

Sample Policy
County Health Department

Fees, Eligibility & Billing Policies & Procedures

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Fees

Foundation

Public health services are increasingly costly to provide. The Health Department serves the public interest best by assuring that all legally required public health services are furnished for all citizens and then providing as many recommended public health services as it can for those citizens with greatest need.

_____ **County Health Department** provides services without regard to religion, race, color, national origin, creed, disability, age, sex, sexual orientation, gender identity, sex characteristics, number of pregnancies, marital status, parity, or contraceptive preference.

Fees are a means to help distribute services to citizens of the county and help finance and extend public health resources as government funding cannot support the full cost of providing all requested services in addition to required services. Fees are considered appropriate, in the sense that while the entire population benefits from the availability of subsidized public health services for those in need, it is the actual users of such services who gain benefits for themselves.

Fees for Health Department services are authorized under North Carolina 130A-39 (g), provided that 1) they are in accordance with a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners, and 2) they are not otherwise prohibited by law. Fees are based on the cost of providing the service.

Fee Setting

Health Departments must develop a pricing policy addressing establishment of usual and customary charges, applying income-based discounts, non-sliding fee scale services, third party billing/reconciliation, Medicaid (physician administered drugs, fee for service drugs (340b), managed care, Medicaid as secondary payer). This information may be included in the agency's Fee and Eligibility or other financial policies. **(see attachment A Fee Setting Policy)**

340b Drugs and Devices

_____ **County Health Department** bills Medicaid the acquisition cost of medication or devices purchased through the 340b drug program. All 340b drugs and devices are identified with a UD modifier in the _____ **billing system**. 340b drugs and devices are billed to Medicaid with an FP and UD modifier. The appropriate NDC code must also be included. Drugs and devices purchased through the 340b program are labeled as 340b and stored separately from other medications and supplies.

Agencies should include specific language outlining how commercial insurers and self-pay clients are billed for 340B drugs. Agencies have the option to:

- Bill commercial insurers at usual and customary cost or acquisition cost
- Bill self-pay clients either at usual and customary cost or acquisition cost
- Agencies are allowed to bill two distinct charging methods simultaneously –

- o i.e. Bill commercial insurance the usual and customary cost **and** bill self-pay the acquisition cost.

For self-pay clients, any fee charged—regardless of the method chosen—must be adjusted according to the client’s eligibility on the sliding fee scale, in compliance with program requirements.

Non-Sliding Fees

The terminology, “Flat Fees” has been replaced and is now known as Non-Sliding Fees.

 County Health Department provides specific services at a non-discounted rate regardless of federal poverty level outside Child Health, Family Planning, Maternal Health and Communicable Disease programs. These fees will not slide on the sliding fee scale. These fees include, but are not limited to TB skin test for employment or school, non-programmatic pregnancy tests, and purchased vaccine rendered outside of Child Health, Family Planning, Maternal Health and Communicable Disease. There is a mechanism in place for waiving fees of individuals who, for good cause, are unable to pay. This process is approved by the Health Director or their designee. Waived fees will be documented in the Electronic Health Record with whom waived the fees and the reason for fees being waived.

Eligibility

Identification

It is considered “best practice” for each person presenting for services to establish identity either with a birth certificate, driver’s license, military I.D., passport, visa, or green card, etc. A local health department may not require a client to present identification that includes a picture of the client for at least immunization, pregnancy prevention, sexually transmitted disease and communicable disease services (Consolidated Agreement, B, 16). However, you may take a photograph of the client, (with their permission) for internal use only.

Determining Family Size

A family is defined as a group of related or non-related individuals who are living together as one economic unit. Individuals are considered members of a single family or economic unit when their production of income and consumption of goods are related. An economic unit must have its own source of income. Also, groups of individuals living in the same house with other individuals may be considered a separate economic unit if each group support only their unit. A pregnant woman is counted as two (including the unborn child) in determining family size.

| Examples | | Determining Family Size |
|----------|---|-------------------------|
| 1 | A foster child assigned by DSS with income considered to be paid to the foster parent for support of the child. | Family of 1 |
| 2 | A student maintaining a separate residence and receiving most of her/his support from her/his parents or guardians. (Self-supporting students maintaining a separate residence would be a separate economic unit.) | Dependent of the family |

| | | |
|---|--|--|
| 3 | An individual in an institution. | Separate Economic unit |
| 4 | A client who requests “confidential services”, regardless of age. | Family of 1 |
| 5 | If a Family Planning client presents for a service and is considered to be a minor or is covered by a parent’s medical insurance policy, interview questions may include the following: <i>1) Ask the client if their parents are aware of their visit? 2) Ask if “both” parents are aware of their visit, since sometimes the mother may be present with the client, however, the father may not be aware of the visit. 3) Ask if you can send a bill to the home, to both parents.</i> | If the client states both parents are aware and it is not a confidential visit, you should treat as such and use all family members in the economic unit. If both parents are not aware, treat this as a confidential visit and use the income of the individual, counting the individual as a family of 1. |

Determining Gross Income

Gross income is the total of all cash income before deductions for income taxes, employee’s social security taxes, insurance premiums, bonds, etc. For self-employed applicants (both farm and non-farm) this means net income after business expenses.

1. Salaries and wages; before any deductions
2. Earnings from self-employment
3. Net receipts from non-farm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses)
4. Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses)
5. Investment income, stocks, bonds, savings account interest, rentals, and all other investment income
6. Periodic trust fund payments
7. Public assistance money
8. Unemployment compensation
9. Alimony
10. Child Support (excluded from Family Planning Clients)
11. Military family allotments or other regular support from an absent family member or someone not living in the household
12. Social Security benefits
13. Veteran's Administration benefits
14. Retirement and pension payments
15. Regular insurance or annuity payments
16. Worker's compensation
17. Educational stipends in excess of the cost of tuition and books
18. Allowances paid for basic living expenses such as housing and utilities
19. Supplemental security income benefits
20. Dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings
21. All other sources of cash income except those specifically excluded

Exceptions

1. Irregular, incidental income that a child may earn from babysitting, lawn mowing, or other similar tasks
2. Proceeds from the sale of an asset
3. Withdrawals from a bank account
4. Gifts
5. Inheritances
6. Life insurance proceeds or other one time insurance settlements
7. Capital gains
8. Any assets drawn down as withdrawals from a bank, the sale of property, a house, or a car
9. Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury

No client will be refused services when presenting for care based on lack of income documentation. With the exception of Family Planning clients*, each client will be billed at 100% until proof of income and family size is provided to the agency. **The client will have ____ days (agency may determine time limit)** to present this documentation in order to adjust the previous 100% charge to the sliding fee scale. If no documentation is produced in ____ days, then the charge stands at 100% for that visit. This does not apply to non-sliding fee scale services which should be paid in full on the date of service.

*For Family Planning clients, the agency may use information from other Health Department programs to which the agency has legal access in order to verify income, but the agency may not charge clients at 100% simply because the client has not provided proof of income. In cases where the agency has no access to income reported in another program and the client does not provide proof of income, eligibility for discounts must be determined based on the client’s verbal attestation of income. Reasonable attempts to verify income include only asking the client for proof of income at the initial and all subsequent Family Planning visits. Under no circumstance should measures to verify income burden clients from low-income families.

Computation of Income

Income will be based on a twelve (12) month period. If the client is working the day they present for a service, income will be calculated weekly, bi-weekly, monthly or annually, depending on the documentation obtained.

If the client is unemployed the day they present for their service, their “employment only” income will be calculated at zero (0), however the client should be required to provide “their mechanism”, in regard to their paying for food, clothing, shelter, utility bills, etc. Refer to “sources of income” counted and apply all sources, as appropriate. “Regular contributions received from other sources outside of the home” is most often considered one of those sources. If the client is receiving unemployment or other “sources” of income, as designated above, all of those sources should be counted.

| | |
|--|---|
| | The client’s income will be determined by the following: |
| Regular Income Formula: (Based on 12 month Period) | Use Gross Income or for self-employed income after business expenses. Weekly = pay x 52 Biweekly = pay x 26 Twice a month = pay x 24 |

| Unemployment or Irregular Income Formula: | |
|--|---|
| <p>Six months' formula (Based on 12 month Period)</p> | <ul style="list-style-type: none"> • Unemployed today = last 6 months income + projected unemployment benefits (if applicable) or zero if client won't receive unemployment benefits. This will give you income for the client for a 12 month period. <ul style="list-style-type: none"> ○ If no unemployment benefits – ask how the client is going to support themselves. • Employed today but unemployed last 6 months – Did the client receive unemployment benefits within the last 6 months? In no, record as zero and then project 6 months forward at current salary/wages. This will give you income for the client for a 12 month period. **Income for FP must be re-assessed at every visit. |

Healthy Mothers Healthy Children (HMHC)/Title V (Well-Child Funding)

Title V policy on applying sliding fee scale: any client whose income is less than the federal poverty level will not be charged for a service if that service is partly or wholly supported by Title V funds. For clients having income above the federal poverty level, the sliding fee scale of the _____ **County Health Department** will be used to determine the percent of client participation in the cost of the service.

The guidance regarding Title V funding and sliding Child Health services to zero is as follows: Any Maternal and Child Health services (even outside of Child Health Clinics) must use a sliding fee scale that slides to "0" at 100% of the Federal Poverty Level per the NC Administrative Code – 10A NCAC 43B.0109 Client and Third-Party Fees.

The NC Administrative Code goes beyond the Title V/351 AA requirements, that all child health services, whether sick or well, no matter where delivered, must be billed on a sliding fee scale that slides to zero.

10A NCAC 43B .0109 CLIENT AND THIRD-PARTY FEES

- (1) If a local provider imposes any charges on clients for maternal and child health services, such charges:
 - (a) Will be applied according to a public schedule of charges;
 - (b) Will not be imposed on low-income individuals or their families;
 - (c) Will be adjusted to reflect the income, resources, and family size of the individual receiving the services.
- (2) If client fees are charged, providers must make reasonable efforts to collect from third party payors.
- (3) Client and third-party fees collected by the local provider for the provision of maternal and child health services must be used, upon approval of the program, to expand, maintain, or enhance these services. No person shall be denied services nor subject to any variation in services because of an inability to pay.

History Note: Authority G.S. 130A-124; Eff. April 1, 1985; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017

Child Health funds may not be used to supplement Medicaid services, support services or activities supported by other Agreement Addenda, and may not support services and activities that have not been approved by the C&Y Branch.

Title X Requirements Related to Income Collection for Confidential Clients

Title X requires that any client seeking confidential services be considered a family of one and that only their income would be used in assessing their percent pay on the sliding fee scale.

A copy of the **Income and Eligibility Statement (Please refer to Attachment B)** should be maintained for future reference. The number in the household, annual gross income and percentage of pay should be reflected on the financial documentation. The documentation should be signed and dated by the interviewer and client. Use of electronic signatures is acceptable.

Income must be assessed at every Family Planning Clinic visit, including clients who have Medicaid or Commercial Insurance. Following the initial financial eligibility determination, the client must be asked at each visit if there has been a change in their financial status. Income will always be based on the “actual date” of service. If there has been a change or it is time for their annual review the income determination process should take place.

Client fees are assessed according to the rules and regulations of each program and the recommended Program’s Poverty Level Scale (Sliding Fee Scale) will be used to determine fees. All third-party providers will be billed, without discount, where applicable.

Clients with third-party health insurance that requires copayments must pay the required copay at the time of service. For Family Planning (Title X) clients, copays, deductibles, and any other fees must not exceed the amount they would owe under the sliding fee scale if they were uninsured. **Copays, deductibles, and/or coinsurance are not adjusted based on the sliding fee scale—collect whichever amount is lower.**

Income information reported during the financial eligibility screening for one program can be used through other programs offered in the agency, rather than to re-verify income or rely solely on the client’s self-report. Exception to the rule, effective November 8, 2021, for family planning, if income was not provided and the client was charged at 100% previously, clients will **not** automatically be charged at 100% in family planning.

Child Health/Health Check

Well child exams (Health Check) conducted by appropriate provider; exam includes medical, social, development, nutritional history, lab work, physical exam and immunizations as needed. Primary Care (Child Health) for sick children provided by an appropriate provider.

Eligibility: _____ County resident; birth to 20 years; document what % Sliding Fee Scale is applied; Medicaid, or Insurance

Vaccine and Administration (Immunization Program)

_____County Health Department will not charge a fee to clients for state supplied vaccines provided to clients that are eligible for such vaccine in accordance to the NCIP Coverage Criteria and Vaccine for Children. Administration fees for the rendering of state supplied vaccine may be billed to Medicaid. State supplied vaccine will be identified with a SL modifier. The appropriate NDC code must also be included.

Clients and Third Party Payers may be charged and/or billed the administration fee and the cost of purchased vaccine by the _____County Health Department as a non-sliding fee when provided outside of programs.

Eligibility: No residency requirements. Vaccine administration and vaccine provided within Child Health, Family Planning, and Maternal Health program will be subject to the sliding fee scale.

Maternal Health

Prenatal care for eligible pregnant women.

Eligibility: _____County resident; document what % Sliding Fee Scale is applied; Presumptive Medicaid, Medicaid or Insurance

Family Planning

Clinic designed to assist men and women, including adolescents, with their family planning needs; services include, but are not limited to detailed history, lab work, physical exam, counseling and education given by appropriate provider.

All family planning services must be client centered, culturally and linguistically appropriate, inclusive, and trauma informed.

Eligibility: Men and Women of childbearing age regardless of residency; **101-250% Sliding Fee Scale;** Medicaid, or Insurance

The following shall apply to Family Planning clients:

- (1) Clients may not be coerced to use contraception, or to use any particular method of contraception or service.
- (2) If a client, including adolescents, is seeking confidential services, they will be considered "confidential" and it will be documented on the Financial Eligibility form. Charges to clients seeking confidential services will be based solely on the individual's income.
- (3) The use of NC Debt Setoff is acceptable for collecting past due amounts for Family Planning clients. Confidential clients must NOT be referred to Debt Set-off.
- (4) The "Bad Debt Write-Off" procedure for aging accounts will be strictly adhered to. A list of proposed bad debt accounts must be reviewed and approved by the Health Director prior to submission to the Board of Health (or other appropriate governing body, in accordance with local policy). No bad debts will be written off without formal approval from the Board.

Official minutes from the Board of Health (or appropriate governing body) will serve as documentation of the approved write-offs.

- (5) Bills/receipts will be given to clients at the time of service show total charges, as well as any allowable discounts (best practice).
- (6) When a third party is responsible for payment, all billing will be submitted directly to that party. Charges submitted will reflect the full, undiscounted amount unless a contracted reimbursement rate is specified in the agreement with the third-party payer, in which case billing will comply with the terms of that agreement.
- (7) Verifying a Family Planning client's income should not burden patients with low incomes or impede access to care. If a Family Planning client's income cannot be verified through access to enrollment in another program within your agency, and the Family Planning client has not provided proof of income, then you must charge the client based on the client's self-reported income.
- (8) If a Family Planning client refuses to provide a verbal declaration of income, and income cannot be verified through access to enrollment in another program within your agency, then you may charge 100% of the cost of services after informing the client that failure to declare income will result in the client owing 100% of the fee.
- (9) Insured Family Planning clients whose family income is between 101% and 250% of the Federal Poverty Level will pay the lesser of the copay, deductibles and additional fees or the amount they would owe when the sliding fee scale is applied to the total charge for their visit as required by Title X.

Communicable Disease Control

This program deals with the investigation and follow-up of all reportable communicable and/or sexually transmitted diseases, to include: testing, diagnosis, treatment, and referring as appropriate. It also provides follow-up and treatment of TB cases and their contacts.

Eligibility: No residency requirements. No fees charged to the client for these services as stated in program rules. Medicaid and Insurance can be billed.

Breast and Cervical Cancer Control Program (BCCCP)

Provides pap smears, breast exams and screening mammograms, assists women with abnormal breast examinations/mammograms, or abnormal cervical screenings to obtain additional diagnostic examinations.

Eligibility: _____ County resident; determined by specific policies and procedures including income guidelines defined by the Breast and Cervical Cancer Control Program (BCCCP). 101-250% Sliding Fee Scale Applied.

Other Services (OS)

Please refer to the Clinical Coverage Policy for Preventive Medicine Annual Health Assessment, 1A-2, and consult with your regional Nurse and Financial Consultant for information regarding changes to OS and PC service approval.

Women's, Infants and Children's Nutrition (WIC)

Supplemental nutrition and education program to provide specific nutritional foods and education services to improve health status of target groups.

Eligibility: WIC is available to pregnant, breastfeeding, and postpartum women as well as infants and children up to age 5. The following criteria must also be met: 1) be a resident of _____ County; 2) be at medical and/or nutritional risk; 3) have a family income less than 185% of the US Federal Poverty Level; Medicaid, AFDC, or food stamps automatically meet the income eligibility requirement.

Billing & Revenue

In accordance with G.S. 130-A-39(g), which allows local health departments to implement a fee for services rendered the _____ County Health Department, with the approval of the _____ County Board of Health and the _____ County Commissioners (or appropriate governing body) will implement specific fees for services and seek reimbursement. Specific methods used in seeking reimbursement will be through third-party coverage, including Medicaid, Medicare, private insurance, and individual client pay. _____ County Health Department currently participates with (include currently participating insurance networks). The agency will adhere to billing procedures as specified by Program/State regulations in seeking reimbursement for services provided.

Charging for Services

1. There shall be no minimum fee requirement or surcharge that is indiscriminately applied to all clients.
2. Persons requesting program services will be encouraged to apply for Medicaid.
3. Charges will not be assessed when income falls below 100% of Federal Poverty Guidelines, for Child Health, Family Planning and Maternity programs.
4. There shall be a consistent applied method of "aging" accounts.
5. No one shall be denied services nor subjected to variation in services based solely on the inability to pay.
6. Clients shall be given a receipt each time a payment is collected (best practice).

Fee Collection

1. Charges in all programs will be determined by a fee scale based on Federal Poverty with the exception of any services deemed as non-sliding fees. (i.e. TB skin test, Non-programmatic pregnancy tests, Adult Health services).
2. Upon each clinic visit, designated staff will determine the income and sliding fee scale status of each client. Staff will be responsible for documentation of financial eligibility on _____ (whatever form/format your department uses to determine eligibility), (see

- Attachment B for sample). With the exception of family planning, clients without required verification will be charged at 100% until income documentation is received.
3. Payment is due and expected at the time services are provided. If a balance remains, a payment agreement and schedule will be established and signed by the client—except in the case of confidential clients. Confidential clients will not be required to sign any payment agreement that includes language about referral to the NC Debt Setoff Program. (See Attachment D)
 4. There is a mechanism in place for waiving fees of individuals who, for good cause, are unable to pay. This process is approved by the Health Director or their designee, and each instance of fee waiver shall be documented in agency records and communicated to the client according to protocol.
 5. Enrollment under Title XIX (Medicaid) shall be presumed to constitute full payment for billable services to Medicaid.
 6. The Accounts Receivable System will be balanced daily.
 7. Emergency services will never be denied.
 8. Statements will be mailed to the client/responsible party as long as confidentiality is not jeopardized, per agency policy.

Billing Medicaid and Third-Party Insurance

1. Clients presenting with third party health insurance coverage where copayments are required shall be subject to collection of the required copayment at the time of service. For Family Planning (Title X) clients, the copay/deductible may not exceed the amount they would have paid for services based on the sliding fee scale.
2. Clients will sign on paper to be scanned or electronically sign a consent allowing the Health Department to file insurance and a copy of the insurance card will be scanned at that time into the client's medical record (Assignment of Benefits).
3. Third party is billed the total amount of the service provided they will not receive the benefit of the sliding fee scale. The charge and any remaining balance with the exception of copayments, is billed to the client based on the sliding fee scale. Copayments are not subject to the sliding fee scale, except that Family Planning clients may not be charged more in copayments and deductibles than they would have been responsible for on the sliding fee scale.
4. Claims are filed electronically using (add the name of the vendor product(s) you use)
5. Payments are posted electronically/manually to client accounts. If applicable, secondary insurance is filed.
6. Denials are researched using the Remittance Advice (RA) for Medicaid and Explanation of Benefits' for private insurance. Any denials deemed incorrect are resubmitted as quickly as possible. Any remittance or final denial is posted to the client's account. Remaining balance for Medicaid clients are adjusted off. (unless it was for a non-covered service that the client was made aware of prior to the service being rendered.)
 - a. If a client has any form of third-party reimbursement, that payer must be billed with the patient's consent, unless confidentiality is a barrier*. Medicaid will be billed as the payer of last resort. Clients should be made aware that they will be responsible for any balance remaining after the claim has been processed. This may include copays, coinsurance, deductibles and non-allowed charges. As required by Title X, Family Planning clients whose family

income is between 101%-250% FPL will not pay more in copayments or additional fees than they would otherwise pay when the schedule of discounts is applied.

7. If an encounter with a client is found to be coded incorrectly, the provider may make corrections by appending the provider's note and e-superbill within the client's medical record and notifying the billing department's supervisor. The billing department will review the corrections and update the charges accordingly. If a client has been charged and have received a monthly statement and the addition or correction of the service made by the provider will increase the client's balance, the correction will be made with no additional cost to the client, unless, the client was over charged.

* Third party billing is processed in a manner that does not breach client confidentiality, particularly in sensitive cases (e.g., adolescents or young adults seeking confidential services, or individuals for whom billing the policy holder could result in interpersonal violence). The confidential client may give you their insurance card not thinking that the subscriber is not aware of the visit. Filing an insurance claim will result in an EOB (explanation of benefits) being sent to the subscriber which would violate confidentiality. Be certain to have the client sign/initial if they want insurance to be filed.

Overpayments and Refunds

Payment for copays, deductibles, coinsurance, account balances and non-sliding fees will be collected at the time of service. If an overpayment is made by the client, the client will be notified of the overpayment and given the option for refund, or application of the overpayment to another date of service balance or for an upcoming appointment. Overpayments that clients choose to have refunded, will be refunded based on county policy.

Overpayments paid by Medicaid, Medicare and insurance will be reviewed and refunded in accordance to the guidelines set forth in our network participatory agreement.

Bad Debt Write Off and NC Debt Setoff

1. Bad Debt Write Off
 - a. Outstanding accounts having no activity in more than ____ months shall be written off as bad debts, at least annually upon **approval of the _____ County Board of Health and the _____ County Commissioners (or health department policy).**
 - b. Once an account has been written off as a bad debt it should not be reinstated. Only if the client returns to the clinic and wants to make a payment should action be taken to reinstate only the payment amount, post the payment and leave the remaining balance that was initially written off as it stands.
2. NC Debt Setoff
 - a. Client accounts fulfilling the requirements of NC Debt Setoff will be submitted to the NC Debt Setoff Program, at least annually. The account balance must be (1.) greater than \$50.00, and (2.) must be 60 days delinquent before it is eligible for Debt Set Off. After being delinquent for a minimum of 60 days, the client/guarantor will be notified of the process of debt setoff, via letter. The

client/guarantor has 30 days to take action via payment or payment plan or the debt will be submitted to NC Debt Setoff.

- b. Debt Setoff should not be used for confidential clients.

Bankruptcy

When legal notification is received from Bankruptcy court, there is no further collection of the outstanding account unless a payment schedule is set up by the Bankruptcy court.

- The client's account is notated/flagged with bankruptcy information, such as the time frame to which the bankruptcy references.
- The account maybe written off if mandated by court.
- The client may volunteer to pay.
- Additional visits to which are not included in the bankruptcy time frame, will be the client's responsibility.

Limiting or Restricting services

- Family Planning: The Title X guidelines do not distinguish between "inability" and "unwillingness" to pay. For Family Planning clients who do not pay, the agency can use debt set-off provided the client is not a confidential client. Even if a client establishes a payment plan but then refuses to honor the plan services cannot be denied or restricted.
- In Maternal Health, denying or restricting services would constitute client abandonment. Therefore, services for Maternal Health may not be denied because a client is unwilling or unable to pay.
- Child Health may not restrict Child Health services due to an outstanding bill. Title V funds are used to prevent barriers to care for clients that are Non-Medicaid, non-insured as well.

No Mail Policy for Confidential Clients

1. When a client requests no mail, discussion of payment of outstanding debts shall occur at the time service is rendered.
2. If the client is unable to pay in full at the time of service rendered, a receipt will be given to the client reflecting the partial payment and the client will sign a payment agreement.
3. Medical record is flagged reflecting-- **"NO MAIL" and every precaution should be taken to ensure bills are "not" sent to clients, requesting "NO MAIL"**.
4. Client is reminded every visit of the amount they still owe.
5. No letters or correspondence concerning insurance, past due accounts or other billing issues will be sent to any client that requests "NO MAIL".

County Health Department Fee Setting Policy & Procedure

PURPOSE:

The procedure to which County Health Department use for setting fees for services.

POLICY:

In accordance with G.S. 130A-39(g), which allows local health departments to implement fees for services rendered, the County Health Department, with the approval of the county's governing board will implement specific fees for services and seek reimbursement for services. The method used for setting fees will be solely based on the cost to provide the service. Resources that may be used in this process include, Cost Report, Medicaid Reimbursement rates, fees charged by surrounding health departments/service providers and/or DPH LHD worksheet for setting fees.

PROCEDURE:

A developed multi-disciplinary committee of the County Health Department will meet at least annually, to determine the cost of providing services and discuss the fees for the services provided.

Fees will be determined based on the cost to provide services, in conjunction with the cost study analysis, which assesses direct and indirect costs including, but not limited to, the salary of staff rendering services, materials and supplies used, building and maintenance fees. In order to set fees, the County Health Department may use multiple resources such as, the Workbook for Setting Service Fees that has been provided by the NC Division of Public Health, the cost study analysis, fees of local health departments within the area and/or review the Medicaid, Medicare and Third Party Insurance rates for services.

Once the fees are reviewed and discussed by the committee, the Health Director will present the fees to the governing board for their review and final approval. Once approval has been received, the appropriate fees are set and will be maintained in the Health Department, noted as the approved "Fee Schedule". The fee schedule may be automatically adjusted (without Board approval) during the fiscal year if the Health Department receives notification of an increase of the cost of supplies.

Name:

DOB:

Affix Label Here

Add Health Department address and phone info here

Income & Eligibility Statement

Circle Correct Answers:

| | | |
|----------------------------|-----|----|
| Resident of North Carolina | Yes | No |
| Medicaid Eligible | Yes | No |
| Insurance | Yes | No |
| Self-Pay | Yes | No |
| No-Pay | Yes | No |

Gross annual income of economic unit:**Total number in household supported by income above:****Sliding Fee Scale Percentage:** %

Gross income is defined as salary, wages, overtime pay, earnings from self-employment, investment income (stocks, bonds, savings account interest, rentals, etc.), public assistance monies, unemployment compensation, alimony and child support payments, military allotments, Social Security benefits, limited Veterans Administration benefits, retirement and pension, Workers Compensation, regular contributions from individuals not living in the household, Supplementary Security Income (SSI) benefits, prize winnings, lawn maintenance as a business and house cleaning as a business.

Economic unit includes persons living in the household, related or non-related, who share their production of income and consumption of goods.

Verification of income is required as noted in the [] Health Dept. () Eligibility & Fee Policy.

Patients who do not provide proof of income at time of registration will be charged 100% of our current fees for services provided, except Family Planning clients. Patients **will have ___ calendar days to return** to the [] with proof of income in order for the sliding fee scale to apply. If proof of income has not been provided **within the ___ calendar day period**, charges will remain at the full 100% of our current fees. Patients who prefer not to provide proof of income will be charged 100% of our current fees. Payment is due at the time of service.

Upon penalties prescribed by law, I hereby affirm that to the best of my knowledge and belief, this income statement is true and correct.

- I prefer not to provide [] with proof of income or declaration of income; therefore, I understand that I am fully obligated for payment of fees for services provided at 100% of **LHD Name's** standard fees.
- Confidential Contact or Emancipated Minor – considered family of one and based on minor's income only
- Declaration of "no income" - reasonable answers for living expenses provided – all programs.
- Proof of income has been provided as required or attested to for family planning services.
- Proof of income will be provided within ---calendar days of signature date below. I understand if proof of income is not provided within the --- calendar day period, charges will remain at 100% of current fees.
- Proof of income has been provided for date of service: [] Within ___ calendar days: Yes No
- I have health insurance but prefer that it not be filed for this visit. I understand that I will be responsible for payment of fees based on income eligibility under the Sliding Fee Scale.

I, the undersigned, verify the above information is true to the best of my knowledge and I understand payment is expected at the time of service for all services rendered.

Signature of Patient/Parent/Authorized Representative

Date

Relationship of Authorized Representative

Signature of Witness

Date

01/2022

Network Participation In Network Third Party Insurances

_____ **County Health Department** is in network and participates with the following Third-Party Insurances:

- NC Medicaid
 - Including Prepaid Health Plans provided by the following
 - Healthy Blue
 - United Health Care
 - Well Care
 - AmeriHealth Caritas
 - Carolina's Complete
 - Eastern Band Cherokee Indian Tribal Option
 - Tailored Plans
- (add other in network third party insurances)
- Medicare

