DODDRIDGE COUNTY HEALTH DEPARTMENT
CLINICAL SERVICES
FINANCIAL POLICY AND PROCEDURES

EFFECTIVE DATE: JANUARY 1, 2016

The Doddridge County Health Department, which shall be further referred to as DCHD, uses a charge schedule with a corresponding discount schedule based on income for persons between 150% and 250% of the Federal Poverty Level. These services are not denied to patients based on their inability to pay. Some services are not subject to the discount policy and require full payment at the time of service. These include Blood Test received from the "Outside Lab" at a reduced rate and **purchase of private vaccine.**

PURPOSES

1. To ensure that revenues are available to meet the expenses of services delivery.
2. To provide some flexibility in the manner patients desire to pay for series received.
3. To assist patients in making payments, taking into consideration their ability to pay.
4. To comply with existing third party requirements.
5. To provide for consistency in administering clinic finances at the DCHD.

PROCEDURE

1. The office staff will inform all patients, at the time of registration, of the Doddridge County Health Department's Clinic Financial Policy and Procedures and issue a summary of the policy to each patient with request that they read and sign it (Exhibit 2). Specific questions about the policy should be promptly referred to the Billing Office. Each client of DCHD should have one signed "Exhibit 2" in their medical record after visiting DCHD. This will ensure that they have been told and understand our new Policies and Procedures.
2. Patients who receive services are directed to the cashier or office staff by the discharge nurse/designated person.

3. The cashier/office staff assesses each Medical Record for services received and determines method of payment.

INSURANCE AND OTHER 3RD PARTY COVERAGE
(Not to include Medicare, Medicaid, or PEIA)

1. Clients will be required to pay, up front, for all services, even if they have insurance coverage, and will be presented with a Superbill so that they can file their own insurance claims.

EXCEPTION: Programs that will be invoiced for services will include Government Programs and any agreements established for services and reimbursement of these services, including any billing requirements stated by these agreements.

Medicaid/HMO Cards:

A copy of the Medicaid card and HMO card, if applicable is to be placed in the client's record.

Medicare: A copy of the Medicare card should be obtained for the client's record.

PEIA Subscribers: A copy of the insurance card(s) should be placed in the client's record. PEIA; those clients that are receiving LabCorp services need to have a copy of their insurance card sent with the lab specimen. The "outside lab" will handle the billing process from their end for the lab tests charges. All of DCHD charges will be billed to PEIA by the Health Department Billing Office Assistant. It is a state requirement that we bill PEIA Insurance. If the client has not met their annual deductible, we are to collect monies up to their deductible amount. If the client is unsure if they have met their deductible, a call needs to be placed to the insurance company.

2. Medicaid and Medicare payments are considered full payment and the patient will not be billed for the balance, unless the procedure is a **non-covered service deemed by Medicaid or Medicare and the patient has signed that they want the service (see exhibit 4). The client will be responsible for the balance.**

3. Patients with special program coverage such as Family Planning, TB Program, and other approved contract coverage will not be responsible for payment of these covered services, unless provided for in the particular program guidelines. Office personnel will verify the patient's eligibility for these program services and process the appropriate report and claim forms. Office personnel are responsible to explain to the patient coverage which affect their visits.

PRIVATE PAY BALANCES (income over 250% FPL)

1. Full payment is due on the date of service, unless credit arrangements are approved by the DCHD Billing Office or those appointed. The office staff will provide the patient with a Superbill showing the charges for services rendered and request payment by cash, check or money order.

2. Upon request, a complete itemized statement of services provided and charges made will be provided to the patient, or authorized third party.

3. The office staff will give the patient a receipt when payment is made on the account.

DISCOUNT, BASED ON SLIDING FEE SCHEDULE

1. Patients with income between 150% and 250% of the Federal Poverty Level can pay charges based on a sliding fee schedule (Exhibit 5). The patient is required to make a minimum payment of $10.00 of the private pay balance on the date of service to qualify for this discount.

2. Special services requests (not related to treatment and preventative care visits) are not subject to discounts and credit arrangements. Examples are any blood tests received from the "outside lab" at a reduced rate. Full payment is due on the date of service and patient is to understand this before receiving services.

3. Patients desiring consideration for discounts will be required to provide proof of income on the date of service.

   2 proofs of gross income within that last 30 days are required (i.e. last two paystubs, print out from employer, etc.)

EXCEPTION: Programs that state they do not require documentation of proof of income; (e.g. Family Planning, PHS) etc.

A. Employment related income verifications:
   a) 2 Pay stubs from their employer within last 30 days
   b) Proof of unemployment received within last 30 days

c) Statement from employer, on letter head, about gross wages made within the last 30 days.

B. Disability or retirement income verifications:
   a) Letter stating award amount of disability or retirement income.
   b) Copy of check stubs within last 30 days
   c) Statement from local office regarding amount.

C. Support Payments:
   a) Statement from Child Advocate or Bureau of Child Support Enforcement.
   b) Copy of check

4. The Office Staff will then have the patient complete and sign Exhibit 3. The office staff will determine if the patient is eligible for a discount by comparing the patient's information with Exhibit 5.

5. After the office staff has determined the sliding fee discount and the patient has paid, the patient will then receive a receipt.

6. If the patient cannot pay the $10.00 at the time of service, a payment plan (Exhibit 1) for the full amount should be signed by the patient and account should be followed as a normal private pay account. The discount does not apply in this situation.

7. If the patient has no income, the client will fill out the income section of the Registration Form answering the questions under income. This will then be referred to the Billing Office Assistant in Clinical Services to determine patient responsibility.

8. The Billing Office Assistant will prepare a monthly report on sliding fee discounts to be turned into Administration and then to the accountant each month.

9. The Billing Office Assistant and Public Health Nurse, who is the Director of Clinical Services, will be responsible for implementing this policy, training personnel in its use, and to monitor to insure the policy is being followed correctly.

10. This policy shall be reviewed by all Clinical staff on an annual and as needed basis.

11. New patient definition-If a patient has been without services for 3 years or greater, they will be considered a new patient.

CREDIT ARRANGEMENTS

1. If full payment cannot be made at the time of service, credit arrangements may be available.

2. Credit arrangements will be recorded on an approved payment plan form (Exhibit 1) and signed by the patient's responsible party.

3. Monthly payments are due within 10 business days of receipt of monthly statement.

4. Credit payments may not be less than 20% of balance per month until balance is -0-, not to exceed five (5) payments.

5. A request to pay less than 20% of the balance per month will be subject to review and approval of the Billing Office personnel.

6. Failure to make one monthly payment could make the full balance due immediately.

CHARITY CARE

1. Patients with verified incomes under 100% of the Federal Poverty Level are eligible for care.

2. Special service requests (not related to treatment and preventive care visits) are not subject to Charity Care. Examples are blood tests received from "outside labs", children's physicals, (except those eligible for EPSDT/Healthcheck and PHS Programs) and other special purchased vaccines. Payment will be expected at the check in process of the visit.

3. Patients will be required to provide proof of income on date of service to qualify for charity care.

4. The office staff will then have the patient fill out and sign Exhibit 3.

5. The Billing Office Assistant will prepare a monthly report on Charity Care to be turned in to the Administrator by the 12th of each month or next business day.

6. The Billing Office Assistant and Public Health Nurse will be responsible for implementing this policy, training personnel, and to monitor to insure the policy is being followed correctly.

GENERAL

1. Notices will be posted in the lobby and other patient areas to alert and explain that proof of income, to qualify for discounted services and charity care, will be required and that payment is expect at time of service on private pay balances. The Clinical Financial Policy will also be posted.

2. Office staff will advise patients to bring proof of income if they want to be considered for discounts or payment arrangements.

3. Office personnel will be trained regarding these policies and be fully prepared to carry out DCHD Financial Policy and Procedures.

4. The Billing Office Assistant and Public Health Nurse will be responsible for implementing this policy, training personnel, and monitoring daily to insure the policy is being followed correctly.

5. The Billing Office Assistant and Public Health Nurse will train personnel with the contents of this policy. It is mandatory that these Clinical Policy/Procedures be followed.

6. Personnel shall sign that they have read, understand and will follow this policy.

7. The Billing Office Assistant will be responsible to assure that each office receives updated materials as needed and that these policies and procedures are being followed. If discrepancies are found, then appropriate action should be taken to correct the problem immediately.

DODDRIDGE COUNTY HEALTH DEPARTMENT
60 PENNSYLVANIA STREET
WEST UNION, WV 26456
304-873-1531

Make checks payable to: DCHD
60 Pennsylvania St.
West Union, WV 26456

Balance: _____
Account: _____

PAYMENT PLAN BETWEEN

_____ (Guarantor Name), and Doddridge County Health Department. I agree to pay $_____ today _____, _____ and to make a regular monthly payment of $_____ beginning on _____. And on the same day of each succeeding month, with the balance not to exceed 5 payments, until my account is paid in full. In the event of default, all the unpaid balance of the obligation shall at the option of Doddridge County Health Department be accelerated and become immediately due and payable.

_____ Office Staff Signature

_____ Date

_____ Patient Signature

_____ Address

_____ City/State/Zip

_____ Phone Number

Exhibit 1 6/2015

CLINIC FINANCIAL POLICY

Thank you for choosing the Doddridge County Health Department for your health needs. We are pleased you are here and we look forward to servicing you and your family. In this regard, we require payment for services provided and we participate in a number of state health related programs which cover the costs of services many patients receive. This clinic charges for services because the cost to provide the services exceeds any funding which may be available. Therefore, charges are made to generate enough revenues to support the cost of the non-profit operation.

The clinic would like you to be aware of the several payment options that may be available to you for the services you are about to receive. Below is a brief description of payment options. Complete descriptions of these are posted throughout the clinic. If you have any questions about these, please ask to speak with a billing clerk.

Full payment is due on the day services are received. If full payment cannot be made for private pay accounts, you may qualify for credit arrangements. Payments must be at least 20% of the balance with the number of payments not to exceed 5 payments. Payments are due within 10 business days of receipt of your monthly statement. If you feel there are extenuating circumstances in your case, please request to talk with the Billing Office Assistant

The clinic has a discount policy for patients whose income falls between 150% and 250% of the Federal Poverty Guidelines. To be eligible for the discount, proof of income is required along with the number of family members, and $10.00 payment on the account at the time of services.

For patients whose income is less than 150% of the Federal Poverty guidelines, the clinic has a Charity Care Policy. Proof of income is required.

A complete copy of the Clinic Financial Policy and Federal Poverty guidelines are posted in the patient waiting area and other areas. If you have any questions about this policy, the Office Personnel will be happy to assist you.

_____ _____

Patient Signature Date

_____ _____

Office Staff Signature Date

Exhibit 2 6/2015

DODDRIDGE COUNTY HEALTH DEPARTMENT
REDUCED FEE COMPUTATION APPLICATION

Patient Name: _________________________________ DOB: _________________

Date of Service: _____________ Total Fee: _____________ SSN: _____________

- -

This portion is completed by the patient or other responsible person for the purpose of determining whether any or all of the charges of the services received today will be reduced. I have been advised and understand that the clinic has a discount policy (based on family income and size) to determine the percentage of the fees for services received today that I will be expected to pay and verify my total income for the household.

1. My family (household) total gross (before taxes and other deductions) monthly income is $__________ and the source of the income is ____.

   Verified by: _________________________ Date: ___________________
   Office Staff Date Verified
2. The total number of persons in my family (household) is ____________.

3. This information is accurate and correct to my knowledge. I understand that I am required to verify my income and pay $10.00 today to the Billing Office to qualify for any discount. I agree to provide the information requested.

______________________________ ________________ ______________
Patient/Guardian Signature Relationship Date

_________________________________ _______________
Office Staff Signature Date

- -

-Circle percentage of charge patient is responsible for after applying the above stated income and family size to the income guidelines.

0% 20% 40% 60% 80% 100% Total Fee: $_________
X_______%
Patient Fee: $_________

Comments:____
____

_________________________________ ____________________
Office Staff Signature Date

Exhibit 3 6/2015

NOTIFICATION OF NONCOVERED SERVICES

DATE: _____

COUNTY: _____

I, _____ acknowledge that I was notified on
(Patients Name)

_____ that _____
(Date) (Type of Service)

service provided to me is not payable by the MEDICARE - MEDICAID Program and
(Circle one)

that I am responsible for those charges.

_____ _____
Signature Date Relationship (if not applicant)

_____ _____
DCHD Staff Signature Date

Exhibit 4 6/2015

REVIEWED ACCORDING TO GROSS MONTHLY INCOME

DODDRIDGE COUNTY HEALTH DEPARTMENT
CLINICAL SERVICES
SLIDING FEE SCALE

FAMILY SIZE	FPL 100% PAT. RESP. 0%	FPL 101%-150% PAT. RESP. 25%	FPL 151%-200% PAT. RESP. 50%	FPL 201%-250% PAT. RESP. 75%	FPL >250% PAT. RESP. 100%
1	$981	$1472	$1962	$2453	$2454
2	$1328	$1992	$2655	$3319	$3320
3	$1675	$2646	$3349	$4186	$4187
4	$2021	$3032	$4042	$5053	$5054
5	$2368	$3552	$4735	$5919	$5920
6	$2715	$4072	$5429	$6786	$6787
7	$3061	$4592	$6122	$7653	$7654
8	$3408	$5112	$6815	$8519	$8520
EACH ADDITIONAL FAMILY MEMBER	$347	$520	$694	$867	$868

PATIENT RESPONSIBILTY IS PERCENTAGE OF TOTAL BILL DUE AT TIME OF SERVICE DEPENDING ON WHAT CATEGORY OF THE FEDERAL POVERTY LEVEL THEY FALL UNDER ON THIS SLIDING FEE SCALE.

BASED ON FEDERAL POVERTY LEVELS FROM FEDERAL REGISTER
JULY 2015

Exhibit 5 6/2015

Billing Notes: