OCH Health System
Patient Finance Policy and Procedure

Reviewed: 9/11, 8/12, 8/13, 8/14, 6/15, 8/16, 10/17, 2/18 **Policy: 250.100.002**

Revised: 11/15, 01/16, 10/16, 2/17, 5/17, 10/17, 01/18, 1/19 **Implemented: 2010**

Subject: Sliding Fee Scale

It is the policy of the OCH Health System, at all its facilities and clinics, to discount usual and customary charges for services provided to those who have no means, or limited means, to pay for their medical services. In addition, patients are entitled to financial counseling by someone who can understand and offer possible solutions for those who cannot pay in full. OCH will adhere to NHSC guidelines in all its clinics and will notify patients of the OCH Sliding Fee Discount program via the organizations website, as well as posting notices in all clinic waiting areas. The Sliding Fee Discount is offered to all who are unable to pay for their medical services and will not discriminate on the basis of age, gender, race, sexual orientation, creed, religion, disability, or national origin. Eligibility for the discount is determined based on household size (those who dwell under the same roof and compose a family) and income (the amount of such gain received in a period of time). Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved. The Eligibility Worksheet must be completed every six months or if the patient's financial situation changes.

Ozarks Community Hospital
Sliding Fee Scale

The patient will be required to provide documentation to staff for verification as according to the Eligibility Worksheet. The discount will be applied as follows:

Discount off of self pay price:

- At or below 100% poverty level
  - Maximum discount off of self pay price (100% discount)
- At or below 200% poverty level
  - 75% discount off of self pay price
- At or below 300% poverty level
  - 50% discount off of self pay price
- At or below 400% poverty level
  - 25% discount off of self pay price

2019 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline
For families/households with more than 8 persons, add $4,420 for each additional person.	
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

Poverty Guidelines, all states (except Alaska and Hawaii)
2019 Annual

Household /Family Size		100%	150%	200%	250%	300%	350%	400%
1		$12,490	18,735	24,980	31,225	37,470	43,715	49,960
2		$16,910	25,365	33,820	42,275	50,730	59,185	67,640
3		$21,330	31,995	42,660	53,325	63,990	74,655	85,320
4		$25,750	38,625	51,500	64,375	77,250	90,125	103,000
5		$30,170	45,255	60,340	75,425	90,510	105,595	120,680
6		$34,590	51,885	69,180	86,475	103,770	121,065	138,360
7		$39,010	58,515	78,020	97,525	117,030	136,535	156,040
8		$43,430	65,145	86,860	108,575	130,290	152,005	173,720
9		$47,850	71,775	95,700	119,625	143,550	167,475	191,400
10		$52,270	78,405	104,540	130,675	156,810	182,945	209,080

2019 Monthly

Household /Family Size		100%	150%	200%	250%	300%	350%	400%
1		$1,041	1,561	2,082	2,602	3,123	3,643	4,163
2		$1,409	2,114	2,818	3,523	4,228	4,932	5,637
3		$1,778	2,666	3,555	4,444	5,333	6,221	7,110
4		$2,146	3,219	4,292	5,365	6,438	7,510	8,583
5		$2,514	3,771	5,028	6,285	7,543	8,800	10,057
6		$2,883	4,324	5,765	7,206	8,648	10,089	11,530
7		$3,251	4,876	6,502	8,127	9,753	11,378	13,003
8		$3,619	5,429	7,238	9,048	10,858	12,667	14,477
9		$3,988	5,981	7,975	9,969	11,963	13,956	15,950
10		$4,356	6,534	8,712	10,890	13,068	15,245	17,423

ELIGIBILITY WORKSHEET

It is the policy of Ozarks Community Hospital to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, prescription drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every six months or if your financial situation changes.

Name:____ DOB:_____________

Address: ____

Telephone: ______________________________

Are you the head of household? Yes No Total number in household: __________

Names of all in household list first and last name:

_____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

_____________________________ _____________________________

Are you employed? Yes No (If No, how are your supporting yourself/household at this time?) _________________________________

Monthly Gross Household Income $__________

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

Pay Stubs _______

Income Tax Return _______

Other _______ (Explain) _________________________________

I certify that I have limited means of paying for medical services and that the information provided above is correct and true to the best of my knowledge. I agree to provide acceptable documentation as proof of my household income. I also authorize the clinic to disclose this information to other healthcare providers as necessary to qualify me for reduced fees for outside services (labs, etc.).

________________________________ ____________

Patient/Responsible Party Date

________________________________ ____________

Ozarks Community Hospital Date

For Office Use Only:

Approved: YES or NO Amount Approved: __________ Clinic & Provider: ____________________