JACKSON-HINDS COMPREHENSIVE HEALTH CENTER
PATIENTS SLIDING FEE DISCOUNT PROGRAM POLICY

POLICY: To make available free or discounted services to those in need.

PURPOSE: All patients seeking health care services at JACKSON-HINDS COMPREHENSIVE HEALTH CENTER (JHCHC) are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay. This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (uninsured or underinsured).

JHCHC will offer a Sliding Fee Discount Program to all who are unable to pay for their services. JHCHC will base program eligibility on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule to determine eligibility.

PROCEDURE:
The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. **Notification:** JHCHC will notify patients of the Sliding Fee Discount Program by:
   - Payment Policy Brochure will be available to all patients at the time of service.
   - Notification of the Sliding Fee Discount Program will be offered to each patient upon admission.
   - An explanation of our Sliding Fee Discount Program and our application form are available on JHCHC's website.
   - JHCHC places notification of Sliding Fee Discount Program in the clinic waiting area.

2. **Request for discount**: Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk and the Billing Department.

3. **Administration:** The Sliding Fee Discount Program procedure will be administered through the Chief Financial Officer or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided to patients. Staff are to offer assistance for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided health care services.

4. **Completion of Application:** The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. Staff will be available, as needed, to assist patient/responsible party with applications. By signing the Sliding Fee Discount Program application, persons are confirming their income to JHCHC as disclosed on the application form.

5. **Eligibility:** Discounts will be based on income and family size only.

   a. **Family is defined as:** a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. JHCHC will also accept non-related household members when calculating family size.

   b. **Income includes:** gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

6. **Income verification:** Applicants may provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self- declaration of Income may be used. Patients who are unable to provide written verification may provide a signed statement of income.

7. **Discounts:** Those with incomes at or below 100% of the federal poverty guidelines (FPG) will receive a full discount for health care services. They will pay a nominal fee. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged a reduced fee according to the attached sliding fee schedule and based on their family size and income. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest Federal Poverty Line Guidelines (FPG).

8. **Nominal Fee:** Patients with incomes at or below 100% of the FPG pay a nominal fee so that patients do not perceive a financial barrier to access of care. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care, and thus is not a minimum fee or co-payment.

9. **Waiving of Charges:** In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges must be approved by JHCHC's designated official. Any waiving of charges should be documented in the patient's file along with an explanation.

10. **Applicant notification:** The Sliding Fee Discount Program determination will be provided to the applicant(s), and, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, JHCHC will work with the patient and/or responsible party to establish payment arrangements. Sliding Fee Discount Program applications cover any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income.

11. **Refusal to Pay:** If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, JHCHC can explore options not limited to, but including offering the patient, a payment plan, or waiving of charges. Discharging patients due to refusal to pay is an action of "last resort" to be taken only after reasonable and extensive efforts have been made to secure payments.

12. **Record keeping:** Applicants that have been approved for the Sliding Fee Discount Program will be logged in JHCHC's practice management system, noting names of applicants, dates of coverage and percentage of coverage.

13. **Policy and procedure review:** The Sliding Fee Schedule is updated based on the current Federal Poverty Guidelines. JHCHC also reviews possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.

ATTACHMENTS:
- 2023 Sliding Fee Schedule
- Patient Application for the Sliding Fee Discount Program

Jackson Hinds Comprehensive Health Center 2023 Sliding Fee Scale

Family Size	$20 (nominal)	>$20 or 20% charge	>$20 or 40% charge	>$20 or 60% charge	>$20 or 80% charge	Full Charge
	% Of FPL					
	A	B	C	D	E	F
	≤100%	101%-125%	126%-150%	151%-175%	176%-200%	>200%
	Annual Income					
1	$14,580	$14,581-$18,225	$18,226-$21,870	$21,871-$25,515	$25,516-$29,160	≥$29,161
2	$19,720	$19,721-$24,650	$24,651-$29,580	$29,581-$34,510	$34,511-$39,440	≥$39,441
3	$24,860	$24,861-$31,075	$31,076-$37,290	$37,291-$43,505	$43,506-$49,720	≥$49,721
4	$30,000	$30,001-$37,500	$37,501-$45,000	$45,001-$52,500	$52,501-$60,000	≥$60,001
5	$35,140	$35,141-$43,925	$43,926-$52,710	$52,711-$61,495	$61,496-$70,280	≥$70,281
6	$40,280	$40,281-$50,350	$50,351-$60,420	$60,421-$70,490	$70,491-$80,560	≥$80,561
7	$45,420	$45,421-$56,775	$56,776-$68,130	$68,131-$79,485	$79,486-$90,840	≥$90,841
8*	$50,560	$50,561-$63,200	$63,201-$75,840	$75,841-$88,480	$88,481-$101,120	≥$101,121

*For families/households with more than 8 persons, add $5140 for each additional person

Approved by Board of Directors, 01/23/2023

Based on HHS 2023 Federal Poverty Guidelines

Source: Federal Register

JACKSON-HINDS COMPREHENSIVE HEALTH CENTER

SLIDING FEE DISCOUNT PROGRAM

Part of being your indispensable healthcare partner means offering a patient-friendly Sliding Fee Discount. JHCHC maintains a standard procedure for qualifying patients for sliding fee discounts for services provided. Sliding fee discounts are available to patients with all incomes at or below 200% of the federal poverty guidelines. Sliding fee discounts apply to all directly provided JHCHC's services, and for all in-scope services. Opportunities for assistance are available to all qualifying patients – regardless of whether you have insurance. Please complete the application and BE SURE TO ATTACH ALL REQUESTED DOCUMENTATION. Applications lacking required proof of income will be voided and you will be responsible for any subsequent visits at Jackson-Hinds.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

(Street Address) (City) (State) (ZIP Code)

PLEASE INDICATE YOUR CURRENT LIVING ARRANGEMENTS

- ❑ Own/Rent
- ❑ Homeless Shelter Name of Shelter_____
- ❑ Transitional (Live in halfway house) Name of Transitional Home _____
- ❑ Doubling up (Live with relative or friend)
- ❑ Street

LIST ALL PERSONS LIVING IN HOUSEHOLD

NAME	RELATIONSHIP TO PATIENT	AGE	INCOME Please circle one: Weekly, Bi-Weekly, Monthly, Yearly	SOURCE OF INCOME Job, SSI, SNAP benefits, etc.
	SELF			
Total Household Annual Income				

****ALL FAMILY MEMBERS OVER THE AGE OF 21 LISTED ABOVE MUST PRESENT INCOME OR A NOTARIZED LETTER STATING HE/SHE HAS NO INCOME AND LIVE WITH YOU FREE OF CHARGE****

Please read carefully before signing:

I hereby certify that I have examined the contents of this form and to the best of my knowledge and belief, the said contents are true and correct statements of my family income and size. Also, I understand that I must provide this information at least yearly to receive sliding fee discount for services. I understand that if I am applying for financial assistance and do not have any source of income or do not have proof of income with me today, Jackson-Hinds will discount my services for today's visit only**. However, I will be totally responsible for any subsequent visits at Jackson-Hinds, if I do not bring proof of income**. I understand that certain payments may be required at the time of, or in advance of, services being provided. I also understand I will be billed for any charges not paid by my insurer, and I will be responsible for paying them. Any false statements, documents or concealment of a material fact will disqualify me from receiving sliding fee discounts.

_____ _____

Signature of Patient or Legal Guardian **Date**

FOR OFFICE USE ONLY: _____ Partial Attestation (one visit per calendar year) OR _____ Full Sliding Fee (year)