Ozark Community Hospital
Patient Finance Policy and Procedure

Reviewed: 9/11, 8/12, 8/13, 8/14, 6/15, 8/16, 10/17, 2/18, 3/19 **Policy: 250.100.002**

Revised: 11/15, 01/16, 10/16, 2/17, 5/17, 10/17, 01/18, 1/19, 9/19, 6/20 **Implemented: 2010**

Subject: Sliding Fee Scale

It is the policy of the Ozarks Community Hospital, 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

2020 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	**$12,760**
2	**$17,240**
3	**$21,720**
4	**$26,200**
5	**$30,680**
6	**$35,160**
7	**$39,640**
8	**$44,120**

Poverty Guidelines, all states (except Alaska and Hawaii)

2020 Annual

Household /Family Size	100%	200%	300%	400%
1	$12,760	$25,520	$38,280	$51,040
2	$17,240	$34,480	$51,720	$68,960
3	$21,720	$43,440	$65,160	$86,880
4	$26,200	$52,400	$78,600	$104,800
5	$30,680	$61,360	$92,040	$122,720
6	$35,160	$70,320	$105,480	$140,640
7	$39,640	$79,280	$118,920	$158,560
8	$44,120	$88,240	$132,360	$176,480
9	$48,600	$97,200	$145,800	$194,400
10	$53,080	$106,160	$159,240	$212,320

2020 Monthly

Household /Family Size	100%	200%	300%	400%
1	$1,063	$2,127	$3,190	$4,253
2	$1,437	$2,873	$4,310	$5,747
3	$1,810	$3,620	$5,430	$7,240
4	$2,183	$4,367	$6,550	$8,733
5	$2,557	$5,113	$7,670	$10,227
6	$2,930	$5,860	$8,790	$11,720
7	$3,303	$6,607	$9,910	$13,213
8	$3,677	$7,353	$11,030	$14,707
9	$4,050	$8,100	$12,150	$16,200
10	$4,423	$8,847	$13,270	$17,693

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.

Head of household (First & Last name)			**Date of birth**	
Street	**City**	**State**	**Zip code**	**Phone number**
Are you currently employed?		☐ **YES**		☐ **NO**
If no, how are you supporting yourself/household at this time?				
Total number of individuals in household:				

Names of ALL in household (First & Last name)	**Date of birth**	**Relationship to Applicant**

***If additional spots are needed, please list them on the following page.**

Source	**Self**	**Spouse**	**Other**	**Total**
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, or other miscellaneous sources				
Total Household Income				

**** Any and all forms of income verification must be provided in monthly or yearly amounts. ****

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 Signature Date

FOR OFFICE USE ONLY:

Approved by: ______________________________ Clinic & Provider: __________________________

Approved Discount Amount: ________________ Approval Date: ____________________________

ELIGIBILITY WORKSHEET

USE ONLY FOR ADDITIONAL HOUSEHOLD MEMBERS

Names of ALL in household (First & Last name)	Date of birth	Relationship to Applicant

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 Signature Date

FOR OFFICE USE ONLY:

Approved by: ____________________________ Clinic & Provider: ________________________

Approved Discount Amount: ________________ Approval Date: ___________________________