

Mid-State Health Center

This policy and/or procedure applies to all Mid-State Health Center locations.

Title: Sliding Scale Policy

Number: FINpol-1900.1

Department: Finance

Effective Date: 05/04/1996

Approved By: Board of Directors

Responsible Party(s): Chief Financial Officer

PURPOSE: To establish definitive procedures and guidelines for identifying and processing of Mid-State Health Center's Sliding Scale/Community Care Program.

SCOPE: This policy applies to all employees and patients of Mid-State Health Center (MSHC).

DEFINITIONS:

POLICY:

Sliding Scale/Community Care/Charity Care is voluntarily provided to patients who are unable to pay for all or part of the costs of their health care. Determination of charity care will be made prospectively using a formal evaluation process based on income and family size only. Discounts are provided in a manner that meets all Health Center Program requirements. Retrospective application of the Community Care Guidelines for existing balances will be made on a case-by-case basis. The evaluation process shall be conducted in a manner sufficient to identify the patient's ability to pay, applied uniformly to all persons regardless of race, color, sex, age, natural origin, disability, religion, or sexual orientation.

Notification: Mid-State Health Center will notify patient of the Sliding Fee Discount Program by:

- Payment policy will be available to all patients at the time of service.
- Notification of Sliding Fee Discount Program will be offered to each patient at check-in.
- An explanation of Mid-State Health Center's Sliding Fee Discount Program and application form will be available on our website, www.midstatehealth.org.
- Mid-State Health Center displays notifications of Sliding Fee Discount Program in the clinic waiting areas.
- Currently Mid-State Health Center offers help to its patients up to 200% of the Federal Poverty Guidelines (FPL). If patient income falls below 100% FPL on the Sliding Scale then it is requested that they pay a nominal fee of \$10 for the visit. If a patient falls between 101% to 200% of FPL they are required to pay a fee based on the income level.
- ***Each clinician encounter will require a fee (Medical and Behavioral Health appointments occurring on the same day will incur 2 nominal fees)***
- ***Lab Draws on the same day as a clinician encounter will only be one fee (no additional nominal fee if done same day as medical office visit)***
- ***Nurse Appointments on the same day as a clinician encounter will only be one fee (no additional nominal fee if done same day as medical office visit)***

PROCEDURE:

The Patient Financial Services Department of Mid-State Health Center will maintain the process that provides controls for the proper identification and evaluation of Sliding Scale/Community Care/Charity Care provided to our patients. Determination of eligibility shall be based on the patient's family¹ size and income³, which must meet the income guidelines indicated on the Sliding Scale outlined on Mid-State Health Center's Community Care Guidelines. Mid-State's Community Care Guidelines are updated annually based on the U.S. Health and Human Services Department's Annual Poverty Guidelines published annually in the Federal Register to determine eligibility for its Sliding Scale/Community Care/Charity Care Program.

When a potential Sliding Scale/Community Care/Charity Care applicant is identified:

- The Patient Account Representative shall provide a Mid-State Health Center application to the patient or person requesting the application. If the applicant is unable to complete the application, the Patient Account Representative will assist in the completion of the application.
- The Patient Account Representative will consider all **family¹ or household² income³** in the eligibility determination process.
- The Patient Account Representative shall review the application to make sure it is complete and includes a signed attestation stating that the information provided is complete and accurate.
- Mid-State Health Center reserves the right to verify the information provided by the applicant and has the right to deny any application that is not signed, deemed to be incomplete, or inaccurately reflects the financial position of the applicant.

Determination of eligibility is granted on a sliding fee basis. Once a determination of eligibility has been made:

- The Patient Accounts Representative will notify the applicant in writing.
- Will apply to services rendered up to 60 days prior to eligibility determination, and may extend up to, but not more than 12 months, without CFO approval.
- The letter to the patient will:
 1. Advise the applicant of the amount or percentage that they are responsible to pay.
 2. Notify the patient of the effective dates during which they will be eligible for the sliding scale discount.
 3. Copy of this letter can be sent to Spear Memorial Hospital, if their services have been utilized.

Should the applicant require assistance with the remaining portion of their bills, payment arrangements will be made and monitored by collections dept.

Incomplete Application:

Should an application be deemed to be incomplete, a notice will be sent to the patient notifying them of the deficiency(ies) with a date that the requested information needs to be returned.

Re-Determination:

Re-determination for community care program eligibility will be done annually for those patients on a fixed income, and every 6 months for those that are unemployed or are low income but working.

Waiving Charges:

See FINpol 1900.2 Waiving Fees Policy

Refusal to Pay⁴ :

See Policy FINpol 1900.3 Refusal to Pay Policy

Nominal Fee Review:

Annually the patient accounts representative (PAR) will poll those patients applying for sliding scale to gauge whether or not the nominal fee amount reasonable. This polling information and the PAR's suggestions will be given to the CFO who will then bring it before the Finance Committee. The Finance Committee will discuss the information from the poll and the PAR recommendations and bring a recommendation before the board, either recommending the polls and/or PAR's nominal fee amount or recommending no change with an explanation why or a different amount with an explanation why.

¹**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.

²**Household** is defined as a group of two people or more, who are not married but live together with a shared child(ren) or one individual with no others residing in the home.

³**Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

Procedure:

Uninsured: At time of check-in an uninsured patient is to be charged the flat rate fee associated with their determined sliding fee level. The remaining balance for the office visit charge is to be adjusted so the patient is only charged at most the fee associated with sliding fee level.

Insured: At time of check-in an insured patient who has a copayment assigned by their insurance carrier shall be charged the amount of the copayment up to the fee associated with their determined sliding fee level (ie: \$30 copay assigned by insurance carrier, qualify as a sliding fee level 2 will only be charged the \$25 fee associated with level 2 sliding fee scale). Once the claim is processed by the insurance company, should there be a remaining balance, the patient shall be responsible for payment up to the fee associated with their determined sliding fee level (ie: \$20 copayment assigned by insurance carrier, qualify as a sliding fee level 4 \$50 copayment, \$60 remaining balance after insurance processed, patient will pay \$20 copayment at check-in, then will be charged \$30 for the remaining balance).

RESOURCES:

- Current Sliding Fee Discount Schedule
- FINpol-1901.1 Sliding Scale Policy for Dental Services
- FINpol-1900.2 Waving Fees Policy
- FINpol-1900.3 Refusal to Pay Policy
- FINpol-1900.4 Payment Plan Policy

Reviewed Date: 08/17/2017, 03/11/2021, 03/27/2023, 3/26/2024, 4/22/2024, 9/13/2024, 2/21/2025, 2/18/2026

Revised Date: 01/25/2021, 03/11/2021, 03/27/2023, 4/22/2024, 9/13/2024, 2/18/2026

By: LD, ACB

Approved By:

Board of Directors: (Print) Chelsea Salomon (Sign):  Date: 2/26/26

