I understand that BRCHS officials may verify information on this form.

Patient Signature _____ Date_____

Employee Certification Statement

I certify that I asked the applicant/recipient about all the sources of income received by the household and, before using this form, used best efforts to obtain other posible sources of documentation. The information reported on this form was provided solely by the applicant/recipient and reflects the income the applicant reported to me.

Employee Signature _____ Date _____