POLICY STATEMENT
South End Community Health Center (SECHC) offers a Sliding Fee Discount Program (SFDP) to eligible patients to reduce the out of pocket expense of receiving care as a barrier to a patient seeking care. The program is available to patients with family incomes at or below the 200% of the prevailing Federal Poverty Level (FPL). The Board and management will review the SFDP at least once every three years, if not more frequently, to identify where changes within the program may be needed to reduce financial barriers to care that patients may be experiencing.

- Patients whose annual incomes are below 100% of the FPL are exempt from making payments.
- Patients whose annual income is between 101% and 200% of the FPL will be charged according to the Sliding Fee Schedule (SFS), which includes three discount pay classes tied to gradations in household income level and family size.
- Patients whose annual household incomes are above 200% of the FPL may be eligible for services through the Massachusetts Health Safety Net (HSN).
- Patients who prefer not to be screened for this program and who are not eligible for health insurance, will be considered self-pay patients.
- Health center staff will make every effort to help patients sign up for health insurance, including Health Safety Net, or be screened for the SFDP, or offered a payment plan that is convenient for the patient.
- No patient will be denied services based on their ability to pay.

This Policy applies to the following services within scope
- Medical Services
- Basic Dental Services
- Behavioral Health Services
- Laboratory Services
- Substance Abuse
- Optometry Services

Exceptions:
- Dentures*
- Selective Eyewear*, Contacts and Eye Care Products
- Civil Surgeon Services
PURPOSE
The purpose of this policy is to ensure that patients’ out of pocket expenses are not a financial barrier to accessing healthcare services at SECHC. This policy follows federal regulations regarding providing a Sliding Fee Discount Program to eligible patients. The Sliding Fee Discount Program is available to all patients whose household income does not exceed 200% of the Federal Poverty Level (FPL) guidelines which are updated each year by the federal government (see Attachment 1). Individuals whose income is between 201-400% of the FPL may be eligible for the Health Safety Net program offered through the Commonwealth of Massachusetts.

PROCEDURE
Check-in Process
SECHC registration staff at check-in will verify a patient's health insurance, via NEHENet, or payor websites, and when the patient does not have health insurance, will refer the patient to an Insurance Coordinator. In addition, when a registration staff member identifies a patient who has active health insurance but presents with a family income at or below 200% FPL, the registration staff member will refer the patient to the Insurance Coordinator.

Screening and Application Process
The Insurance Coordinator will screen patients to determine if they are eligible for health insurance and help them complete applications as appropriate.

The Insurance Coordinator will also verify the patient’s family income to determine their eligibility for the SFDP and will process applications, monitor usage and report findings.

The Insurance Coordinator will complete the following steps with all patients referred to them:

- Collect documentation (e.g., identification, pay stub, W2, income tax form or self declaration affidavit) from patient (see Attachments 2 and 3).
- Patients must provide income verification documentation within 30 days of application or they will need to re-apply.
- Have individual complete the Consent Form (see Attachment 4). The Consent Form also asks for specific applicant feedback on effectiveness of the SFDP in reducing financial barriers to care for patients at or below 200% of the FPG.
- Enter family size and income level in the Federal Poverty Level (FPL) tab within OCHIN Epic and verify eligibility for Sliding Fee Discount Program.
- Determine the patient’s eligibility based on their Federal Poverty Level and family size. Patients whose annual incomes are below 100% of the FPL are exempt from making payments. Patients whose annual income is between 101 and 200% FPL, will be charged according to the Sliding Fee Scale (SFS) (see Attachment 5) as follows:
  - FPL Level of 101-133% : $10 per visit
  - FPL Level of 134-166% : $15 per visit
  - FPL Level of 167-200% : $20 per visit
- Patients whose annual incomes are above 200% of the FPL may be eligible to participate in the Massachusetts Health Safety Net (HSN).
- Update the Sliding Fee Scale page in OCHIN Epic and insurance screen to reflect type of payment the patient is eligible for.
- File Consent Form and documentation, including self-declaration form if applicable.
- Remind patient that if there are any changes in family status including family size, income, and/or health insurance coverage, they must notify SECHC.
- Track patient eligibility, which is twelve (12) months from the date of application unless there is a change in the patient’s income and/or family size which will affect their on-going eligibility.
- Patient eligibility may be backdated up to six (6) months.

**Family** is defined as Family is defined as the head of household, their parents, dependents and spouse living within the same household. This includes dependents living outside the household that are largely supported by the patient’s income (e.g. 50% or more). Unmarried/unrelated individuals living together and sharing expenses will be treated as family members.

**Income** can include any of the following:
- The full amount of gross income earned before taxes and deductions.
- The net income earned from the operation of a business, i.e., total revenue minus business operating expenses. This also includes any withdrawals of cash from the business or profession for your personal use.
- Monthly interest and dividend income credited to an applicant's bank account and available for use.
- The monthly payment amount received from Social Security, annuities, retirement funds, pensions, disability and other similar types of periodic payments.
- Any monthly payments in lieu of earnings, such as unemployment, disability compensation, SSI, SSDI, and worker’s compensation.
- Monthly income from government agencies excluding amounts designated for shelter, and utilities, WIC, food stamps, and childcare.
- Alimony, child support and foster care payments received from organizations or from persons not residing in the dwelling.
- All basic pay, special day and allowances of a member of the Armed Forces excluding special pay for exposure to hostile fire.

**Program Assessment and Evaluation**
The health center evaluates, at least once every three years, its sliding fee discount program. At a minimum, the health center:
- Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPL, are accessing health center services;
- Utilizes this and, if applicable, other data (for example, patient feedback on SFDP consent forms, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
- Identifies examples of areas where changes to the SFDP are needed, if applicable, and implements and documents changes as needed.

**MISCELLANEOUS:** SECHC will post signage, in English and Spanish, to inform patients of the SFDP. Notice will also be included in New Patient Information/Welcome Packets, and the health center's website, www.sechc.org (see Attachment 6).
## ATTACHMENT 1: FEDERAL POVERTY LEVEL (FPL) GUIDELINES

The 2018 Federal Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in family</th>
<th>Poverty guideline: 0-100% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$12,140</td>
</tr>
<tr>
<td>2</td>
<td>$16,460</td>
</tr>
<tr>
<td>3</td>
<td>$20,780</td>
</tr>
<tr>
<td>4</td>
<td>$25,100</td>
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<tr>
<td>5</td>
<td>$29,420</td>
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<tr>
<td>6</td>
<td>$33,740</td>
</tr>
<tr>
<td>7</td>
<td>$38,060</td>
</tr>
<tr>
<td>8</td>
<td>$42,380</td>
</tr>
</tbody>
</table>

For families/households with more than 8 persons, add $4,320 for each additional person.

ATTACHMENT 2: LIST OF DOCUMENTS REQUIRED FOR INCOME VERIFICATION

One (1) of the following forms of income documentation must be presented/sent to Insurance Services to verify income for eligibility for the Sliding Fee Discount Program:

- Two (2) pay stubs
- Most recent W-2
- IRS Form 1040 (Income Tax Form/Return)
- IRS Form 1099 (Income other than wages)
- Letter from employer
- Unemployment, disability compensation, SSI, SSDI, and worker's compensation.
- Patient Self-Declaration/Attestation if s/he is not working or does not have income verification documents

Patients must provide income verification documentation within 30 days of application or they will need to re-apply.
ATTACHMENT 3: SELF-DECLARATION OF INCOME

This form should only be used if third party verification of income has not yet been completed.

Print Applicant Name: _________________________________________________________

The patient will be presumed eligible for the SFDP program for fourteen days from the initial date of application. After fourteen days, if the patient does not provide income verification documents, they will no longer be presumed eligible for the SFDP and will be considered 100% self-pay unless they decide to apply for health insurance coverage. If the patient is found to be ineligible for the SFDP after the fourteen day period, full charges for services provided within that period will be reinstated. SECHC staff is expected to have exhausted all alternative options for verifying income prior to use of a self-declaration of income.

This is to certify the income status for the above named individual.

Check only one box and complete only that section

☐ I certify, under penalty of perjury, that I currently receive the following income:

Source: __________________________ Amount: _____________ Frequency: _____________
Source: __________________________ Amount: _____________ Frequency: _____________
Source: __________________________ Amount: _____________ Frequency: _____________

Applicant Signature: _________________________________ Date: ______________________

☐ I certify, under penalty of perjury, that I do not have any income from any source at this time.

Applicant Signature: _________________________________ Date: ______________________

Staff Verification
I understand that third-party verification is the preferred method of certifying income for assistance. I understand self-declaration is only permitted when I have attempted to but cannot obtain third party verification.

Documentation/description of attempt made for third-party verification:
____________________________________________________________________________________
____________________________________________________________________________________

Staff Signature: _________________________________ Date: _____________
PARTE 3: AUTO DECLARACIÓN DE INGRESO

Este formulario debe solo utilizarse si la verificación de ingresos por parte de un tercero aún no se ha completado.

Nombre Impreso Del Aplicante: _________________________________________________________

Se presumirá que el paciente es elegible para el programa SFDP (Escala de Tarifa) durante catorce días desde la fecha inicial de la solicitud. Después de catorce días, si el paciente no provee documentos de verificación de ingresos, ya no se presumirá que son elegibles para el SFDP (Escala de Tarifa) y se considerarán 100% (cien por ciento) de auto-pago a menos que decidan solicitar cobertura de seguro médico. Si se determina que el paciente no es elegible para el SFDP (Escala de Tarifa) después del período de catorce días, se reintegrarán los cargos completos por los servicios prestados dentro de ese período. Se espera que el personal de SECHC haya agotado todas las opciones alternativas para verificar los ingresos antes del uso de una autodeclaración de ingresos.

Esto es para certificar el estado de ingresos del individuo mencionado anteriormente.

Marque solo una casilla y complete solo esa sección.

☐ Certifico bajo pena de perjurio que, actualmente recibo los siguientes ingresos:

Fuente: __________________________  Cantidad: _____________  Frecuencia: _____________

Fuente: __________________________  Cantidad: _____________  Frecuencia: _____________

Fuente: __________________________  Cantidad: _____________  Frecuencia: _____________

Firma Del Solicitante: _________________________________________________________ Fecha: ______________________

☐ Certifico bajo pena de perjurio que, actualmente recibo los siguientes ingresos:

Firma Del Solicitante: _________________________________________________________ Fecha: ______________________

Verificación Del Personal
Entiendo que la verificación de un tercero es el método preferido para certificar los ingresos por asistencia. Entiendo que la autodeclaración solo está permitida cuando he intentado pero no puedo obtener la verificación de un tercero.

Documentación / descripción del intento realizado para la verificación de un tercero:
_________________________________________________________________________________________________________________

Firma De Personal: __________________________________________________________________________________________ Fecha: ______________________
Attachment 4: SLIDING FEE CONSENT FORM

PATIENT’S NAME: ____________________________ TODAY’S DATE ____________________________
MEDICAL RECORD NUMBER: ____________________________ DATE OF BIRTH ____________________________

Please read this section carefully and sign at the bottom.

I authorize my employer and my health insurer to give to South End Community Health Center (SECHC) information about income, health insurance premiums, coinsurance, co-payments, deductibles, and any covered benefits that I have.

If I am seeking assistance because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers’ compensation or an insurance carrier, I will repay SECHC for any medical services paid by the federal grant. I give SECHC the right to collect payments from insurers for medical care as appropriate.

While I am eligible for the Sliding Fee Discount Program, I agree to tell SECHC of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for the sliding fee scale.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize the SECHC to give to the granting agency or its designee the information needed to confirm my eligibility. I understand that SECHC cannot share confidential information contained in this application, with any state or federal agency, except as stated above, without my prior approval.

_______________________________________________________________________________________________________
Print name of applicant

_____________________________________________________________________________/_ ________________________________
Signature of applicant       Date

How would you rate the helpfulness of our Sliding Fee Schedule and Program in reducing your financial barriers to accessing care at SECHC? (check one box) Excellent ☐ Good ☐ Fair ☐ Poor ☐

Optional: Please take a moment to share your feedback on the effectiveness of this Sliding Fee Discount Program and Schedule in reducing financial barriers to accessing health care services.

_______________________________________________________________________________________________
_______________________________________________________________________________________________

FOR OFFICE USE ONLY

Eligibility Date:______________________________ Renewal/Termination Date:______________________________

Family Income $__________________________ Family Size__________________________

Attach income documentation: ☐ Pay stub(s) ☐ Tax Form(s) ☐ Self Declaration ☐ Other__________________________

Sliding Fee Discount Approved (check box):
☐ 0 – 100% of FPL = $0 payment  ☐ 101% – 133% of FPL = $10.00 payment
☐ 134% – 166% of FPL = $15.00 payment  ☐ 167% – 200% of FPL = $20.00 payment

Application processed/approved by:__________________________ Title:__________________________
Parte 4. CONSENTIMENTO DE ESCALA DE TARIFA FEDERAL

NOMBRE DEL PACIENTE: ___________________________________ FECHA DE HOY __________________________
NUMERO DE RECORD MEDICO: ___________________ FECHA DE NACIMIENTO ___________________

Lea esta sección detenidamente y firme al final

Yo autorizo a mi empleador y a mi seguro medico de salud proveer al South End Community Health Center (SECHC), mi informacion sobre ingresos, prima de seguro medico, co-pagos, co-seguro, deducibles o cualquier beneficio cubierto que tenga.

Si estoy buscando ayuda, debido a un accidente u otro incidente y recibo dinero debido a ese accidente o incidente de cualquier recurso, como compensacion a los trabajadores o una compania de seguros, yo re-pagare al centro de salud por algun servicio medico pagados por le subsidio federal. Yo autorizo al Centro de de al SECHC colectar pagos de aseguradoras para el servicio medico como sea apropiado.

Mientras sea elegible para la Escala de Tarifa, yo me comprometo a notificarle al SECHC de cualquier cambio en mi estatus familiar, incluyendo el tamaño de la familia, cambio de ingresos y cobertura de seguro medico que pueda cambiar mi elegibilidad para la Escala de Tarifa.

Toda informacion en esta aplicacion es cierta segun mi saber y entender. Yo me comprometo a proporcionar documentacion cuando sean requeridos. Yo autorizo al SECHC ceder a una agencia otorgante o su designado la informacion necesaria para que confirme mi elegibilidad. Yo entiendo que este SECHC no puede compartir, informacion confidencial proveida en esta aplicacion, con ningun estado o agencia federal, exeto como se indico anteriormente sin mi aprobacion previa.

Nombre impreso del aplicante
___________________________________________________________________________________________
Firma del aplicante                                      /                                   Fecha

Cómo calificaría nuestro Programa Escala de Tarifa para reducir sus barreras financieras para acceder a la atencion en SECHC? ( marque una casilla)  ☐ Excelente  ☐ Muy Bueno  ☐ Bueno  ☐ Regular  ☐ Deficiente

Opcional: Tómese un momento para compartir sus comentarios sobre la efectividad de este Programa Escala de Tarifa para reducir las barreras financieras para acceder a los servicios de atencion medica.
___________________________________________________________________________________________
___________________________________________________________________________________________

Solo para uso Oficial

Fecha de elegibilidad: ___________________________ Renovacion/Fecha de Terminación: ___________________________
Ingreso De Familia: $_________________________ Tamaño De La Familia: ___________________________
Adjunte documentacion de ingresos: ☐ Talonario(s) ☐ Impuesto(s) ☐ Auto Declaración ☐ Otro(s) ________________

Categoría de Escala de tasa de compensacion federal:
☐ 0 - 100% of FPL = $0 payment    ☐ 101% - 133% of FPL = $10.00 payment
☐ 134% - 166% of FPL = $15.00 payment  ☐ 167% - 200% of FPL = $20.00 payment

Aplicacion procesada/aprovado por: __________________________ Titulo: __________________________
ATTACHMENT 5 - SLIDING FEE SCALE
Effective: July 1, 2018

Who Can Qualify
The Sliding Fee Scale is a discount of charges for those eligible patients who either have no insurance or who have insurance but have high out of pocket expenses or the services are not paid for by insurance. Regardless of whether you have insurance or not, you must still meet the income guidelines. The sliding fee is a formula used to determine the availability of reduced charges to patients who qualify according to the number 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 last row under the column to find the copayment amount you will need to pay.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>0-100% of FPL Income level between:</th>
<th>101-133% of FPL Income level between:</th>
<th>134-166% of FPL Income level between:</th>
<th>167-200% of FPL Income level between:</th>
<th>201+% of FPL Income level</th>
</tr>
</thead>
<tbody>
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<td>$12,141 $16,146</td>
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<td>$56,366 $70,357</td>
<td>$70,358 $84,760</td>
</tr>
</tbody>
</table>

†Individuals with income levels over two-hundred percent (201%+) may be eligible for financial assistance through the Health Safety Net.
Attachment 6 – Sliding Fee Program Notice

SLIDING FEE POLICY NOTICE
As a Federally Qualified Health Center, South End Community Health Center (SECHC) offers sliding fee discounts to patients who meet the eligibility guidelines. No patient will be denied services based on their ability to pay. Information about SECHC’s sliding fee schedule, eligibility guidelines, eligible and non-eligible services, as well as our Board-approved Sliding Fee Policy is available at our registration desks and administrative offices.

Spanish Version -

AVISÓ DE CUOTA POLÍTICA DE DESCUENTOS
Como un Centro de Salud Federalmente Calificado, South End Community Health Center (SECHC) ofrece descuentos a pacientes que cumplen con los requisitos de elegibilidad. A ningún paciente se le negarán servicios basado en su capacidad de pagar. Información sobre los descuentos de SECHC, requisitos de elegibilidad, servicios elegibles y no elegibles, así como nuestra política de cobro de descuentos aprobada está disponible en nuestros escritorios de registro y oficinas administrativas.