Title/Description Sliding Fee Scale				Filing Number CHC\#
Date Reviewed	Date Revised 1/1/2020	Date Effective 9/25/96	Applies to: Clinic Staff & Business Office Staff	Approved By: Kristen Templeton

STANDARD

The Sliding Fee Scale is for self-pay patients who request medical care at Hazel Hawkins Community Health Clinics and need financial assistance to pay their bill. To qualify for the Sliding Fee Scale program they must be ineligible for federal or state government assistance programs and/or insurance coverage through any third party payer. They must meet the Federal Poverty level laid out in the Slide Fee Scale Procedure below.

PROCEDURE:

The Sliding Fee Scale Guidelines are determined by the current year "Federal Poverty Income Guidelines" for size of household and income. (Example A)

An Assessment for Sliding Fee Scale Consideration Form will be completed on all patients that are self-pay who state that they would like to apply for the program on the Patient Questionnaire Form. (Example B)

Upon completion of the Assessment for Sliding Fee Scale Form by the patient, the Clinic Front Office clerk will:

- The Clinic Staff will verbally ask the patient for the number of members in their household
- The Clinic Staff will advise them that they have seven (7) calendar days to bring in the following required income documentation:

    1. Current month and last month's payroll stubs,
    2. Bank statements for the last 2 months,
    3. A copy of the last year's tax return or W2

- If the patient brings in one of the required income verification documentation they will be approved for the Sliding Fee Scale for one month. If they bring in two of the required income verification documentations they will be approved for the Sliding Fee Scale for 6 months.
- The Clinic Staff will advise the patient that if they are not able to bring the required documentation into the clinic within the seven (7) calendar days they will need to go to the Business Office located on the main hospital campus within thirty (30) calendar days with the required income documentation to qualify for the Sliding Fee Scale. Anything after thirty (30) calendar days will disqualify the patient for the Sliding Fee Scale and the patient will be charged full rate.

- Once the above information is received the Clinic Front Office staff or Business Office staff will compare the size of family and income to the Sliding Fee Scale Guidelines. Monthly or Yearly Income Guide will be used to determine the appropriate percentage level. The following is the amount the patient will pay for the clinic visit according to where they fall in the Federal Poverty Guidelines by the department of Health Care Services:

    1. Less than 100% of Federal Poverty Guideline patient will be discounted 100% of the clinic visit
    2. 100% to 149% of Federal Poverty Guideline patient will owe $10.00 per clinic visit
    3. 150% to 200% of Federal Poverty Guideline patient will owe $25.00 per clinic visit
    4. 201% to 250% of Federal Poverty Guideline patient will owe $50.00 per clinic visit
    5. Anything over the 250% of Federal Poverty Guideline patient will not qualify for the Sliding Fee Scale and will owe 100% of the visit.

- If the patient qualifies for the Sliding Fee Scale they will be asked to pay the full amount owed on the day that they qualify and/or at the time of the visit
- A copy of their charge sheet will be kept in a pending file for seven (7) calendar days.
- The Assessment for Sliding Fee scale Consideration Form will be scanned in the patient account.

ASSESSMENT FOR SLIDING FEE SCALE CONSIDERATION

All of the following questions MUST be answered

Number of family members that you provide sole support for _____ (must live in your home)

Total annual income _____

OR

Total monthly income _____

YOUR INCOME AMOUNT MUST BE SUPPORTED BY THE FOLLOWING:

1. Copies of payroll stubs for the current month and last month [ ]
2. Copies of your bank statements for the last 2 months [ ]
3. Copies of last year's tax return **OR** W2 Forms [ ]

Patient qualifies for: **[ ] One time visit only** **[ ] 3 months**

Date _____ **Percentage qualified at** _____ **%**

To qualify for the program all of the financial information must include the current month's income.

By signing I agree to bring in income verification and pay office visit within 7 calendar days.

Firmando esta forma entiendo que tengo que traer verficacion de ingresos y pagar por la consulta antes de 7 dias.

Signature / Firma: _____ **Date / Fecha:** _____

NOTE: IF YOU HAVE ANY TYPE OF HEALTH INSURANCE INCLUDING MEDI-CAL WITH A SHARE OF COST, YOU DO NOT QUALIFY FOR THE SLIDING FEE SCALE PROGRAM.

Hazel Hawkins
MEMORIAL HOSPITAL
SKILLED NURSING FACILITIES
HOME HEALTH AGENCY
San Benito Health Care District

HAZEL HAWKINS MEMORIAL HOSPITAL
911 SUNSET DRIVE • HOLLISTER, CA 95023
"A PUBLIC AGENCY"
(831) 637-5711

ASSESSMENT FOR SLIDING FEE SCALE CONSIDERATION

ADMFEESCALE

Patient Sticker