KIOWA COUNTY HOSPITAL DISTRICT
FISCAL SERVICES

EFFECTIVE DATE: 04/01/2008	LAST REVIEWED: 07/06/2023
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INTRODUCTION – Sliding Fee Scale

Scope – District Wide

Policy: This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (Uninsured or Underinsured). Kiowa County Hospital District (KCHD) offer a Sliding Fee Scale to all who are unable to pay for their services. KCHD will not base program eligibility on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule to determine eligibility.

Completion of Application: The patient/responsible party must complete the Sliding Fee Scale Approval Form in its entirety. By signing the form, persons authorize KCHD access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Scale Approval Form will result in all Sliding Fee Discounts being revoked and the full balance of the account(s) restored and payable immediately.

Eligibility: Discounts will be based on income and family size only. KCHD uses the Census Bureau definitions of each.

a. **Family** is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
b. **Income** includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. **Noncash benefits (such as food stamps and housing subsidies) do not count.**

Income Verification: Applicants must provide one of the following: Last year's income tax return, prior year W2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Adequate information must be made available to determine eligibility for the program.

Discounts: Those with incomes at or below 100% of poverty will receive a full 100% discount with a nominal fee. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest Federal Poverty Guidelines.

Nominal Fee: Patients should be made aware that there are minimums which will be required from them such as clinic visits $10.00 and $10.00 for hospital/emergency room visits, even if they qualify for the maximum discount possible. However, patients will not be denied services due to an inability to pay. All KCHD collection rules shall apply. In certain situations, patients may not be able to pay the minimum fee. Waiving of charges may only be used in special circumstances and must be approved by the CEO, CFO, or their designee.

Notification: The CFO will determine if the patient qualifies and will notify the patient and clinic 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. This payment plan should be no less than $10.00 per month.

Please use the attached forms: Sliding Fee Scale Approval Form, Payment Plan Form and Sliding Fee Scale

KIOWA COUNTY HOSPITAL DISTRICT

SLIDING FEE SCALE 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._____________________________________

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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 payments should be at least $10.00 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 are 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.