Sliding Fee Discount Program

EFFECTIVE DATE: July 15, 2024

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

PURPOSE: All patients seeking health care services at Goodland Family Health Center (GFHC) 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 and behavioral health services (uninsured or underinsured). GFHC will offer a Sliding Fee Discount Program to all who are unable to pay for their services.

GFHC will base program eligibility on a person's ability to pay and will not discriminate based on 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: GFHC will notify patients of the Sliding Fee Discount Program by:
    - Payment Policy Brochure will be available to all patients at the time of service.
    - An explanation of our Sliding Fee Discount Program and our application form are available on Goodland Regional Medical Center's website.
    - GFHC will post a 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 Business Office.
3. Administration: The Sliding Fee Discount Program procedure will be administered through the Business Office Manager 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 GFHC as disclosed on the application form.
5. Eligibility: Discounts will be based on income and family size only. *No other factor (e.g., assets, insurance application and/or coverage, citizenship, population type) can be used to assess eligibility. GFHC does not require Medicare, Medicaid, or Children's Health Insurance Program (CHIP) application or proof of denial before allowing a patient to apply and be eligible for the Sliding Fee Discount Program.*
    - 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. GFHC will also accept non-related household members when calculating family size.
    - 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 poverty will receive a full 100% discount for health care services. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged a nominal fee according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest Federal Poverty Line Guidelines.
8. Nominal Fee: Patients with incomes above 100% of poverty, but at or below 200% poverty will be charged a nominal fee according to the attached sliding fee schedule and based on their family size and income. 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 GFHC 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) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, GFHC will work with the patient and/or responsible party to establish payment arrangements. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and 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. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.
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, GFHC can explore options not limited to, but including offering the patient a payment plan, waiving of charges, or referring the patient to collections.
12. Record keeping: Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Business Office Manager's Office, in an effort to preserve the dignity of those receiving free or discounted care.
    - Applicants that have been approved for the Sliding Fee Discount Program will be logged in GFHC practice management system, noting names of applicants, dates of coverage and percentage of coverage.
    - The Business Office Manager will maintain an additional monthly log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials and applications not returned will also be logged.
13. Policy and procedure review: The Sliding Fee Schedule will be updated based on the current Federal Poverty Guidelines. GFHC will also review 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.
14. Budget: During the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed into the budget as a deduction from revenue.

ATTACHMENTS

- Patient Application for the Sliding Fee Discount Program

SLIDING FEE DISCOUNT PROGRAM PATIENT APPLICATION

It is the policy of Goodland Family Health Center (GFHC) to provide essential services regardless of the patient's ability to pay. GFHC offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

Name		SS #	
Address		Phone	

Please list all household members, including those under age 18.

	Name	Date of Birth	Insurance/Self Pay	Employer
Self				
Other				
Other				
Other				
Other				
Other				
Other				

If uninsured, do you have an insurance application pending? Yes No

Source	Self	Other	Total
Gross wages, salaries, tips, etc.			
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			
TOTAL INCOME			

I certify that the family size and income information shown above is correct.

Name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

GOODLAND REGIONAL MEDICAL CENTER

SLIDING FEE SCALE APPLICATION

PATIENT NAME:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

SPOUSE/PARENT:_____

ADDRESS:_____CITY_____STATE:_____ZIP:_____

PHONE NUMBER:_____DO YOU HAVE INSURANCE? YES_____NO_____

WE WILL NEED YOUR LAST 3 MONTHS CHECKSTUBS AND INCOME TAX RETURN

HOUSEHOLD INCOME: GROSS WAGES, SALARIES, TIPS, ETC

NAME	AMOUNT	FREQUENCY	EMPLOYER
_____	$_____	WK/MO/YR	_____
_____	$_____	WK/MO/YR	_____
_____	$_____	WK/MO/YR	_____
_____	$_____	WK/MO/YR	_____
_____	$_____	WK/MO/YR	_____
TOTAL	$_____		

OTHER INCOME INCLUDING DEPENDENTS:

SELF EMPLOYMENT	$_____	WK/MO/YR
SOCIAL SECURITY/PUBLIC ASSISTANCE	$_____	WK/MO/YR
UNEMPLOYMENT/WORK COMP/PENSION	$_____	WK/MO/YR
CHILD SUPPORT/ALIMONY	$_____	WK/MO/YR
TOTAL	$_____	
TOTAL OF ALL INCOME	$_____	

HOUSEHOLD SIZE (HEAD OF HOUSEHOLD, SPOUSE, DEPENDENTS)

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VERIFICATION MUST BE RECEIVED WITHIN 14 DAYS OF APPLICATION DATE. YOUR ANNUAL INCOME AND YOUR FAMILY SIZE WILL BE USED TO CALCULATE YOUR DISCOUNT.

I DO HEREBY SWEAR OR AFFIRM THAT THE INFORMATION PROVIDED ON THIS APPLICATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE THAT ANY MISLEADING OR FALSIFIED INFORMATION, AND/OR OMISSIONS MAY DISQUALIFY ME FROM FURTHER CONSIDERATION FOR THE SLIDING FEE PROGRAM AND WILL SUBJECT ME TO PENALTIES UNDER FEDERAL LAW WHICH MAY INCLUDE FINES AND IMPRISONMENT. I FURTHER AGREE TO INFORM GOODLAND REGIONAL MEDICAL CENTER/GOODLAND FAMILY HEALTH CENTER IF THERE IS A SIGNIFICANT CHANGE IN MY INCOME. IF ACCEPTANCE TO THE SLIDING FEE PROGRAM IS OBTAINED UNDER THIS APPLICATION, I WILL COMPLY WITH ALL RULES AND REGULATIONS OF GOODLAND REGIONAL MEDICAL CENTER/GOODLAND FAMILY HEALTH CENTER. I HEREBY ACKNOWLEDGE THAT I READ THE FOREGOING DISCLOSURE AND UNDERSTAND IT.

DATE_____ NAME (PRINT):_____

SIGNATURE_____

APPROVED DISCOUNT:_____

APPROVED BY:_____

DATE APPROVED:_____

EXPIRATION DATE_____

NOTES: