

**A. Staff Time Documentation/Expenditure Reporting/Budget**

(All Items Funding Conditions)

Instructions: Review 1 month's Staff Time Documentation. Compare expenditure documentation with Aid-To-County Monthly Expenditure Report requested for review.

1. What services are provided within your agency?

- Family Planning  Immunization  Adult Health   
 Maternal Health  STD  Other: \_\_\_\_\_  
 Child Health  TB

**Details**

2. Were the activity categories listed on the time records detailed enough to document the expenditures charged to each activity?

- Family Planning  Yes  No Immunization  Yes  No  
 Maternal Health  Yes  No STD  Yes  No  
 Child Health  Yes  No TB  Yes  No

**Details**

*(Ensure time sheets are broken down by program)*

3. Did direct service staff record time based on their actual work activity?

- Family Planning  Yes  No Immunization  Yes  No  
 Maternal Health  Yes  No STD  Yes  No  
 Child Health  Yes  No TB  Yes  No

**Details**

4. Was the amount of time documented in each activity applied to the employee's gross salary and fringe benefits by activity?

- Family Planning  Yes  No Immunization  Yes  No  
 Maternal Health  Yes  No STD  Yes  No  
 Child Health  Yes  No TB  Yes  No

**Details**

5. Was all administrative time: <ul style="list-style-type: none"> <li>a. Allocated to the General Budget?</li> <li>b. Allocated in proportion to the actual time worked in each activity?                         <ul style="list-style-type: none"> <li>1. Was the appropriate staff allocated across all activities?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</li> </ul> </li> </ul>													
<b>Details</b>													
6. Was the salary expense reported on the DHHS Aid-To-County Expenditure Report based on documentation from the Staff Time Equivalencies in review? <table style="width: 100%; margin-top: 5px;"> <tr> <td style="width: 30%;">Family Planning</td> <td><input type="checkbox"/> Yes    <input type="checkbox"/> No</td> <td style="width: 30%;">Immunization</td> <td><input type="checkbox"/> Yes    <input type="checkbox"/> No</td> </tr> <tr> <td>Maternal Health</td> <td><input type="checkbox"/> Yes    <input type="checkbox"/> No</td> <td>STD</td> <td><input type="checkbox"/> Yes    <input type="checkbox"/> No</td> </tr> <tr> <td>Child Health</td> <td><input type="checkbox"/> Yes    <input type="checkbox"/> No</td> <td>TB</td> <td><input type="checkbox"/> Yes    <input type="checkbox"/> No</td> </tr> </table>		Family Planning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunization	<input type="checkbox"/> Yes <input type="checkbox"/> No	Maternal Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	TB	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Planning	<input type="checkbox"/> Yes <input type="checkbox"/> No	Immunization	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Maternal Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	STD	<input type="checkbox"/> Yes <input type="checkbox"/> No										
Child Health	<input type="checkbox"/> Yes <input type="checkbox"/> No	TB	<input type="checkbox"/> Yes <input type="checkbox"/> No										
<b>Details</b>													
7. Review (AC) support documentation for all DHHS program expenses reported on the DHHS Aid-to-County Expenditure Report for the month of <u>September</u> , _____ <u>August</u> expenditures). Was there sufficient documentation to verify expenditures for the month in review? <input type="checkbox"/> Yes <input type="checkbox"/> No													
<b>Details</b>													
8. Does the local agency balance their Aid-to-County Expenditure Report with their monthly General Ledger? <input type="checkbox"/> Yes <input type="checkbox"/> No													
<b>Details</b>	<i>(State expenditures on Internal County Ledger) (BCCCP #452 and WW #465) (Total of state expenditures minus BCCCP and WW)</i>												
9. Do all local agency program managers participate in budget planning and review for the program they manage? <input type="checkbox"/> Yes <input type="checkbox"/> No													
<b>Details</b>													
<b>B. Program Income</b> (All Items Funding Conditions)													

**Administrative Assessment SFY: 2025-2026**

**Health Department:**

**Date of Review:**

**Financial Consultant:**

	<p>1. Were fees collected deposited to the account of the agency to be expended for public health programs in accordance with the County Fiscal Act?</p> <p>Family Planning    <input type="checkbox"/> Yes   <input type="checkbox"/> No      Immunization   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Maternal Health    <input type="checkbox"/> Yes   <input type="checkbox"/> No      STD                <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Child Health        <input type="checkbox"/> Yes   <input type="checkbox"/> No      TB                 <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
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<b>Details</b>	<i>(Monthly Revenue Report) (Were fees deposited into the programs where they were collected?)</i>
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	<p>2. Were records maintained of the amount of program income generated by payment source?</p> <p>Family Planning    <input type="checkbox"/> Yes   <input type="checkbox"/> No      Immunization   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Maternal Health    <input type="checkbox"/> Yes   <input type="checkbox"/> No      STD                <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Child Health        <input type="checkbox"/> Yes   <input type="checkbox"/> No      TB                 <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
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<b>Details</b>	
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**C. Patient Eligibility/Financial Policies and Procedures**

*(All Items Funding Conditions)*

	<p>1. Are there additional requirements other than residency to determine client eligibility to receive program services? (i.e., VFC Eligibility, FP Requirements)</p> <p>Family Planning    <input type="checkbox"/> Yes   <input type="checkbox"/> No      Immunization   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Maternal Health    <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Child Health        <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
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<b>Details</b>	<i>(CH &amp; MH are allowed residency restrictions, must be in policy)</i>
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	<p>2. Were eligibility requirements for this program documented in written policies?</p> <p>Family Planning    <input type="checkbox"/> Yes   <input type="checkbox"/> No      Immunization   <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Maternal Health    <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Child Health        <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
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<b>Details</b>	
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	<p>3. Did the financial eligibility scale meet the state program requirements? (must slide to \$0)</p> <p>Family Planning    <input type="checkbox"/> Yes   <input type="checkbox"/> No    <input type="checkbox"/> 101-250   <input type="checkbox"/> Other</p> <p>Maternal Health    <input type="checkbox"/> Yes   <input type="checkbox"/> No    <input type="checkbox"/> 101-250   <input type="checkbox"/> Other</p> <p>Child Health        <input type="checkbox"/> Yes   <input type="checkbox"/> No    <input type="checkbox"/> 101-250   <input type="checkbox"/> Other</p>
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<b>Details</b>	<i>(Must document within policy, which SFS is used for each program, 101-250 (FP), 101-200, 100-300, 100-350).</i>
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**D. Medicaid Eligibility/ Residency**

(All Items Funding Conditions Except 1 and 2)

1. Were persons requesting program services referred for assistance to apply for Medicaid?

- |                 |                              |                             |              |                              |                             |
|-----------------|------------------------------|-----------------------------|--------------|------------------------------|-----------------------------|
| Family Planning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immunization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Maternal Health | <input type="checkbox"/> Yes | <input type="checkbox"/> No | STD          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Child Health    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | TB           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Details** *Although not required, this is best practice.*

2. How does the local agency verify Medicaid eligibility?

**Details**

3. Are program services available to county residents only?

- |                        |                              |                             |                     |                              |                             |
|------------------------|------------------------------|-----------------------------|---------------------|------------------------------|-----------------------------|
| <b>Family Planning</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>Immunization</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Maternal Health        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>STD</b>          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Child Health           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <b>TB</b>           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Details**

4. Was the local agency's residency policy in compliance with state program requirements?

- |                 |                              |                             |              |                              |                             |
|-----------------|------------------------------|-----------------------------|--------------|------------------------------|-----------------------------|
| Family Planning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immunization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Maternal Health | <input type="checkbox"/> Yes | <input type="checkbox"/> No | STD          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Child Health    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | TB           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Details** *Maternal Health & Child Health may have county residency requirement per agency decision. Family Planning, STD, TB & Immunization cannot have residency requirement.*

**E. Patient Fees**

(All Items Funding Conditions Except items 5 & 15)

1. Is the Economic Unit the method of income collection used to determine financial eligibility?

- |                 |                              |                             |              |                              |                             |
|-----------------|------------------------------|-----------------------------|--------------|------------------------------|-----------------------------|
| Family Planning | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Immunization | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Maternal Health | <input type="checkbox"/> Yes | <input type="checkbox"/> No | STD          | N/A                          |                             |
| Child Health    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | TB           | N/A                          |                             |

**Details**



<p>7. Were patient fees for program services based on related costs for services?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. Review the agency policy for setting fees. Is the agency policy an acceptable method of setting fees for services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<b>Details</b>	
<p>8. Were fees for Family Planning services assessed using the sliding fee scale between 101-250%?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<b>Details</b>	
<p>9. Were third parties that were authorized or legally obligated to pay for clients at or below 100% of the Federal Poverty Level billed properly?  <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)</p> <p>a. Were third party payors billed the usual and customary charges? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<b>Details</b>	
<p>10. Were there policies in place that substantiate Family Planning clients are not being charged more in copayments or additional fees than they would otherwise pay according to the sliding fee scale?  <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)</p>	
<b>Details</b>	<i>(Must determine the amount the patient would pay being uninsured vs what insurance applies to the patient's responsibility. Agency must collect the lesser of the two amounts).</i>
<p>11. For the purpose of determining Family Planning charges, were all adolescents requesting confidential services considered a household of one?  <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)</p>	
<b>Details</b>	<i>(All individuals requesting confidential services would be considered a household of one).</i>
<p>12. Was "Confidential Patient" documented on the financial eligibility forms/EHR of patients who requested confidential Family Planning services?  <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)</p>	
<b>Details</b>	<i>(All individuals, including STD program)</i>

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<p>13. Were fees imposed on persons or their families whose incomes fall within the “no pay” category?                  Maternal Health <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)                  Family Planning <input type="checkbox"/> Yes <input type="checkbox"/> No                  Child Health <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<b>Details</b>	
<p>14. Does the agency policy demonstrate reasonable efforts to collect charges without jeopardizing client confidentiality? <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)</p>	
<b>Details</b>	
<p>15. Were all patient consent forms signed and dated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<b>Details</b>	<i>(Best practice: HIPAA-annually. Assignment of benefits-per encounter (potential confidential services), all others (CH, MH, Imm.) annually).</i>
<p>16. Did the Patient Fee Policy state that the Health Director, or designee, has the right to waive fees for individuals who, for a good reason, are unable to pay? For FP, agency must have a policy/procedure/protocol that specifies how and where decisions to waive fees are documented.  <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)</p>	
<b>Details</b>	<i>Best practice for all programs.</i>
<p>17. Is client income collected and/or re-evaluated on an annual basis for ALL clients, including Medicaid and Private Insurance?  <input type="checkbox"/> Yes <input type="checkbox"/> No                  a. Are Family Planning client income collected/re-evaluated at each visit? <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)</p>	
<b>Details</b>	<i>ALL FP clients must be re-evaluated at each visit, including Medicaid and private insurance. This must be in policy.</i>
<p>18. Does the Fee policy state that the agency:                  a. May use income reported in another program to which the agency has lawful access.                  b. State that when a client’s income cannot be verified, the client’s verbal declaration will be used to determine eligibility for discounts, and                  c. If the client refuses to provide a verbal declaration of income AND the income cannot be verified through another program, then the client will be charged 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?”  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<b>Details</b>	

19. Were the patient financial records reviewed in compliance with state program requirements? <input type="checkbox"/> Yes <input type="checkbox"/> No (Title X)	
<b>Details</b>	
<b>F. Billing/Accounts Receivable</b> (Item 2 is a Funding Condition. All others are Recommendations.)	
1. What Electronic Health Record (EHR) system does the local agency use?	
<b>Details</b>	
2. Did the local agency bill Medicaid and other third-party payers for which the agency is a credentialed provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	<i>Per CA, Section III Funding Stipulations, B-compliance ,3- LHD Charges/Billing, c. "Make every reasonable effort to collect charges for services through public or private third-party payors (except where prohibited by federal regulations or State law)"</i>
3. Review the written policy for handling denied claims, Medicaid, and all others. Is the procedure appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	
4. Review one Medicaid RA denied claims report for SFY under review. Examine three denials on the report. Were denied claims rebilled when appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	
5. Is there an assigned individual(s) for reviewing: a. Claims for billing accuracy: <input type="checkbox"/> Yes <input type="checkbox"/> No b. Interpretation of Medicaid bulletins and other Medicaid Billing policy: <input type="checkbox"/> Yes <input type="checkbox"/> No c. Distributing information related to Medicaid billing Policy and changes or updates: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	

6. Does the local agency review the aged accounts report(s)(30, 60, 90) on a monthly basis? <input type="checkbox"/> Yes <input type="checkbox"/> No a. Does the local agency take action based on the report(s) which are reviewed each month? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	
7. Does the local agency use a specific report to identify amounts due for bad debt write-off? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	
8. Does the local agency have a Bad Debt Write Off policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	
9. Does the agency policy include a method for aging client accounts for bad debt write off? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	
10. Is the Bad Debt Write Off policy being followed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	<i>Last Bad Debt Write Off Date:</i>
11. Does the local agency use NC Debt Set Off as a means of collection of delinquent accounts (with the exception of confidential clients)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	
12. Does the local agency have a policy addressing NC Debt Set Off? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Details</b>	