Kiowa County Hospital District **Effective 04/01/2008**
Fiscal Services Policies and Procedures

Sliding Fee Scale Guidelines

The sliding fee scale is strictly based on income. The income guideline will be based on the most current U.S. Department of Health and Human Services poverty guidelines. The guidelines give us the income levels according to the number in the household. To establish the income and dependent level we will need the following information to make these determinations.

1. **# of dependents** – A signed last year's income tax return for the household. Whether they applied individually or jointly whatever shows the # of dependents in the household. If the # in the household has changed we will need a birth certificate or death certificate, something that proves another dependent is in or out of the house.

2. **Income level** – Last years income tax will give us the level of income and the last two (2) pay stubs will verify the current level has not changed. If the last two (2) pay stubs are not available, then a letter from the employer is needed in order to verify the current income level of the applicant. If their situation has changed drastically then they will need to bring in proof that it has changed (unemployment check, something proving reduction in other benefits, etc.)

3. **Frequency** – To prove continual need, bi-annually or as circumstances change, they will need to bring a paycheck stub or proof that income has not gone up.

4. **Timing** – If the patient is aware of the sliding scale and knows they will be coming to the clinics or hospital they may apply in advance for the sliding fee scale. If they come in and are in need of services, they will be required to pay for the office visit and then apply for the sliding fee scale.

Patients should be made aware that there are minimums, which will be required from them such as office visits $35.00 and five (5) percent of hospital/emergency room visit, even if they qualify for the maximum discount possible. They will be required to pay these minimums and the fees. The charges which the clinics and hospitals do directly pay must be paid in full by the patient.

The CFO will determine if the patient qualifies and will notify the clinics and hospital. At this time a detailed charge list will be generated with all the charges. This information will be gone over with the patient so they have a clear understanding of what they owe. If they are not able to pay, a payment plan should be set up. The CFO will be informed of the plan. This payment plan should be no less than 10% of the bill or below $20.00 per month. This way in 10 months the bill will be paid. If they are not able to pay at least 10% other arrangements need to be cleared through the CEO.

Please use the attached form: 1. Sliding Fee Scale Approval Form
2. Payment Plan Form

KIOWA COUNTY HOSPITAL DISTRICT
SLIDING FEE SCALE APPLICATION/APPROVAL FORM

Patient's Name____ Date_____________________

Address____
City___________________________ State____________________ Zip Code________________
Home Phone__________________________ Work Phone_________________________________

Proof of Income & Dependent Information

Tax Form Year_______________ Income__________________ # Dependents_____________

Pay Stubs 1. Month_________________ Income $_______________________
2. Month_________________ Income $_______________________

List any other dependents not on tax form:

1. Name______________________________ Age________ Relationship____________________
2. Name______________________________ Age________ Relationship____________________
3. Name______________________________ Age________ Relationship____________________
4. Name______________________________ Age________ Relationship____________________

Provide information why they were not on last year's income tax form such as birth certificate.

List any other income of the household and why it is not on income tax form.

1. Income_______________________ Source____
2. Income_______________________ Source____
3. Income_______________________ Source____

My signature attests to the fact that everything I have provided is accurate and current.

Patient's Signature____ Date_____________________

Please attach copies of income tax forms; pay stubs and any other supporting documents.

Please submit to CFO

Reviewed by:____ Date_____________________
Approved:________________ Not Approved___________________
Discount percentage____
Date needs to be updated and verified by check stub____

KIOWA COUNTY HOSPITAL DISTRICT

SLIDING FEE SCALE
PAYMENT PLAN FORM

Patient's Name__________________________________ Date___________________

Total of Original Bill $______________________
Total Discounts $______________________
Total Remaining $______________________

If you qualify for the sliding fee scale and are not able to totally pay the amount due we will be happy to work out payments for the balance.

If you are uninsured and do not qualify for the sliding fee scale we will offer you a 20% discount on your bill if paid at the time of service.

If you are unable to pay at this time we will be willing to work out payments with you.

Monthly payment should be at least 10% of your bill per month.

Payment Plan

Total Owed $__________________

Monthly payment agreed upon $_______________ Starting date________________________
Number of month's payments will be made____

If any other arrangements need to be made the CEO must be contacted.

I verify that I agree to the payments above and realize if a payment is missed that the total will be due in full and collection procedures will be started.

Patient's Signature_____________________________________ Date___________________

Witnessed by____ Date___________________

We hope these arrangements help you meet obligations and is beneficial to you. Please know that we are here to serve you and your medical needs. Any questions please ask the receptionist and feel free to contact the CEO.