# Valley Health Sliding Fee Policy

## PURPOSE

The purpose of this policy and program is to offer significant discounts to individuals and families who qualify on the basis of limited income and/or family size. Valley Health strives to ensure that quality healthcare is readily accessible to everyone & serves patients regardless of their ability to pay. This policy is uniformly applicable to all patients, and all in-scope services are covered under this policy.

## DETERMINING SLIDING FEE PROGRAM ELIGIBILITY

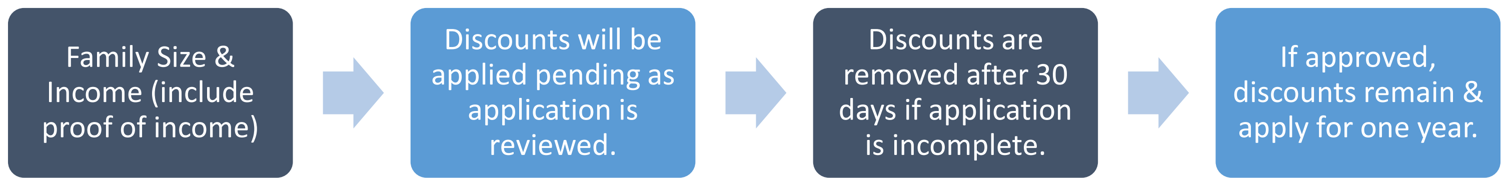
Valley Health's Sliding Fee Policy & Discount program uses the most current Federal Poverty Level guidelines when reviewing applications of individuals at or below 200% of the FPL (Federal Poverty Level). Determination is based upon family income (adjusted by family size) with appropriate supporting documentation provided by the patient. Patients above 200% of the FPL are not eligible to receive sliding fee discounts. *All documentation provided in the application process must be legible*. *After 30 days, incomplete applications expire & discounts will be removed.*

## ELIGIBILITY FOR PATIENTS WITH OTHER INSURANCE

Valley Health's Sliding Fee Policy & Discount program do not exclude patients who currently have healthcare coverage. Patients who meet the guidelines within this policy and have commercial insurance may also be eligible. The patient's primary insurance will be billed and any sliding fee discounts (as covered in this policy) will be applied to the patient due balances after the primary insurance has processed the claim.

## APPLYING FOR THE SLIDING FEE DISCOUNT PROGRAM

Valley Health's Sliding Fee Policy & Discount program guidelines are available for patients to review at all Valley Health sites. It is the policy of Valley Health to make Sliding Fee Discount program applications available at any Valley Health site or online for patients to download/print.




## INABILITY TO PAY NOMINAL FEE

Valley Health's Sliding Fee Policy & Discount program require nominal payments be made upon the time of service. Nominal fees are determined to be nominal from the patient's perspective based, for example, on patient survey and focus group results. Nominal fees are not reflective of the cost of services provided. Patients unable to pay the nominal fee at the time of service will be responsible for satisfying this obligation timely, as per billing policies. If the patient does not make an effort to pay within 90 days, or contact the Billing Department to set up a formal payment plan arrangement, it is the policy of Valley Health to refer the account/unpaid balance to collections. It is the policy of Valley Health to require nominal fees/discounted charges be paid for services listed on the Other Services Scale to help cover the cost of materials/products purchased by Valley Health to perform the service, and may result in rescheduled appointments that fall under this category until the nominal fee/discounted charge can be paid.

## DEFINITIONS

| FAMILY SIZE | FAMILY INCOME | GROSS INCOME | NOMINAL/ ESTABLISHED FEE | SF DISCOUNT LEVEL |
|---|---|---|---|---|
| Taxpayer (includes married tax payers filing jointly) and all claimed tax dependents. * | Includes the gross incomes of all persons included in the Family Size. (Federally defined exclusions may apply.) | Gross wages and salary, pensions, government payments, social security, sale of goods, and value of bartered services. | The payment amount expected at the time services are provided. ** | The category (A, B, C, or D) on the sliding fee scale to which approved participants are assigned based on family size & income. |

**Family Size definition source: The Marketplace; at healthcare.gov*

Effective March 2021

***Nominal & Established Fee amounts, which are due upon date of service for Sliding Fee participants, do not reflect the actual value of the services provided, but rather were set based upon patient surveys, Board of Director members/patients' feedback, and reasonable expectation for a portion of cost reimbursement.*

| TYPES OF APPROVED INCOME VERIFICATION |
|---|
| W-2 * 1 month of pay stubs * 1 unemployment stub<br>Government assistance statement * Alimony * Denials from other assistance |

**DETERMING SLIDING FEE DISCOUNT LEVEL**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **1** | ≤ | $12,880 | $12,881 | $17,130 | $17,131 | $21,381 | $21,382 | $25,760 |
| **2** | ≤ | $17,420 | $17,421 | $23,169 | $23,170 | $28,917 | $28,918 | $34,840 |
| **3** | ≤ | $21,960 | $21,961 | $29,207 | $29,208 | $36,454 | $36,455 | $43,920 |
| **4** | ≤ | $26,500 | $26,501 | $35,245 | $35,246 | $43,990 | $43,991 | $53,000 |
| **5** | ≤ | $31,040 | $31,041 | $41,283 | $41,284 | $51,526 | $51,527 | $62,080 |
| **6** | ≤ | $35,580 | $35,581 | $47,321 | $47,322 | $59,063 | $59,064 | $71,160 |
| **7** | ≤ | $40,120 | $40,121 | $53,360 | $53,361 | $66,599 | $66,600 | $80,240 |
| **8** | ≤ | $44,660 | $44,661 | $59,398 | $59,399 | $74,136 | $74,137 | $89,320 |
| | | | | | | | | |

Match family size (first column) to family income range to determine Sliding Fee discount level. *FPL 2021*

| **In-Scope Services-** *Payment expected at visit.* | A | B | C | D |
|---|---|---|---|---|
| MAT Individual & Group Counseling | $5 | $6 | $7 | $8 |
| Medical/Lab & Radiology/Behavioral/Audiology | $20 | $40 | $60 | $75 |
| Vision | $65 | $90 | $100 | $115 |
| Basic Dental & Psych Testing | $85 | $90 | $100 | $115 |
| Surgical | $100 | $200 | $300 | $400 |
| **Out-of-Scope Services-** *Patient pays greater of the nominal fee or discounted charge.* | | | | |
| Care Connect | $1 | $1.25 | $1.50 | $1.75 |
| Prescriptions (VH Patient) | $4 or 50% off | 40% off | 30% off | 20% off |
| Prescriptions (Public) | $4 or 30% off | 25% off | 20% off | 15% off |
| Dental Supplies | $15 or 30% off | 25% off | 20% off | 15% off |
| Glasses (excludes contacts) | $39 or 50% off | 40% off | 30% off | 20% off |
| Dental Appliances | $500 or 30% off | 25% off | 20% off | 15% off |
| Hearing Aids (excludes batteries) | $500 or 40% off | 35% off | 30% off | 25% off |

**NOTIFICATION OF PROGRAM APPROVAL OR DENIAL**

Once eligibility is reviewed, the patient will receive a letter notifying them of approval or denial. If approved, the patient will also receive a sliding fee card via U.S. mail, which will be valid for **one year** from the date of the application. Valley Health will adjust any charges incurred during the three months prior to the approval date. (Patients will receive a letter **one month prior to the end of the one year** period to outline next steps for renewal/re-evaluation.) Failure to supply eligibility documentation or falsifying information provided on an application will result in automatic program ineligibility. Patients who are not in the discount program who verbally express a refusal to pay or leave the health center without paying for services will be provided a Sliding Fee discount program application. If a patient does not make an effort to apply for the program or pay their full balance within 90 days (which can include a formal payment plan arrangement), this constitutes as refusal to pay. Valley Health will then refer the patient to collections, as per the billing policies.

**FOR ADDITIONAL INFORMATION**

Additional information, including how to receive assistance completing this application, can be found in Valley Health's Sliding Fee Discount Program procedure(s). This Policy and the Sliding Fee Application are also available in Spanish and Chinese, and other languages can made be available upon request.