CCAP
COMPREHENSIVE COMMUNITY ACTION PROGRAM
YOUR COMMUNITY'S HELPING HAND

Sliding Scale Discount

FI 540.00

Effective Date: 11/15/2023

Policy: Comprehensive Community Action will not deny care to any individual or family for an inability to pay. A Sliding Fee Discount Program will be provided to eligible persons/families based on the patient's family size and income. The persons/families eligibility for the Sliding Fee Discount Program will be determined by their family size and income based on the Federal Poverty Income Guidelines establishing the persons/families ability to pay under the Sliding Fee Discount Schedule.

Purpose: To assure access to health care services, limit interruption of health care services for all families and individuals meeting the criteria. Affordable fees are based on eligible person's ability to pay.

Procedure:

Annually, the sliding fee discount schedule (SFDS) will be reviewed and/or updated along with applicable policies and procedures by the Chief Financial Officer and FHS Director of Operations. This review will also be used to ensure amounts owed for health center services are adjusted based on the eligible patient's ability to pay. This will coincide with the annual release of the Federal Poverty Guidelines (FPG). All fee schedules, SFDS, updated policies and procedures and updated FPG will be presented to the board of directors for approval at the first board meeting that takes place after the FPG are released.

The Health Center will make notice of the sliding fee discount with posted signs in the waiting area as well as include information in the Patient Welcome Packet distributed to all new Health Center patients. Patients will also be educated during the new patient intake of the availability of the sliding fee discount based on the patient's family size and income.

The sliding fee discount will be applicable to all patients and families with annual incomes above 100% and at or below 200% of the FPG. A nominal fee of $30 will apply to all patients and families who are at or below 100% of the FPG; additionally, patients and families with incomes above 100% and at or below 200% of FPG will receive an adjustment of fees after completing the application process. Any patient or family with an annual income above 200% of FPG will not be eligible for the sliding fee discount. On a limited basis a patient may request a one-time charge waiver due to financial hardship(s). A financial hardship could be defined by but not limited to the following: loss of employment, release from incarceration, loss of home or loss of family income earner. These cases will be reviewed on an individual basis by the Director of Operations in consult with the Health Center Director.

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All patients applying for the SFDS must complete the SFDS application and provide written verification of gross annual income and family size living in the same home. A patient's family size will be determined by the number of persons sharing the same home; therefore, the SFDS application must include the names of all persons who are being claimed. Additionally, written verification of gross annual income must be presented in the form of but not limited to; pay stubs, W-2 forms, tax returns or award letters for state or federal income. Any failure to provide said documentation within 30 days of services will result in denial of the sliding fee discount. On a very limited basis, a self-declaration may be permitted at the discretion of the site manager. Any patient unable or unwilling to provide any level of documentation are not eligible to participate in the SFDS and will be required to pay 100% of their charges.

All applications for the SFDS will need to recertify each calendar year. Each patient will be asked to re-apply for the SFDS at the first Health Center visit of a new year. Additionally, patients are asked to notify the Health Center if there are any changes to their income amount or family size during the approved year.

Payment for all services performed in the Health Center is expected at the time of service per CCAP collection policy. Any outstanding balance will be discussed with the patient and options for payment plans and/or appointment with a financial counselor will be offered. Patients may be required to meet with a financial counselor to maintain their care at the Health Center. All patients will be billed on a monthly cycle. Any account with insufficient activity for 90 days will be reviewed for referral to an outside collection agency.

The Health Center may discharge any patient that demonstrates a clear "refusal to pay" for services. This will only take place after attempts to set up a payment plan, coordinate a meeting with a financial counselor and/or referral to an outside collection agency. This decision can only be made by management staff or higher administrative staff. These patients will be provided necessary prescriptions and acute care for a length of 30 days and may return to the practice after 1 year.

Scope: Operations at Family Health and Dental Services and Behavioral Health

Responsibility: Front Desk Staff, Financial Counselors, Billing Department

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Attachment:

Sliding Fee Scale Application

Patient Name				Date of Birth
Name of Head of Household				
Street	City	State	Zip	Phone
Health Insurance Name				

Please list spouse and dependents living in the same household

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				

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Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment, and dependents				
Rent, interest, dividend, and other income				
Total Income				

Verification Checklist (attach copies)	Yes	No
Identification/Address: Driver's license, birth certificate, employment ID, social security card or other		
Income: Prior year tax return, four most recent pay stubs, or other		

I certify that the information shown above is correct and understand verification is required for approval.

_____ _____

Patient or Guardian Signature Date

_____ _____