Tuscarawas County Health Department Payment Agreement

Medical Clinic & Alcohol and Addiction Program

Co Pays: Are due at time of service. The Alcohol and Addiction Program reserves the right to reschedule your appointment if the co-pay is not paid at time of service.

Self-Pay: Unless the service is paid entirely by a third party, such as an insurance company, you are expected to pay any balance due. You MUST bring proof of income and complete the sliding fee discount application to be eligible for the sliding fee scale. Sliding fee discounts are only available to persons without insurance. Failure to complete the application or provide proof of income at the time of service will render you responsible for 100% of the service charges.

Alternative payment sources: All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs.

Completion of Sliding Fee Discount Application: The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize Tuscarawas County Health Department (TCHD) access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program 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. TCHD uses the Census Bureau definitions of each.

1. 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.

2. 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 for Sliding Fee Discount: Applicants must provide one of the following: prior year 1040, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may only be used in special circumstances including patients enrolled in the reproductive health and wellness program (RHW). Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to TCHD's Health Commissioner or his/her designee for review and final determination as to the sliding fee percentage. Self-declared patients will be responsible for 100% of their charges until management determines the appropriate category.

For Reproductive Health and Wellness patients only, TCHD cannot require proof of income and must rely on patient declaration of income if no other income verification is available in order to determine where the patient falls on the sliding fee scale. Eligibility for discounts for un-emancipated minors who receive confidential services is based on the income of the minor.

Sliding Fee Discounts: Those with incomes at or below 100% of poverty will receive a full 100% discount. Those with incomes above 100% of poverty, but at or below 250% 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.

Voluntary Donations: Donations are accepted regardless of placement on the sliding fee scale.

Nominal Fee: Clinic patients receiving a full discount will be assessed a $20 nominal charge per visit. However, patients will not be denied services due to an inability to pay. If unable to pay at time of service the patient's account should be billed accordingly. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

Alcohol and Addiction Program: clients receiving a full discount will be assessed a $20 nominal charge per visit; not to exceed $20 per week in charges.

Sliding Fee Discount Applicant Notification: The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must immediately establish payment arrangements with TCHD.

Insurances: If you want TCHD to process your claim you MUST bring in proof of insurance at the time of service. If you do not provide this verification, you will be responsible for 100% of the cost of services.

Please Note: Any service not covered by your insurance will be your responsibility.

Refusal to Pay: If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, TCHD can explore options not limited, but including offering the patient a payment plan, waiving of charges, or referring the patient collections efforts.

Collections Practices: In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, TCHD or their third party billers may engage in collection activities to collect outstanding patient balances.

Accounts with uncollected balances greater than 90 days will enter the internal collections process which includes formal letters at 90 and 120 days. No letters should be sent to reproductive health and wellness patients with no contact agreements.

If no response is received the account is forwarded to outside collection agencies.

Fees for Service: Alcohol and Addiction clients will be provided with a list of fees for services. Medical clinic patients may request estimated fees for service at any time.

__________ I agree to notify TCHD of any changes in my financial status if I have been deemed eligible for the sliding fee discount.

__________ I agree to notify TCHD of any changes to insurance coverage, if applicable.

__________ I acknowledge and understand the billing policies of TCHD as stated on this form.

__________ I acknowledge that I have had a chance to discuss the fee and payment policies and that I understand them.

__________ The cost for services has been explained to me and I understand that I am responsible for the fee set below.

- __________ Private Insurance
  - __________ Co-Pay
- __________ Consumer Pay
  - __________ % Sliding Fee
  - __________ Nominal Fee, if applicable
- __________ Medicaid
- __________ Medicare

For AAP client use only:

________ number of persons in the household

__________ I acknowledge that lab services, including those performed by Lab Corp, may be offered on site but billing is separate, not by TCHD.

__________ I acknowledge that I have been given a copy of this form.

I hereby authorize payment directly to TCHD of the insurance benefits otherwise payable to me; and if the insurance company reimburses me directly, I understand that I will be billed for that amount. I further understand that I will be responsible for payment of 100% of my charges if I fail to cooperate with TCHD in securing and/or making payments. I hereby authorize the release of dates of service, diagnosis and other information (which may include treatment for alcohol or drug abuse) required to process this claim.

Signature of Consumer/Person Financially Responsible

____ Date: ____________________

Witness: ____Date: ___________________