

Policy #: 8.11

Issued: October 2009

**Reviewed/Revised: May 2013, December 2013, March 2015, March 2017,
March 2018, May 2018, March 2019, April 2020, March 2021, December 2021**

Section: Finance

SLIDING SCALE DISCOUNT PROGRAM POLICY AND PROCEDURE

Purpose:

This purpose of the policy is to provide our patients with the opportunity to apply for further financial assistance through the Health Resources and Services Administration (HRSA) Sliding Fee Discount Schedule (SFDS) Policy for all in-scope services that DotHouse Health (DHH) provides. DHH participates in all programs available to support the care of patients and to assure maximization of revenue in accordance with Federal guidelines and requirements.

Policy Statement:

It is the policy of DotHouse Health (DHH) to ensure that all patients seeking care, receive services regardless of ability to pay. In addition to quality health care, patients are entitled to financial counseling by someone who can offer potential solutions for those patients who can't pay in full. The Financial Counselor at DHH works with the patient and guarantor to find reasonable payment alternatives. On an annual basis, DHH will evaluate the effectiveness of the SFDP in reducing financial barriers to care by communicating with patients and DHH staff members most responsible for the policy and procedure implementation, collecting utilization data by discount pay classes to study the effectiveness of the SFDP.

DHH will offer sliding fee discounts on all services that are within our federal scope of project. For services within our federal scope but that we do not provide directly (Column III of Form 5A), we will ensure that those eligible patients are offered comparable discounts and are not balanced billed. A sliding fee schedule is used to calculate the basic discount and is updated each year using the most recently approved Federal Poverty Guidelines. These guidelines are structured using the total annual income and total number of family or household members residing within a home. DHH will base program eligibility on a person's ability to pay and will not discriminate on the basis of age, gender identity, race, sexual orientation, creed, religion, disability or national origin. Notice of the availability of sliding scale discounts will be displayed in a variety of locations and methods throughout the health center.

A schedule of discounts is available to all eligible individuals and families with annual incomes below 200% of the Federal Poverty Level (FPL), with a full discount available to individuals and families with annual incomes 100% and below the FPL. Patients who qualify for the sliding fee discount will receive said discount after all third party

adjudications have been exhausted. Patients below 200% of FPL with third party insurance may be eligible for this discount for services that are not covered through their insurance, annual deductibles and co-payments.

The Federal sliding fee scale does not provide for discounts to individuals over 200% of the Federal Poverty Level. Other state or local programs (e.g. Massachusetts Health Safety Net Program, a state-funded public program) may provide for other levels of discounts (e.g. tiered discounts to individuals up to 400% of the Federal poverty level.).

Supplies and Equipment

1. For certain defined Dental and Eye care supplies and equipment, DHH charges fees based on reasonable costs and to which the SFDS does not apply. Patients who are considering these services will be informed in advance of their estimated out-of-pocket fees and associated payment plans.

Federal funds allocated to DotHouse Health will not be utilized for sliding fee discount over the required guidance of 200% FPL.

Interpretation of this policy should be directed to the Chief Financial Officer or designee.

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

- 1) **Notification:** DHH will notify patients of the Sliding Fee Discount Program upon first time registration, advertisements in clinic waiting areas and on the health center's website and other electronic media (digital signage.)
- 2) **Ability to pay:** All patients seeking health care services at DHH are assured they will be served regardless of ability to pay. No one is refused services because of a lack of financial means to pay. DHH acknowledges that there is a difference between ability to pay and refusal to pay (See #10, Refusal to Pay).
- 3) **Request for Discount and Administration:** Requests for discounted services may be made by patients, family members, staff or others who are aware of the existing financial hardship. Information and forms can be obtained from the Office of Financial Counseling.

Sliding Fee Discount Program (SFDP) Coverage

- a. All patients of DHH are eligible to apply for the SFDP. For patients who have insurance coverage and who are eligible for the SFDP, the discounts applied through the program would be applied to patient out-of-pocket expenses, such as copayments and deductibles, for eligible services.
- b. For patients who have applied and deemed eligible to participate in the SFDP and who have health insurance that does not fully or partially cover the DHH's fees, their out-of-pocket cost-sharing will be reduced/discounted to ensure that the maximum out-of-pocket

amount he/she is charged will be the amount he/she would have paid under his/her respective pay class, subject to any contractual limitations.

c. The SFDP extends to all services provided directly by DHH that are within our federal scope of project.

d. For services within our federal scope of project that we do not offer directly (Column III of Form 5A), patients are offered comparable discounts and are not balance billed.

The Sliding Fee Discount Program (SFDP) procedure will be administered by the Financial Counselor Manager. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application. Confidentiality will be respected for all who seek and/or provided with this service.

- 4) Completion of Application:** A completed application, including required documentation of home address, family/household size and income, must be completed in its entirety, on file and approved by the DHH Financial Counselors in order to initiate the discount. By signing the Sliding Fee Discount Program application, persons authorize DHH access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application form will result in all discounts being revoked and the full balance of the account(s) restored and payable.

Eligibility date would be the visit date, upon the application's approval. If an application is unable to be processed due to need for additional information, the applicant has two (2) weeks from the date of notification to supply the necessary information without having the date on their application adjusted. If a patient doesn't provide the requested information within the two week time period, their application will be re-dated to the date which they supply the requested information. Any accounts turned over for collection as a result of the applicant's delay in providing the information will not be considered for the Sliding Fee Discount Program.

All alternative payment sources will be exhausted including all third party payment from insurance(s), Federal and State programs.

5) Eligibility:

Discounts will be based on income and family size, only.

a) "Family/Household" is defined as a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and physically residing in the same home who are the legal responsibility of the guarantor. The guarantor is the financially responsible person within the household. All such people are considered as members of one family.

b) "Income" is defined as earnings over a given period used to support an individual/household unit based on a set of inclusions, listed as follows:

- Earnings
- Supplemental Security Income
- Retirement payments from Social Security or pension or retirement income
- Public assistance
- Short-term or long-term disability payments
- Veterans' payments
- Survivor benefits
- Unemployment compensation
- Child support payments
- Alimony
- Workers compensation
- Income from rental property, interest, dividends and royalties.
- Income from estates, trusts, and educational assistance.
- Assistance from outside the household.

Non-cash benefits (such as food stamps and housing subsidies) do not count.

6) **Income Verification**

Applicants must provide one (1) of the following documents to support proof of income:

- Prior year W-2 or Form 4506-T (if W2 not filed) or Copy of Federal Tax Return
- Copies of two most recent employment check stubs
- Copy of Federal tax return (W-2 only is not acceptable)
- Dated letter from employer
- Self-employed individuals will be required to submit detail of most recent three (3) months of income and expenses for the business.
- Dated letter from homeless shelter (contact shelter for verification of continued residency)
- Dated letter from head of hold and/or family member where patient resides
- Self-declaration (may only be used for the first visit)

If a patient has no means to prove their income, self-declaration may be accepted for initial visit only. The patient must sign a Self-Declaration Application guaranteeing the authenticity of this information. This is to be used as last resort and must be approved by management. Documentation of application of self-declaration is noted in patients chart.

- 7) **Discounts:** Below is the patient payment amount and discount amount or percentage according to the sliding fee schedule. However, patients will not be denied services based on an inability to pay. The sliding fee schedule will be updated during the first quarter of every calendar year consistent with the most recent Federal Poverty Guidelines.

FPL Range	Patient Pay Amount: Discount:						
100% or Below	\$0.00	100%					
101% to 133%	\$10.00	Balance other than \$10.00 patient pay amount					
134% to 167%	\$15.00	Balance other than \$15.00 patient pay amount					
168% to 200%	\$20.00	Balance other than \$20.00 patient pay amount					
201% to 250%	20% of Charges	80%					
251% to 300%	40% of Charges	60%					
301% to 350%	60% of Charges	40%					
351% to 400%	80% of Charges	20%					

- 8) **Waiving of Charges:** In certain situations, patients may not be able to pay the discounted fee. Waiving of charges may only be used in special circumstances and must be approved by DHH's CEO or their designee. Any waiving of charges should be documented in the patient's file along with an explanation.
- 9) **Applicant determination and notification:** DHH will render a conditional or final determination of eligibility upon receipt of a signed and completed application. The Sliding Fee Discount Program determination will be provided in writing and include the percentage of Sliding Fee Discount Program write-off or reason for denial. If the applicant is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with DHH. Reapplication for the sliding scale discount must be submitted annually for approval or anytime there has been a change in family size or income. Upon approval, DHH will retain the completed paper application for 1 year within the patient's record.
- 10) **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 a 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 doesn't make an effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point, DHH will explore options, not limited to, offering the patient a payment plan, waiving of charges or referring the patient to collections efforts.
- 11) **Record keeping:** Information related to Sliding Fee Discount decisions will be maintained and preserved in a confidential file located in the office of the Manager of Financial Counseling.
- 12) **Policy and procedure review:** Annually the Sliding Fee Discount Program Policy, Procedures and schedule will be presented to the board for review and approval.

Forms:

**Attachment A - Current Federal Poverty Guideline Fee Schedule
Sliding Scale Self-Declaration Application
Federal Scope of Project, Form 5A**

This policy has been reviewed, approved, and adopted by the Governing Board and Administration as attested to by the signatures below:



Michelle Nadow
President and CEO

December 9, 2021

Date



Megan Sonderegger
Governing Board Chair

December 9, 2021

Date

DotHouse Health, Inc.

2021 Sliding Fee Scale Table

Effective March 11, 2021

2021 Annual Poverty Guidelines, all states (except Alaska and Hawaii)

Household / Family Size	Coverable by Federal Grant Resources										Coverable by State Health Safety Net									
	50%	~100%*	125%	130%	133%	135%	135%	150%	175%	185%	200%	225%	250%	275%	300%	325%	350%	375%	400%	
1	6,440	\$12,880	16,100	16,744	17,130	17,388	17,774	19,320	22,540	23,828	25,760	28,880	32,200	35,420	38,640	41,860	45,080	48,300	51,520	
2	8,710	\$17,420	21,775	22,646	23,169	23,517	24,040	26,130	30,485	32,227	34,840	38,195	43,550	47,905	52,260	56,615	60,970	65,325	69,680	
3	10,980	\$21,960	27,450	28,548	29,207	29,648	30,305	32,940	38,430	40,628	43,920	49,410	54,900	60,390	65,880	71,370	76,860	82,350	87,840	
4	13,250	\$26,500	33,125	34,450	35,245	35,775	36,570	39,750	46,375	49,025	53,000	59,625	66,250	72,875	79,500	86,125	92,750	99,375	106,000	
5	15,520	\$31,040	38,900	40,352	41,283	41,904	42,835	46,560	54,320	57,424	62,080	68,840	77,600	85,360	93,120	100,880	108,640	116,400	124,160	
6	17,790	\$35,580	44,475	46,254	47,321	48,033	49,100	53,370	62,265	65,823	71,180	80,055	88,950	97,845	106,740	115,635	124,530	133,425	142,320	
7	20,060	\$40,120	50,150	52,156	53,360	54,162	55,366	60,180	70,210	74,222	80,240	90,270	100,300	110,330	120,360	130,390	140,420	150,450	160,480	
8	22,330	\$44,660	55,825	58,058	59,398	60,291	61,631	66,980	78,155	82,621	89,320	100,485	111,650	122,815	133,980	145,145	156,310	167,475	178,640	
9	24,600	\$49,200	61,500	63,960	65,436	66,420	67,896	73,800	86,100	91,020	98,400	110,700	123,000	135,300	147,600	159,900	172,200	184,500	196,800	
10	26,870	\$53,740	67,175	69,862	71,474	72,549	74,161	80,610	94,045	98,419	107,480	120,915	134,350	147,785	161,220	174,655	188,090	201,525	214,960	
11	29,140	\$58,280	72,850	75,784	77,512	78,678	80,428	87,420	101,990	107,816	116,560	131,130	145,700	160,270	174,840	189,410	203,980	218,550	233,120	
12	31,410	\$62,820	78,525	81,686	83,551	84,807	86,682	94,230	109,935	116,217	125,640	141,345	157,050	172,755	188,460	204,165	219,870	235,575	251,280	
13	33,680	\$67,360	84,200	87,568	89,589	90,936	92,857	101,040	117,880	124,616	134,720	151,560	168,400	185,240	202,080	218,920	235,760	252,600	269,440	
14	35,950	\$71,900	89,875	93,470	95,627	97,065	99,222	107,850	125,825	133,015	143,800	161,775	179,750	197,725	215,700	233,675	251,650	269,625	287,600	
Each Additional Family Member add:		\$4,540	5,675	5,902	6,038	6,129	6,265	6,810	7,945	8,399	9,080	10,215	11,350	12,485	13,620	14,755	15,890	17,025	18,160	

Charged Amount:

- 101% to 133% \$ 10.00
- 134% to 167% \$ 15.00
- 168% to 200% \$ 20.00
- 201% to 250% 20% of Charges
- 251% to 300% 40% of Charges
- 301% to 350% 60% of Charges
- 351% to 400% 80% of Charges

DotHouse Health, Inc. 2021 Sliding Fee Scale Table Effective March 11, 2021

2021 Monthly

Poverty Guidelines, all states (except Alaska and Hawaii)

Household /Family Size	Coverable by Federal Grant Resources										Coverable by State Health Safety Net									
	60%	*100%*	125%	130%	133%	135%	138%	150%	175%	185%	200%	225%	250%	275%	300%	325%	350%	375%	400%	
1	537	\$1,073	1,342	1,385	1,428	1,449	1,481	1,610	1,878	1,986	2,147	2,415	2,683	2,952	3,220	3,488	3,757	4,025	4,293	
2	726	\$1,452	1,815	1,887	1,931	1,960	2,003	2,178	2,540	2,686	2,903	3,266	3,629	3,992	4,355	4,718	5,081	5,444	5,807	
3	915	\$1,830	2,288	2,379	2,434	2,471	2,525	2,745	3,203	3,386	3,660	4,118	4,575	5,033	5,490	5,948	6,405	6,863	7,320	
4	1,104	\$2,208	2,760	2,871	2,937	2,981	3,048	3,313	3,865	4,085	4,417	4,969	5,521	6,073	6,625	7,177	7,729	8,281	8,833	
5	1,293	\$2,587	3,233	3,363	3,440	3,492	3,570	3,880	4,527	4,785	5,173	5,820	6,467	7,113	7,760	8,407	9,053	9,700	10,347	
6	1,483	\$2,965	3,706	3,855	3,943	4,003	4,082	4,448	5,189	5,485	5,930	6,671	7,413	8,154	8,895	9,636	10,378	11,119	11,860	
7	1,672	\$3,343	4,179	4,346	4,447	4,514	4,614	5,015	5,851	6,185	6,687	7,523	8,358	9,194	10,030	10,866	11,702	12,538	13,373	
8	1,861	\$3,722	4,652	4,838	4,960	5,024	5,136	5,563	6,513	6,885	7,443	8,374	9,304	10,235	11,165	12,095	13,026	13,956	14,887	
9	2,050	\$4,100	5,125	5,330	5,453	5,535	5,658	6,150	7,175	7,585	8,200	9,225	10,250	11,275	12,300	13,325	14,350	15,375	16,400	
10	2,239	\$4,478	5,598	5,822	5,956	6,046	6,180	6,718	7,837	8,285	8,957	10,076	11,196	12,315	13,435	14,555	15,674	16,794	17,913	
11	2,308	\$4,612	5,765	5,985	6,134	6,228	6,364	6,918	8,070	8,532	9,223	10,376	11,529	12,682	13,835	14,988	16,141	17,294	18,447	
12	2,486	\$4,972	6,215	6,463	6,612	6,712	6,861	7,458	8,700	9,186	9,943	11,186	12,429	13,672	14,915	16,158	17,401	18,644	19,887	
13	2,668	\$5,332	6,665	6,931	7,081	7,188	7,358	7,998	9,330	9,864	10,663	11,986	13,329	14,662	15,995	17,328	18,661	19,994	21,327	
14	2,848	\$5,692	7,115	7,399	7,570	7,694	7,855	8,538	9,960	10,530	11,393	12,806	14,228	15,652	17,075	18,498	19,921	21,344	22,767	
Each Additional Family Member add:		\$378	473	492	503	511	522	568	662	700	757	851	946	1,040	1,135	1,230	1,324	1,419	1,513	

Patent Charged Amount:

- 101% to 133% \$ 10.00
- 134% to 167% \$ 15.00
- 168% to 200% \$ 20.00

- 20% of Charges
- 40% of Charges
- 60% of Charges
- 80% of Charges

SLIDING SCALE SELF-DECLARATION APPLICATION

Explanation of the Sliding Fee Discount Program

The Sliding Fee Discount Program is a federal program that permits DotHouse Health Inc. to discount normal charges for medical visits. According to law, it requires two pieces of information in order to qualify: the amount of income in the household and the number of people who live in the household. In order to be eligible for the Sliding Fee Scale, you must provide accurate and acceptable proof of income as well as list all persons in the household. These forms of documentation must be presented upon applying for the Sliding Fee Discount Program. Failure to provide such documentation in a timely manner will cause a delay in processing your application and you will be responsible for 100% of all charges including any lab work performed. You must report any changes in family income or number of members in the household when these changes occur. Falsification of this information will result in forfeiture of the Sliding Fee Scale privileges and possible release from the practice as it is a violation of Federal Law.

Eligibility

All DHH patients are eligible to apply for the slide. Determination of the discount, if any, is dependent upon household income and household size in comparison to the current Federal Poverty Guidelines. This discount may apply to any out of pocket costs for services that DotHouse Health provides, with the exception of certain defined dental and eye care supplies and equipment.

Term

Information must be updated every twelve (12) months or with any change of household income or household size.

Definitions and Examples of Acceptable Proof Required

Income determination

1. Income is based on the **gross income** of **all** household members earning income.
Income used to compute poverty status: Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trust, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources.
2. Acceptable forms of proof for determining income include the following:
 - a. **Income tax return:** A signed copy of the most recent tax return showing Adjusted Gross Income.
 - b. **Pay check stubs:** Two or more consecutive pay stubs indicating gross pay within the past thirty (30) days
 - c. **W2 forms (no handwritten ones accepted).**
 - d. **Agency letter:** A letter from the Social Security Administration, Veterans Administration, or Social Service Agency (i.e., FNS, food stamps)
 - e. **Unemployment Verification:** Paperwork from the Employment Securities Commission (ESC) proving unemployment status and the amount of compensation being received.
 - f. **Court Documents:** Official documents citing child support or alimony awarded by a judge.
 - g. **Official Paperwork:** Paperwork documenting retirement, disability, SSI benefits.
 - h. **Employer Letter:** For those not receiving an actual paycheck, a letter from the patient's employer detailing current gross income and frequency of pay period may be accepted. Contact information must be provided so that information can be verified.

Household size determination:

1. All members of a household who are pooling financial resources including room and board and/or are supporting one another financially are counted as one household.
2. Household size can be documented with any of the following:
 - a. A copy of the most recent tax return showing household size.
 - b. Social Security Card
 - c. Birth Certificate
 - d. Medicaid cards for any dependent children
 - e. Driver's License or State ID's



If you wish to apply for a discount, you will need to answer **all** of the questions below and **provide proof of all income**. If married, you must provide this for yourself **and** your spouse. If proof is not attached, your application will be returned.

PATIENT Name: _____

Today's Date: _____

List spouse and dependents under age 18 currently living with you on a full time basis (put additional people on the back)

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

Please indicate the amount and source of your household income:

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Alimony, Child Support, or assistance from outside the household.				
Gross wages, salaries, and tips (most recent 2 weeks)				
Retirement, SSI, Social Security, Worker's Compensation or Welfare Payments				
Unemployment Compensation (One check stub or determination letter)				
Income from business, self-employment, and dependents.				

Your total income: \$ _____ Weekly Every two weeks Monthly Other (please explain)

Spouse/Other total income: \$ _____ Weekly Every two weeks Monthly Other (please explain)

I understand that I am financially responsible for any balance not covered by the sliding scale. A copy of this signature is as valid as the original. The information I have provided is accurate and complete. I understand that DotHouse Health may confirm and/or share income and demographic information in order to receive the state, federal and private funds that allow it to offer services at a reduced cost. I have seen a copy of the Patient Bill of Rights and am aware of its contents.

Signature _____

Date _____


Spouse/Other Signature _____

Date _____

FOR OFFICE USE ONLY

FPL	100% FPL	101%- 133% FPL	134%- 167% FPL	168%- 200% FPL	201%- 250% FPL	251%- 300% FPL	301%- 350% FPL	351%- 400% FPL
Charged to Patient	\$ -	\$10	\$15	\$20	20%	40%	60%	80%
Review In:	3 months	1 year	Expires: _____		Staff initials: ____			

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 **Self Updates: Services details**

▼ **H80CS11300: DOTHOUSE HEALTH, INC., Dorchester, MA**

Grant Number: H80CS11300 **BHCNIS ID:** 01E00089 **Project Period:** 04/01/2009 - 03/31/2023
Budget Period: 04/01/2021 - 03/31/2022

▼ **Resources** 

View

[Form 5A](#) | [Form 5B](#) | [Form 5C](#)

Pending Approved Changes

Required Services	Additional Services	Specialty Services
Pending Approved Changes (0)	Pending Approved Changes (0)	Pending Approved Changes (0)

Approved Required Services

Service Type	Service Delivery Methods		
	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
General Primary Medical Care	X	X	X
Diagnostic Laboratory	X	X	X
Diagnostic Radiology	X	X	X
Screenings	X	X	X
Coverage for Emergencies During and After Hours	X	X	X
Voluntary Family Planning	X		
Immunizations	X	X	
Well Child Services	X	X	
Gynecological Care	X	X	
Obstetrical Care			
Prenatal Care	X	X	X
Intrapartum Care (Labor & Delivery)		X	X
Postpartum Care	X	X	X
Preventive Dental	X		
Pharmaceutical Services	X	X	X
Case Management	X		X
Eligibility Assistance	X		
Health Education	X		
Outreach	X		
Transportation	X		X
Translation	X	X	

Service Type	Service Delivery Methods		
	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
Additional Dental Services	X		
Behavioral Health Services			
Mental Health Services	X		X
Substance Use Disorder Services	X		X
Optometry	X		
Nutrition	X		X
Complementary and Alternative Medicine	X		

Approved Specialty Services			
Service Type	Service Delivery Methods		
	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
Podiatry		X	
Psychiatry	X		
Ophthalmology		X	
Cardiology		X	
Dermatology	X	X	
Infectious Disease	X		
Gastroenterology		X	
Other - Periodontics	X		
Other - Nephrology			X
Other - Oral and Maxillofacial Surgery	X		X