College of Nursing
UNIVERSITY OF COLORADO
ANSCHUTZ MEDICAL CAMPUS

Sheridan Health Services
COLLEGE OF NURSING
UNIVERSITY OF COLORADO

FINANCE

Title:	Sheridan Sliding Fee Program Procedures
Source:	HRSA Compliance Manual
Approved by:	Sheridan Health Services Board of Directors
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Applies to:	☑ Belleview Point ☑ Sheridan Family Health Clinic ☑ Sheridan Youth Health Clinic ☑ Sheridan Pharmacy

I. PURPOSE

A. A sliding fee schedule(s) has been developed to meet regulations that require federally funded health centers, such as Sheridan Health Services, to charge fees according to the patient's ability to pay. As a federal grant recipient, the clinic must demonstrate an effort to provide services beyond the time, scope, and amount of federal funding. Grantee funding must be matched by income generated for the delivery of services. Clinic health care recipients are expected to pay a share of the cost of their care.

B. Sheridan Sliding Fee Schedule program (SFS) is only valid at Sheridan Health Services locations. SFS is not insurance. It is not intended to be used outside of SHS. We will screen first for Medicaid, Child Health Plan Plus (CHP+), or any other state-funded program in which we participate. The enrollment specialists will also assist clients to apply for commercial insurance through the Colorado insurance marketplace. If eligible for any of these programs, and patients refuse to enroll, they can apply for SFS. This is less than ideal, as SFS is not insurance. Individuals must be within 0-200% Federal Poverty Level (FPL) and must provide proof of income and household members (detailed below). Patients who refuse to provide (the required documentation will be deemed ineligible.

C. SHS is not responsible to cover any charges incurred by patients outside of SHS. To be enrolled in the program an individual must apply and comply with a financial screening. Ratings are completed yearly or if there is a change in family size and income before the 12 months.

II. PROCEDURE

A. Sheridan Sliding Fee Schedule program (SFS) is only valid at Sheridan Health Services locations. SFS is not insurance. It is not intended to be used outside of SHS. We will screen first for Medicaid, Child Health Plan Plus (CHP+), or any other state-funded program in which we participate. The enrollment specialists will also assist clients to apply for commercial insurance through the Colorado insurance marketplace. If eligible for any of these programs, and patients refuse to enroll, they can apply for SFS. This is less than ideal, as SFS is not insurance. Individuals must be within 0-200% Federal Poverty Level (FPL) and must provide proof of income and household members (detailed below). Patients who refuse to provide (the required documentation will be deemed ineligible.

a. Eligibility Process

1. In-person or virtual screening with the Outreach and Enrollment Specialist to determine eligibility.
2. Complete SFS application. All fields must be completed.
3. The Outreach and Enrollment Specialist will review income documents and complete the assessment calculations. Both the Outreach and Enrollment Specialist and the applicant must sign and date the application.

b. Family Composition Determination

1. For purposes of eligibility assessment for the Sheridan Health Services Sliding Fee Schedule Program, SHS will use the term of family, rather than household. Family is defined as a group of two or more persons related by birth, marriage, or adoption who live together; all such related persons are considered as members of one family if they are applying together as one family unit. As an example, if an older married couple, their daughter and her husband and two children, and the older couple's nephew all lived in the same abode; they would all be considered members of a single-family as long as they are applying together as a family unit. If perhaps, the daughter and her husband and children support themselves and have insurance, they would not be considered as part of the family unit for purposes of assessment for the SFS program.
2. Examples of family members that can be included:
   - Children, step-children, adopted children, foster children (even though not related by blood).
   - Spouse, common law, civil union partners.
   - Adult children over the age of 18 with disabilities being cared for as a dependent.
   - Adult children who are still in high school can be counted in the household size; if employed, their income must be included if older than 15.
   - And, as an exception, a non-related person living in the household with the family unit, for which the medicals bills are being guaranteed by the householder.
3. If an applicant is residing in a household where the householder is guaranteeing the medical bills, then you need to complete the application to include the financial information of the guarantor.

c. Family Income Determination
   1. The income of the family unit includes that of the householder and all other family members in the household, over the age of 15, is included in the family unit application.
   2. And, as an exception, the income of the non-related person living in the household with the family unit, for which the medicals bills are being guaranteed by the householder.

d. Income Verification
   1. Patients must bring proof of income for the last 3 calendar months (consecutive pay periods). Proof of income can be paycheck stubs, or income verification letter completed by employer or manager. A tax return may be used as supplementary information if there are no significant income changes.
   2. If self-employed, patients can self-declare income using an employment ledger. Self-employed individuals can use business-related expenses as deductions if incurred in the month reported. A tax return may be used as supplementary information if there are no significant income changes.
   3. Unearned income is self-declared.

e. Income Average Pay Method Calculations
   1. Weekly: Add gross pay amounts from checks for the entire period collected. Divide the amount by the number of checks provided. Multiply by 4.333 (this equals the monthly amount). Then multiply by 12 (this equals the yearly amount).
   2. Bi-weekly (paid every 2 weeks): Add the gross pay amounts from checks for the entire period collected. Divide the amount by the number of checks provided. Multiply by 2.1666 (this equals the monthly amount). Then multiply by 12 (this equals the yearly amount).
   3. Semi-monthly (paid twice a month): Add gross pay amounts from checks for the entire period collected. Divide the amount by the number of checks provided. Multiply by 2 (this equals the monthly amount). Then multiply by 12 (this equals the yearly amount).
   4. Monthly: Multiply gross pay amount by 12 (this equals the yearly amount).

f. Gross Income Calculation
   1. Obtain the applicants most current year-to-date paystub.
   2. Annualized gross based on the applicant's cumulative year-to-date gross earnings on the pay stub.
      - To determine the annualized income, count the number of pay periods that have occurred since January 1, or the person's start date with employer.
      - Divide that number into the gross year-to-date earnings indicated on the pay stub.
      - Multiplied by the number of pay periods in a year to determine the annualized gross earnings.

g. Proof of Identity

1. Patients must bring an ID regardless of the country where it was issued. Patients do not need proof of lawful presence.
2. Homeless patients do not need to furnish an ID if they do not have it and can't afford to replace it. Homeless status can be self-attested.

h. Proof of Address
   1. This can be a public service bill, water bill, phone bill, telephone bill, bank statement, or other proof of address. This has to reflect the applicant's name, address, and date issued. The bill must be from either the previous calendar month or the current month.
   2. If the applicant resides with someone else, the person they reside with can provide the bill under their name and write a letter stating the applicant lives with them.
   3. Homeless patients do not need to furnish proof of address. Homeless status can be self-attested.

i. Assets
   1. Assets are not part of the calculation for eligibility.
   2. Assets are NOT counted to determine fee schedule category.

j. Eligibility
   1. Once assessed, the SFS is effective for one year from the time of approval unless there are changes that require a new application. See k below. The date of the application must be entered into the system. Provide the patient with an SFS eligibility card.

k. Re-evaluation
   - Is required if certain changes in the household occur. Patient re-evaluations affect only future charges. Therefore, charges incurred after the initial rating, but before the re-evaluation, are discounted based on the client's initial fee category.

   2. Patients requests a re-evaluation and provides documentation that show that their circumstances have changed since the initial assessment.
   3. Documentation is reviewed by an Outreach and Enrollment Specialist, and they determine if the re-evaluation is approved.
      - Reasons for a re-evaluation to occur may include one or more of the following:
        (a) Family income has changed significantly;
        (b) The number of family members has changed;
        (c) An error in the initial calculation; OR
        (d) The annual assessment period has expired.

l. SHSSF as a secondary payer
   1. Patients with health insurance are also eligible for SFS
   2. The SFS would be for services not covered by the primary plan or for patient responsibility such as deductibles, co-pays, co-insurance.

m. Covered services
   1. Services provided at SHS include Dental, Medical, and Behavioral Health visits.

2. Supplies and equipment provided in service may be charged. Patients must be informed of these costs in addition to visit costs. Examples would be things like IUDs or dentures, etc. Medical items have an associated CPT code and fee; dental items will be charged to the patient account using the code of "DENTLAB" and the amount of the actual item plus an overhead percentage.

n. Fees
   1. Patients must pay fees at the time of service.
   2. There should be reasonable collection efforts made.
   3. If the patient is unable to pay the full amount due at the time of service, attempts to collect a partial payment should be made. Patients will be billed for any unpaid balances. (Refer to Billing & Collection Policy.)

o. Other notes
   1. Sliding Scales do not apply to medications/vaccines. Medications/vaccines are still subject to the regular SHS fee for each item.
   2. Lab, office visit, procedures, behavioral health individual and group sessions, and dental preventive and restorative visits are subject to the slide and have separate charges.
   3. Dental Devices are under a different sliding scale and have additional charges applied.
   4. During the approval process, the Outreach and Enrollment Specialist will inform the patient of possible costs not covered by the sliding scale.

References

Health Center Program Compliance Manual
https://bphc.hrsa.gov/compliance/compliance-manual/introduction