

**Premier Mobile Health Services / Premier Mobile Health Services, INC.  
POLICY & PROCEDURE MANUAL**

<b>Premier Mobile Health Services Patient Sliding Fee Scale Discount Policy</b>		<b>LOCATOR NUMBER:</b> Premier Mobile Health Services
<b>T Y P E</b>	<input type="checkbox"/> <b>System-wide</b> - A formal statement of values, intents (policy), and expectations (procedure) that applies to every employee throughout the System.	<b>CHAPTER:</b>
	<input type="checkbox"/> <b>Multidisciplinary</b> - A formal statement of values, intents (policy), and expectations (procedure) that applies to more than one discipline and is usually of a clinical nature. <b>Check below all areas to which this applies.</b>	<b>TAB:</b>
	<input checked="" type="checkbox"/> <b>Departmental</b> - A formal statement of values, intents (policy), and expectations (procedure) exclusive to a particular department or group of people within a department at one or multiple locations that does not impact any other area.	<b>POLICY #:</b>
<b>Disciplines / locations to which this multidisciplinary policy applies:</b>		
<input type="checkbox"/> Health Information Management <input type="checkbox"/> Pharmacy <input type="checkbox"/> Kimmies Recovery <input type="checkbox"/> Housekeeping <input type="checkbox"/> All United Way Houses <input type="checkbox"/> Gladiolas Food Pantry <input type="checkbox"/> Information Systems <input type="checkbox"/> Cafe of Life <input type="checkbox"/> Laboratory <input type="checkbox"/> St. Mathews House <input type="checkbox"/> Legal Services <input type="checkbox"/> Pine Manor <input type="checkbox"/> Nutrition <input checked="" type="checkbox"/> Other Business Operations: Premier Mobile Health Services Inc. _____		
<b>Effective date:</b> 9/28/2018 Revised for FPL Data Annually each February	<b>Reviewed/No Revision:</b>	<b>Dates Revised:</b> 1/29/2024
<b>Next Review Date:</b>		
<b>Author(s):</b> Health Center Management Committee made up of: Diane Spears, Karen Krieger and Amy Pinter		
<b>Reviewed by:</b>		
<b>Premier Mobile Health Services Management Committee</b>	<b>Nadine Singh, Committee Chairperson</b>	<b>1/29/2024</b>
<b>Clinical Education Council</b>	<b>Education Complete:</b>	<b>Date:</b>
<b>Education Plan Required:</b> Yes No: <input type="checkbox"/> <input checked="" type="checkbox"/>		<b>Date:</b>
<b>Approved by:</b>		
<b>Policy Administrator:</b>	<b>Nadine Singh</b>	<b>1/29/2024</b>
<b>Date:</b>		
<b>As Needed:</b>		
<b>Board of Directors:</b>	<b>Kevin Anderson, Chairperson</b>	<b>Date: 1/29/2024</b>

**PURPOSE:** This policy establishing a sliding fee scale for the payment of service charges is adopted in accordance with Premier Mobile Health Services' mission to provide the right care, in the right place at the right time to the uninsured and low-income residents of Lee County.

**POLICY:** Premier Mobile Health Services' medical offices provide care to low income and medically indigent patients without discrimination on grounds of race, religion, sex, or national origin. Such patients may be residents of Lee County. This policy also establishes that no patient will be denied services due to their inability to pay. The subsequent procedures will be used to determine patient eligibility for receipt of sliding fee discounts for their medical care based on their household income..

**PROCEDURE:** To determine whether a patient is qualified for a sliding-fee discount, for each visit, Premier Mobile Health Services' Financial Counselor shall employ the following procedures:

1. Conduct a complete intake process beginning with basic information such as patient's name, address, phone number, members of household, and gross household income in order to assess the patient's eligibility for insurance or to receive a sliding fee discount.
2. Review the patient's potential eligibility to receive Medicaid, Medicare, a subsidy to purchase insurance under the Affordable Care Act of 2010, or any other third-party payer source. Patients who have been denied any such third-party insurance coverage shall provide documentation of that denial to Premier Mobile Health Services' Financial Counselor.
3. Complete a Financial Information Record (see attached) for each patient to include a signed attestation to be accepted as sufficient supporting documentation of reported income. Supporting documentation will contain any or all of the following:
  - a. Valid state ID/voter registration for Lee County to validate residency.
  - b. Pay stubs (4 consecutive)
  - c. Income tax return (prior year)
  - d. Written verification of wage from employer
  - e. W-2 withholding form
  - f. Written verification from a governmental agency attesting to the patient's income status (social security administration and unemployment verification)
  - g. Statement of support received from family/friend when income reported is \$0. Must be notarized and denote monetary value of assistance or in-kind support.
  - h. Vehicle registration
  - i. Property tax bill or lease
  - j. EBT eligibility letter
4. Patients identified as self-employed must provide both personal and business income tax records for the 12 months prior to the date of service in order to be considered. Any exception to this policy must be approved by a member of Premier Mobile Health Services' management team.
5. Patients whose documented gross household family (see attached addendum for determining Gross Annual Household Income) income falls at or below 200% of the Federal Poverty Level (FPL) will be eligible to receive a discount based on the adopted sliding fee schedule. Each year a schedule will be reviewed and adopted by Premier Mobile Health Services' Board of Directors that utilizes the income guidelines for determining the Federal Poverty Level published by the U.S. Department of Health and Human Services. This schedule will be furnished to all Premier Mobile Health Services

staff in order to assess a patient’s eligibility for discounted fees. Patients whose documented gross household family income falls below 100% of FPL will be given a full discount and charged only a “nominal fee” of \$10.00, or actual charges if lower. Patients whose household incomes exceed 200% of FPL are excluded from receiving a sliding fee discount per Premier Mobile Health Services’ Board’s approval of this policy.

<b>2024 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA</b>		
<b>Persons in family/household</b>	<b>Poverty guideline</b>	
	<b>100%</b>	<b>200%</b>
1	\$15,060	\$30,120
2	\$20,440	\$40,880
3	\$25,820	\$51,640
4	\$31,200	\$62,400
5	\$36,580	\$73,160
6	\$41,960	\$83,920
7	\$47,340	\$94,680
8	\$52,720	\$105,440
For families/households with more than 8 persons, add \$5,380 for each additional person.		

(SOURCE: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>)

6. In addition to all other criteria in this policy, a patient’s gross household income that is between 100% and 200% of the Federal Poverty Level should be evaluated as follows:
  - a. Beginning on October 1, 2013 through March 31, 2014, an application to obtain health insurance coverage via the Federally Facilitated Exchange (FFE) should be completed.
  - b. Beginning on April 1, 2014 and each year thereafter, an application to obtain health insurance coverage via the Federally Facilitated Exchange (FFE) should be completed during the open enrollment period specified by the FFE.

7. The patient sliding fee program will be used to discount service charges to ensure financial barriers to care are minimized for patients who meet certain eligibility criteria. The discount program will operate as follows:

- a. Premier Mobile Health Services' financial counselor will evaluate each patient's eligibility for insurance or third party coverage and assist the patient with applying for such coverage as may be contemplated in item 6 above or otherwise.
- b. If not eligible for third party coverage the financial counselor will assess the patient's eligibility to receive a discount based on their household income as shown in the sliding-fee schedule below.
- c. If during the first office visit a patient is unable to provide sufficient documentation of household income as defined in paragraph #3 of this policy he or she will be permitted to self-declare their annual household income. This shall serve as the basis for that individual's receipt of a discounted sliding fee charge for no longer than 30 days. If after the expiration of this 30-day grace period the patient has not provided sufficient documentation of their household income they will then forfeit their privilege to receive a service fee discount.
- d. The patient's share of payment is expected at time of services. No one will be denied services based on their inability to pay.

8. Patients having private insurance and high deductibles may receive a sliding fee discount for their care if they qualify under the household income guidelines defined previously in this policy. If a patient has insurance coverage, and does NOT qualify for a sliding fee discount under the terms of this policy, the patient will be held responsible for all patient co-pays due as assigned by the insurance company. This includes deductible, copay, co-insurance, share of cost and all non-covered services. Applicable ABN or patient liability forms are to be used.

9. Premier Mobile Health Services' Financial Counselor or Information Referral Specialist will obtain all necessary information to qualify patients for a sliding scale discounted fee. Upon approval, validation of the patient's eligibility for a discount will be extended to all on-site services and any referred services provided within Premier Mobile Health Services System (approved service list) for a time period not to exceed 180 days. Upon the patient's return after 180 days from the initial visit the patient will be required to provide all documents necessary to receive approval to receive continued service discounts. All documents must be scanned for audit purposes.

10. Any accounts involving a friend, family member or anyone known to a Premier Mobile Health Services staff member must be brought to the attention of the office or operations manager.

11. Exceptions to the above listed criteria may be granted if extenuating circumstances exist. Any exception to the criteria must have the approval of the office or operations manager prior to treatment.

12. In the event that household income or payment become available, Premier Mobile Health Services reserves the right to reverse the original adjustment. This could be through the identification of Medicaid eligibility, liability settlements, insurance obtained, etc. after the account has been written off or guarantor payments on this or other accounts.

13. Patients with Medicare, Straight Medicaid, or any other third party payer source, or Self Pay accounts will be responsible for all co-pays as outlined by their coverage or self-pay contract. Patients with Medicaid – Share of Cost or Denied Medicaid will be registered through Premier Mobile Health Services by the Florida Agency for Healthcare Administration. Patient will be expected to pay their share of cost expenses at every visit. The expected payment will be estimated on a 99213 level of service.

14. Premier Mobile Health Services' Board of Directors shall review the Sliding Fee Discount Program on a triennial basis (once every three years) to ensure that it is not creating barriers to patients seeking and securing care. This review will be based on taking the following actions:

- a. Collection of data to assess the rate at which patients within each of the four discount pay classes (A, B1, B2 and C) are accessing Premier Mobile Health Services' services;
- b. Utilization of data from various sources (e.g. - patient satisfaction surveys, direct questioning of patients, etc.) to evaluate the effectiveness of the sliding fee discount program in minimizing financial barriers to care; and
- c. Identification and implementation of any modifications to the Sliding Fee Discount Program supported from the review and analysis of the data collected in compliance with paragraphs a. and b. above.

## Addendums



**What should be included in calculating the Gross Annual Household Income?** Gross Annual Household Income" means all money received by all persons living in the household, including Social Security benefits, Veterans benefits, Alimony, Child Support, Interest income, Unemployment benefits, Workers Compensation benefits, Strike benefits, Cash, Public Assistance benefits, Wages and Tips. (This definition was obtained in the United States Department of Health and Human Services 2004 Federal Poverty Guideline As published in the February 13, 2004 Federal Register.)

**Household defined:** as it applies to qualifying for charity or discount consideration.

**Family:** A group of two or more persons related by birth, marriage, or adoption that live together; all such related persons are considered as members of one family. For example, if an older married couple, their daughter and her husband and two children all lived in the same house or apartment; they would all be considered members of a single family.

**Unrelated individuals:** an individual who is not living with any relatives. An unrelated individual may be the only person living in a house or apartment (or in group quarters such as a rooming house) in which one or more persons also live who are not related to the individual in question by birth, marriage, or adoption. Examples of an unrelated individuals residing with others include a lodger, a foster child, a ward, or an employee.

**Calculating Household Income:** use the definitions below to determine whose income information is required for charity or discount consideration.

1.) For applicants who live with other **family (as defined above) members** in the same house or apartment, the income for all the working individuals in the household must be obtained. In situations where making this determination is questionable please seek Management for clarification. (If there are individuals in the household 18 years of age or older who are unemployed then that information should be noted at the bottom of the FIR). The goal is to account for the working status of all family members over the age of 18.

2.) For couples living together, both incomes must be considered.

# Premier Mobile Health Services

## Financial Information Report



Admit Date: \_\_\_\_\_ Account Number: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Marital Status: S M D W

### HOUSEHOLD COMPOSITION (PERSON/PERSONS LIVING AT HOME)

NAME	SFX	AGE	RELATIONSHIP

(please list additional names on back of page)

### ANNUAL INCOME INFORMATION (PREVIOUS 12 MONTHS FROM DATE OF SERVICE)

Employer (present): \_\_\_\_\_ Length of Employment: \_\_\_\_\_ Phone # \_\_\_\_\_  
 Gross Wages: \_\_\_\_\_  Hourly  Weekly  Monthly  Yearly Number of hours: \_\_\_\_\_  
 Do you own the business?  Yes  No If yes, please supply personal & business Tax Returns.  
 Employer (past): \_\_\_\_\_ Length of Employment: \_\_\_\_\_  
 Gross Wages: \_\_\_\_\_  Hourly  Weekly  Monthly  Yearly Number of hours: \_\_\_\_\_  
 Spouse Employer \_\_\_\_\_ Length of Employment: \_\_\_\_\_ SS # \_\_\_\_\_  
 Gross Wages: \_\_\_\_\_  Hourly  Weekly  Monthly  Yearly Number of hours: \_\_\_\_\_

Retirement Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____	Health Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Describe: _____ _____ _____
SS Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____	
VA Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____	
IRA's? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____	
Unemployment Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____	
Any other household income? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amount \$ _____	

### MEDICAID QUESTIONNAIRE

Have you applied for Medicaid?  Yes  No When: \_\_\_\_\_ Where: \_\_\_\_\_  
 Comments: \_\_\_\_\_

COMBINED GROSS INCOME FOR THE PAST 12 (TWELVE) MONTHS HAS BEEN \$ \_\_\_\_\_ AND THERE ARE \_\_\_\_\_ (# OF) PEOPLE IN MY FAMILY. THE INCOME INFORMATION CAN BE VERIFIED BY CALLING THE ABOVE EMPLOYERS. ADDITIONALLY, I UNDERSTAND THAT IN ACCORDANCE WITH FLORIDA STATUTES 817.50, PROVIDING FALSE INFORMATION TO DEFRAUD A HOSPITAL FOR THE PURPOSES OF OBTAINING GOODS OR SERVICES IS A MISDEMEANOR IN THE SECOND DEGREE. FURTHER, THE UNDERSIGNED HEREBY CONSENTS TO THE HEALTH CENTER'S INQUIRIES INTO HIS/HER CREDIT HISTORY IN CONFORMITY WITH THE LEGITIMATE BUSINESS NEEDS AND APPLICABLE LAWS, RULES, AND REGULATIONS.

IN THE EVENT THAT ASSETS OR A PAYMENT BECOME AVAILABLE, LEE COMMUNITY HEALTHCARE, INC. RESERVES THE RIGHT TO REVERSE THE ORIGINAL ADJUSTMENT.

I HEREBY CERTIFY THE ABOVE INFORMATION TO BE TRUE AND CORRECT

Patient/Guarantors Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness Signature \_\_\_\_\_

Spouse Signature \_\_\_\_\_ Date \_\_\_\_\_