County of Solano
Community Healthcare Board
Special Meeting

February 28, 2023
3:00 pm-4:00 pm
Conference Call Microsoft Teams
MS Teams Dial-in number: 1-323-457-3408 and Conference ID: 686 273 886#

On June 13, 2022, due to a surge of COVID-19 in Solano County, it was advised and decided by the Solano County Health Officer, the Clinic Operations Officer and the Chair of the Board that the June 15. 2022, Community Healthcare Board Meeting be held as a virtual meeting, and future meetings, until there is a notable decrease in the COVID surge in Solano County. The meeting on February 28, 2023, will be held via teleconference. To join in for audio only, please use the dial in number and Conference ID above.

The County of Solano Community Health Board does not discriminate against persons with disabilities. If you wish to participate in the meeting and you require assistance to do so, please call Solano County Family Health Services at 707-784-8775 at least 24 hours in advance of the event to make reasonable arrangements to ensure accessibility to the meeting.

Public Comment: To submit public comment, please see the options below.

Teleconference: Contact the Clerk at 707-784-8775.

Mail: If you wish to address any items listed on the Agenda by written comment, please submit comments in writing to FHS Community Healthcare Board Clerk by U.S. Mail. Written comments must be received no later than 8:30 A.M. on the day of the meeting. The mailing address is: Solano County H&SS, ATTN: FHS CHB Clerk (MS 9-100), P. O. Box 4090, Fairfield, CA 94533. Copies of comments received will be provided to the Board and will become part of the official record but will not be read aloud at the meeting.

Phone: To submit comments verbally from your phone during the meeting, you may do so by dialing 1-323-457-3408, and Conference ID: 686 273 886#. No attendee ID number is required. Once entered in the meeting, you will be able to hear the meeting and will be called upon to speak during the public speaking period.

Non-confidential materials related to an item on this Agenda, submitted to the Board after posting of the agenda will be posted and updated online at:
https://www.solanocounty.com/depts/ph/bureaus/fhs/community_healthcare_board/
and posted at Family Health Service Clinics located at 1119 E. Monte Vista, Vacaville, CA; 2101 Courage Drive, Fairfield, CA; 2201 Courage Drive, Fairfield, CA; and 365 Tuolumne Drive, Vallejo, CA.

Materials may also be e-mailed upon request. You may request materials by contacting the Clerk at 707-784-8775.

County of Solano
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Special Meeting

February 28, 2023
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AGENDA

1) CALL TO ORDER – 3:00 PM

a) Welcome
b) Roll Call

2) UPDATE BY DEPUTY COUNTY COUNSEL

On June 13, 2022, due to a surge of COVID-19 in Solano County, it was advised and decided by the Solano County Health Officer, the Clinic Operations Officer and the Chair of the Board, that the June 15, 2022, Community Healthcare Board Meeting be held as a virtual meeting, with consideration of the safety of the Board Members and meeting participants, until there would be a notable decrease in the COVID surge in Solano County. The prior findings expire the earlier of March 1, 2023, or such time the Board makes subsequent AB 361 findings.

County Counsel recommends the Board consider making AB 361 findings before each meeting.

ACTION ITEM: Consider making the findings that:

i) Pursuant to Government Code section 8625, Governor Gavin Newsom declared a State of Emergency in the State of California on March 4, 2020, as a result of the threat of the Coronavirus (COVID-19) pandemic; and the proclaimed State of Emergency remains in effect; and,
ii) As of the date of this Meeting, neither the Governor nor the state Legislature have exercised their respective powers pursuant to Government Code section 8629 to lift the state of emergency either by proclamation or by concurrent resolution the state Legislature; and,
iii) The California Department of Industrial Relations has issued regulations related to COVID-19 Prevention for employees and places of employment. Title 8 of the California Code of Regulations (CCR), Section 3205(5)(D) specifically recommends physical (social) distancing as one of the measures to decrease the spread of COVID-19 based on the fact that particles containing the virus can travel more than six feet, especially indoors; and,
iv) Based on the California Department of Industrial Relations' issuance of regulations related to COVID-19 Prevention through Title 8 of the

California Code of Regulations, Section 3205(c)(5)(D), the Board finds that state or local officials have imposed or recommended measures to promote social distancing; and,

v) Title 8 of the California Code of Regulations, Section 3205(c) requires the County to establish, implement and maintain a COVID-19 Prevention Program, which the County has done; and,

vi) The County's COVID-19 Prevention Program either recommends or requires County employees to social distance or not to enter County facilities under certain circumstances; and,

vii) Starting from October 2021, the Board previously made findings that the requisite conditions existed for its legislative bodies to conduct its meetings without complying with Government Code section 54953(b)(3); and,

viii) As a result, the Board hereby proclaims that state officials have imposed or recommended measures to promote social (physical) distancing based on the California Department of Industrial Relations' issuance of regulations related to COVID-19 Prevention through Title 8 of the California Code of Regulations, Section 3205(c)(5)(D); and,

ix) The Board will conduct open and public remote teleconferencing meetings in accordance with AB 361 immediately upon making these findings until the earlier of (1) March 1, 2023, or (2) such time that the Board makes subsequent findings in accordance with Government Code section 54953(3)(3) to extend the time during which the Board may continue to teleconference without compliance with Government Code section 54953(b)(3), or (3) the Governor or the state Legislature have exercised their respective powers pursuant to Government Code section 8629 to lift the state of emergency.
(Government Code section 54953(e)(3).)

3) PUBLIC COMMENT

This is the opportunity for the Public to address the Board on a matter not listed on the Agenda, but it must be within the subject matter jurisdiction of the Board. If you would like to make a comment, please announce your name and the topic you wish to comment and limit comments to three (3) minutes.

4) BUSINESS GOVERNANCE

a. Review and approve the Family Health Services (FHS) Sliding Fee Scale Program Analysis – Janine Harris
   i. **ACTION ITEM:** The Board will consider approval of the FHS Sliding Fee Scale Program Analysis

b. Review and approve the Family Health Services (FHS) Sliding Fee Scale Policy Number: 100.03 – Janine Harris
   i. **ACTION ITEM:** The Board will consider approval of the FHS Sliding Fee Scale Policy Number: 100.03

5) NEXT COMMUNITY HEALTHCARE BOARD MEETING

DATE: March 15, 2023
TIME: 12:00 PM
LOCATION: 2201 Courage Drive
Fairfield, CA 94533

6) ADJOURN

GERALD HUBER
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DEPARTMENT OF HEALTH & SOCIAL SERVICES

SOLANO COUNTY

275 Beck Avenue, MS 5-200
Fairfield, CA 94533
(707) 784-8400
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MEMORANDUM

To: Community Healthcare Board

From: Janine Harris, Revenue Cycle Manager/Policy & Financial Analyst

Date: February 15, 2023

Subject: Analysis of Sliding Fee Discount Program (SFDP)

Per HRSA's Health Center Program Compliance Manual and Family Health Services (FHS) Sliding Fee Discount Program (SFDP) Policy, FHS must do the following:

(1) Evaluate, at least once every three years, its sliding fee scale discount program. At a minimum, the health center:

- Collects utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100 percent of the FPG, are accessing health center services;
- Utilizes this and, if applicable, other data to evaluate the effectiveness of its sliding fee discount program in reducing financial barriers to care; and
- Identifies and implements changes as needed.

(Health Center Program Compliance Manual, page 41)

An analysis of patients eligible for SFDP from January–December 2022 shows the following:

Nominal Charge:
Solano County FHS provides a full 100 percent discount and does not use a nominal charge for patients at or below 100% FPG.

Utilization:

- Patients on the SFDP accessed medical services at an average rate of 2.10 visits per patient. This utilization rate is lower than the overall utilization of the health center of 2.24 medical visits per patient. The difference in utilization is minimal. This suggests that being on the SFDP is not a barrier to accessing care at FHS.
- Patients on the SFDP accessed dental services at an average rate of 3.17 visits per patient. This utilization rate is higher than the overall utilization of the health center of 3.06 dental visits per patient. This suggests that being on the SFDP is not a barrier to accessing care at FHS.
- Patients on the SFDP accessed mental health services at an average rate of 2.24 visits per patient. This utilization rate is lower than the overall utilization of the health center of 3.23 mental health visits per patient. We will continue to monitor Mental Health visits to ensure being on the SFDP is not a barrier to accessing care at FHS.

RECOMMENDATION:

Utilization data suggests that being on the SFDP is not a barrier to accessing care at FHS for medical and dental services. FHS will continue to monitor Mental Health visits to ensure being on the SFDP is not a barrier to accessing care. Due to overall underutilization of Mental Health services, FHS will continue to monitor and recommend improvements on how to increase utilization across the board.
In the 2019 patient satisfaction survey, 75% of patients who were assessed fees found that fees and explanation of fees were "good" or "very good". Fees and explanation of fees will continue to be part of future patient satisfaction surveys and any significant findings will be presented to the board.

TABLE 1: JANUARY - DECEMBER 2022: SFDP PROGRAM ANALYSIS MEDICAL SERVICES						
SFDS Class	**Discount Percentage**	**Total Encounters**	**Total Patients**	**Average Visits Per Patient**	**Average Payment**	**% Patients Paying 100% Fee**
A	100%	965	445	2.17	$0.00	N/A
B	80%	289	148	1.95	$75.53	71%
C	60%	134	74	1.81	$109.85	57%
D	50%	115	67	1.72	$99.57	49%
E	FULL FEE	14	10	1.40	$133.29	43%

TABLE 1: JANUARY - DECEMBER 2022: SFDP PROGRAM ANALYSIS DENTAL SERVICES						
SFDS Class	**Discount Percentage**	**Total Encounters**	**Total Patients**	**Average Visits Per Patient**	**Average Payment**	**% Patients Paying 100% Fee**
A	100%	438	147	2.98	$0.00	N/A
B	80%	243	73	3.33	$174.06	81%
C	60%	104	36	2.89	$205.97	74%
D	50%	90	28	3.21	$325.65	71%
E	FULL FEE	3	2	1.50	$74.50	33%

TABLE 1: JANUARY - DECEMBER 2022: SFDP PROGRAM ANALYSIS MENTAL HEALTH SERVICES						
SFDS Class	**Discount Percentage**	**Total Encounters**	**Total Patients**	**Average Visits Per Patient**	**Average Payment**	**% Patients Paying 100% Fee**
A	100%	31	12	2.58	$0.00	N/A
B	80%	3	2	1.50	$43.56	67%
C	60%	1	1	1.00	$0.00	0%
D	50%	3	2	1.50	$0.00	0%
E	FULL FEE	0	0	0.00	$0.00	N/A

Sliding Fee Scale Discount Program

Policy Number: 100.03

Effective Date	March 1, 2023
Frequency of Review	Annual
Last Reviewed	February 7, 2023
Last Updated	February 7, 2023
Author	Janine Harris
Responsible Department	Revenue Cycle Management

PURPOSE:
The purpose of this policy is to reduce and/or eliminate financial barriers to patients who qualify for the program to ensure access to services regardless of the patient's ability to pay. At no time will a patient be denied services because of an inability to pay.

BACKGROUND
It is the policy of Solano County Health and Social Services to uphold compliance with government regulations. Family Health Services (FHS) is a Federally Qualified Health Center (FQHC) and receives federal funding under the Health Center Program authorized by section 330 of the Public Health Services (PHS) Act (42 U.S.C. 254b) ("section 330"), as amended (including sections 330(e) and (h)). The program is administered by the federal Health Resources and Services Administration (HRSA).

POLICY:
Family Health Services shall provide medical, dental and mental health services regardless of a patient's ability to pay. The Sliding Fee Scale Discount Program (SFSDP) is available for all patients to apply for. FHS will base program eligibility only on income and family size. A full discount is provided for individuals and families with annual incomes at or below 100% of the current Federal Poverty Guidelines (FPG); partial discounts are provided for individuals and families with incomes above 100% of the current FPG and at or below 200% of the current FPG; no discounts are provided to individuals and families with annual incomes above 200% of the current FPG. Sliding Fee Scale Discount levels are described in Attachment 1.

Exception: All Ryan White patients may be eligible for sliding fee discounts as described in the Ryan White Part C / North Bay AIDS Center Sliding Fee Scale and Billing Caps Policy.

DEFINITIONS:
Income – Earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, alimony, child support, or any other sources that typically become available. Noncash benefits, such as food stamps and housing subsidies, do not count.

Family – A group of two or more people who share a common residence, are related by blood, marriage, adoption or otherwise present themselves as related, and share the costs and responsibilities of the support and livelihood of the group.

Proof of Income – Any of the following documentation of gross income shall be accepted as proof of income. Two current pay stubs, most recent federal tax return, award or benefit letter from affiliated agency, income verification documentation from affiliated agency, letter from employer on letterhead, another generally accepted proof of income, or the approved self-declaration form. The self-declaration form may only be used in special circumstances for patients who are otherwise unable to provide proof of income. Use of the self-declaration form must be approved by the front office accounting clerk, a supervisor or a manager. Self-declared patients will be responsible for 100% of their charges until the self-declaration form is approved.

PROCEDURE:

1. Notification of SFSDP
    a. FHS will notify patients of the SFSDP by:
        i. Posting notification in the health center waiting area.
        ii. Verbal notification upon registration
2. Assessing Income and Family Size
    a. All patients will self-report income and family size on the Health Center Patient Welcome Packet form.
    b. Patients applying for the SFSDP will also self-report income and family size on the SFSDP Application.
    c. All patients are re-assessed if income or family size changes, as self-reported by the patient, or when the SFSDP eligibility period expires and a new application is received.
3. Completion of Application for the SFSDP
    a. The patient or responsible party must complete the Sliding Fee Scale Discount Program application and provide proof of income.
    b. Incomplete applications will not be processed, and discounts will not be applied until the application is complete.
    c. FHS front office accounting clerks or a supervisor or manager will review applications for completeness and accuracy.
    d. Information from the application is input into the practice management system, NextGen. The application and proof of income is scanned into NextGen.
    e. In instances where the patient is applying for retro eligibility for the program, front office accounting clerks may approve up to 90 days of retro eligibility. Retro eligibility beyond the 90 days may be reviewed and approved by the Revenue Cycle Manager.
4. Eligibility for the SFSDP
    a. Eligibility is based on income and family size only.
    b. All patients are eligible to apply for the program.
    c. Eligibility will be honored for 12 months.
        i. Upon registration for each subsequent encounter, the patient will be asked if family size or income has changed. If family size or income has changed, the patient will be reassessed for program eligibility by completing a new application and providing updated proof of income.
5. Applicability to Patients with Third Party Coverage

a. Patients who are covered by a Qualifying Health Plan with which FHS is contracted, but with "out of pocket" costs (i.e. co-insurance, co-pays, share of cost) may apply for the SFSDP, if it is not prohibited by the Qualifying Health Plan.
b. Staff will screen patient for eligibility for the SFSDP by asking the patient to complete the SFSDP Application and provide proof of income.
c. Once sliding fee level for the patient is assessed, the patient may pay the lesser of the charge discounted to the patient's sliding fee level OR the patient's out of pocket costs.

6. Services, supplies, and equipment
   a. The SFSDP shall apply to all services listed in the Form 5A: Services Provided (Required Services) on the Health Resources and Services Administration (HRSA) Service Area Compete (SAC) Application.
   b. The same methodology will apply to supplies or equipment that are related to, but not included in, the service itself as part of prevailing standards of care (for example, dentures).
7. Collections
   a. FHS front office staff will review the patient's account upon check-in. If the patient has a balance due, front office staff will request applicable payments from the patient, according to the FHS Insurance Eligibility policy, #100.01.
   b. Payment plans are available upon request, according to the FHS Cash Handling policy, #100.02 and Fee Waiver & Payment Plans, #100.08. The Payment Plan Agreement form is completed by the patient and approved by the front office accounting clerk or office supervisor or manager. The agreement is scanned into NextGen.
8. Refusal to Pay
   a. Refusal to pay is defined as a patient who has the ability to pay but is unwilling to pay the amount owed, as expressed verbally by the patient or if the patient does not make an effort to pay upon receipt of monthly statements from FHS. All patients qualify to apply for the SFSDP, payment plans, and fee waivers.
   b. Patients who refuse to pay will still be eligible for services. Patients will not be turned away because of a refusal to pay.
   c. If a patient refuses to pay the amount owed, FHS abides by the Health and Social Services collection policy and Bad Debt Write Off policy, #100.14, which places the patient's account as delinquent without payment made within the last 120 days and may refer the patient to a collections agency.
9. Request for Waiver of Fees
   a. Patients may request a fee waiver, or a fee waiver may be requested on their behalf as described in the Fee Waiver & Payment Plans policy #100.08.
10. Record Keeping
    a. All documentation received from the patient related to the SFSDP application and payment plan agreements are scanned and filed electronically in NextGen.
11. When a patient needs referred care services not provided by FHS, the patient will be referred to a facility which has an agreement for services with FHS. The referred facility must have a sliding fee scale discount program if they charge patients for services rendered under the agreement. Fees for these services must be discounted such that:

a. Individuals and families with incomes above 100% of the current FPG and at or below 200% of the FPG receive an equal or greater discount for these services than if FHS SFSDP were applied to the referral provider's fee schedule; and
b. Individuals and families at or below 100% of the FPG receive a full discount or a nominal charge for these services.

12. FHS will annually assess SFSDP activity and present findings to the Community Healthcare Board that ensure the SFSDP does not create a barrier for patients access to care. At a minimum, FHS will:
    a. Collect utilization data that allows it to assess the rate at which patients within each of its discount pay classes, as well as those at or below 100% of the FPG, are accessing health center services;
    b. Utilize this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its sliding fee scale discount program in reducing financial barriers to care; and
    c. Identify and implement changes as needed.

Knowledge of a violation or potential violation of this policy must be reported directly to the FHS Revenue Cycle Manager and the FHS Clinic Operations Officer, or to the employee compliance hotline.

Sliding Fee Scale Discount Program

Policy Number: 100.03

Attachment 1: Sliding Fee Scale Discount Program Guidelines

Annual Gross Income

SOLANO COUNTY HEALTH AND SOCIAL SERVICES DEPARTMENT
FAMILY HEALTH SERVICES

SLIDING FEE DISCOUNT PROGRAM SUMMARY - Effective Starting Date of Service 3/1/2023

Patients must complete a sliding fee discount application and submit supporting documents to determine eligibility for participation in the program. Eligibility is re-certified every year. Participating members receive discounts on services, as summarized below.
https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references

Each applicant household is assigned a category based on annual income and number of people.

Category	A		B		C		D		E		F	
% Federal Poverty Guidelines (FPG)	100% and under		101-138%		139-170%		171-200%		201-250%		251-300%	
Income Range for Each Category by Family Size												
Family Size	From	To	From	To	From	To	From	To	From	To	From	To
1	$0	$14,580	$14,581	$20,120	$20,121	$24,786	$24,787	$29,160	$29,161	$36,450	$36,451	$43,740
2	$0	$19,720	$19,721	$27,214	$27,215	$33,524	$33,525	$39,440	$39,441	$49,300	$49,301	$59,160
3	$0	$24,860	$24,861	$34,307	$34,308	$42,262	$42,263	$49,720	$49,721	$62,150	$62,151	$74,580
4	$0	$30,000	$30,001	$41,400	$41,401	$51,000	$51,001	$60,000	$60,001	$75,000	$75,001	$90,000
5	$0	$35,140	$35,141	$48,493	$48,494	$59,738	$59,739	$70,280	$70,281	$87,850	$87,851	$105,420
6	$0	$40,280	$40,281	$55,586	$55,587	$68,476	$68,477	$80,560	$80,561	$100,700	$100,701	$120,840
7	$0	$45,420	$45,421	$62,680	$62,681	$77,214	$77,215	$90,840	$90,841	$113,550	$113,551	$136,260
8	$0	$50,560	$50,561	$69,773	$69,774	$85,952	$85,953	$101,120	$101,121	$126,400	$126,401	$151,680
For each additional person:	*Add*	*$5,140*	*Add*	*$7,093*	*Add*	*$8,738*	*Add*	*$10,280*	*Add*	*$12,850*	*Add*	*$15,420*

Patient Discount Percentages

Category	A	B	C	D	E	F
Medical/Dental/Mental Health	100%	80%	60%	50%	Full Fee Based on Schedule of Charges	

Exceptions: *Ryan White services may be provided at no charge for patients at 300% or below FPG. See Ryan White Program Policies.

Monthly Gross Income

SOLANO COUNTY HEALTH AND SOCIAL SERVICES DEPARTMENT
FAMILY HEALTH SERVICES

SLIDING FEE DISCOUNT PROGRAM SUMMARY - Effective Starting Date of Service 3/1/2023

Patients must complete a sliding fee discount application and submit supporting documents to determine eligibility for participation in the program. Eligibility is re-certified every year. Participating members receive discounts on services, as summarized below.
https://aspe.hhs.gov/prior-hhs-poverty-guidelines-and-federal-register-references

BASED ON MONTHLY INCOME

Each applicant household is assigned a category based on annual income and number of people.

Category	A		B		C		D		E		F	
% Federal Poverty Guidelines (FPG)	100% and under		101-138%		139-170%		171-200%		201-250%		251-300%	
Income Range for Each Category by Family Size												
Family Size	From	To	From	To	From	To	From	To	From	To	From	To
1	$0	$1,215	$1,216	$1,677	$1,678	$2,066	$2,067	$2,430	$2,431	$3,038	$3,039	$3,645
2	$0	$1,643	$1,644	$2,268	$2,269	$2,794	$2,795	$3,287	$3,288	$4,108	$4,109	$4,930
3	$0	$2,072	$2,073	$2,859	$2,860	$3,522	$3,523	$4,143	$4,144	$5,179	$5,180	$6,215
4	$0	$2,500	$2,501	$3,450	$3,451	$4,250	$4,251	$5,000	$5,001	$6,250	$6,251	$7,500
5	$0	$2,928	$2,929	$4,041	$4,042	$4,978	$4,979	$5,857	$5,858	$7,321	$7,322	$8,785
6	$0	$3,357	$3,358	$4,632	$4,633	$5,706	$5,707	$6,713	$6,714	$8,392	$8,393	$10,070
7	$0	$3,785	$3,786	$5,223	$5,224	$6,435	$6,436	$7,570	$7,571	$9,463	$9,464	$11,355
8	$0	$4,213	$4,214	$5,814	$5,815	$7,163	$7,164	$8,427	$8,428	$10,533	$10,534	$12,640
For each additional person:	*Add*	*$428*	*Add*	*$591*	*Add*	*$728*	*Add*	*$857*	*Add*	*$1,071*	*Add*	*$1,285*

Patient Discount Percentages

Category	A	B	C	D	E	F
Medical/Dental/Mental Health	100%	80%	60%	50%	Full Fee Based on Schedule of Charges	

Exceptions: *Ryan White services may be provided at no charge for patients at 300% or below FPG. See Ryan White Program Policies.

Sliding Fee Scale Discount Program

Policy Number: 100.03

REFERENCED POLICIES	• Ryan White Part C / North Bay AIDS Center Sliding Fee Scale and Billing Caps • Policy #100.01: Insurance Eligibility • Policy #100.02: Cash Handling • Policy #100.08: Fee Waiver & Payment Plan • Policy #100.14: Bad Debt Write Off • Health & Social Services Collection Policy: Board of Supervisor Agenda Item #20, Board Meeting Dated January 11, 1994, Subject: Report on Primary Care Clinic Addressing Fiscal Issues, Controls, Adding Staff and New Operating Policies
REFERENCED FORMS	• Self-Declaration Form (English) • Self-Declaration Form (Spanish) • Sliding Fee Scale Discount Program Application (English) • Sliding Fee Scale Discount Program Application (Spanish) • Payment Plan Agreement (English) • Payment Plan Agreement (Spanish) • Fee Waiver Form (English) • Fee Waiver Form (Spanish) • Health Center Patient Welcome Packet
REFERENCES	

Chair - Community Healthcare Board **Date**

Vice-Chair - Community Healthcare Board **Date**

Solano County Family Health Services

Self-Declaration Form

Patient Information	
Patient's Name:	Patient's D.O.B:
Address:	Phone Number:

Declaration of Employment:

I _____ declare that my current status of employment is: [ ] I am working. [ ] I am not working.

Declaration of Income and Family size:

I declare that my combined household income is $_____ weekly, bi-weekly, monthly or annually (circle one). I also certify that a total number of _____ people--including spouse, children, parents, grandparents, etc.--are currently residing in my household.

I certify that the information that I provided is correct and I authorize the health center to use it. I understand that this information will be used to determine my eligibility for a Sliding Scale Discount, and if eligible, I will receive discounted health services for one year. If my family size or income changes at any time, I will notify the health center to be reassessed for program eligibility.

Applicant's Signature: _____ **Date:** _____

Approved by: _____ **Date:** _____
Health Center Representative - Name / Signature Title

Revised: 02/07/23

Solano County Family Health Services

Declaración Personal

Información del Paciente	
Nombre del Paciente:	Fecha de Nacimiento:
Dirección	Número de Teléfono

Declaración de Empleo:

Yo _____ declaro que en el presente mi estado de empleo es : [ ] Yo estoy trabajando. [ ] Yo no estoy trabajando.

Declaración de Ingresos y cuantos en la Familia:

Yo declaro que el total de ingresos combinado de la familia es $_____ semanal, cada dos semanas, mensual o anual (seleccione una). Yo también certifico que el total de personas—incluyendo esposa, hijos, padres, abuelos, etc. son _____ que están viviendo en mi hogar.

Yo declaro que la información que estoy dando es correcta y autorizo al centro de salud de usarla. Yo entiendo que esta información será usada para determinar mi elegibilidad para la tarifa escalada de descuentos, y si califico, yo recibiré descuentos en los servicios de salud por un año. Si mi familia o los ingresos cambian en algún momento, yo notificaré al centro de salud para ser reevaluado para el programa.

Firma del Aplicante: _____ **Fecha:** _____

Aprobado por: _____ **Fecha:** _____
Representante del Centro de Salud - Nombre / Firma Title

Solano County Family Health Services

Sliding Fee Scale Application

I. Patient Name: _____ DOB: _____

II. Any health insurance: ____ No ____ Yes

III. If yes, name of health insurance plan: _____

IV. Household Size Information (Household is considered a group of two or more people who share a common residence, are related by blood, marriage, adoption or otherwise present themselves as related, and share the costs and responsibilities of the support and livelihood of the group).

Please list below **all** members of your household, including yourself.

	Name	Relationship	Date of Birth		Name	Relationship	Date of Birth
1.				5.			
2.				6.			
3.				7.			
4.				8.			

V. Household Income Information

Please list below all sources of income for all adult members of your household, including yourself (Income includes but is not limited to, earnings, unemployment compensation, SSI, SSDI, public assistance, veteran's pay, survivor benefits, pension or retirement income, alimony, and child support). Proof of income includes (1) Your last two current paystubs, (2) most recent federal tax return, (3) income documentation from affiliated agency, (4) letter from employer on letterhead, (5) Self-Declaration (special circumstances, see Accounting Clerk for criteria to use this form). Adults are considered those persons 18 years of age and older.

This application must be returned with proof of income to be considered for our Sliding Fee Scale Discount program.

Name	Relationship	Source of Income	Amount/Frequency	Annualized

For Office Use Only		
Qualified	*Sliding Fee Scale:*	*% FPG*
☐	*A – 100% Discount*	*< 100%*
☐	*B – 80% Discount*	*101-138%*
☐	*C – 60% Discount*	*139-170%*
☐	*D – 50% Discount*	*171-200%*
	Does not qualify	
☐	*E – 0%Discount*	*201-250%*
☐	*F – 0% Discount*	*251-300%*
☐	*0% Discount*	*> 300%*

_____

Date Print Name Signature Relationship (if not applicant)

Accepted By: _____ Title: _____ Date: _____

Print Name Signature

**Retro eligibility may be available upon approval*

Solano County Family Health Services

Sliding Fee Scale Application

Appeal Process: We understand that you might not agree with the decision made regarding your eligibility for the Sliding Fee Scale Discount Program. If you wish to appeal the determination of eligibility for the Sliding Fee Scale Discount Program, please submit a new application to Family Health Services. You may walk into one of the clinics listed below and ask to speak to an accounting clerk, or you may call 707-784-2010 and ask to speak to an accounting clerk.

If you do not qualify for a discount due to your income and family size, you may still qualify for a payment plan agreement or, in certain circumstances, a fee waiver. Please call 707-784-2010 and ask to speak to an accounting clerk regarding your account. **At no time will a patient be denied services because of an inability to pay.**

Fairfield Adult Primary Care Clinic – 2201 Courage Drive, Fairfield, CA 94533

Fairfield Pediatric and Dental Clinic – 2101 Courage Drive, Fairfield, CA 94533

Vacaville Adult, Pediatric and Dental Clinic – 1119 East Monte Vista Avenue, Vacaville, CA 95688

Vallejo Adult, Pediatric and Dental Clinic – 365 Tuolumne Street, Vallejo, CA 94590

Solano County Family Health Services

Solicitud Para Tarifa Escalada

I. Nombre del Paciente: _____ Fecha de Nacimiento: _____

II. Tiene algún seguro médico: ____ No ____ Si

III. Nombre del plan de seguro médico, si lo tiene: _____

IV. Información de cuantos viven en el hogar (Hogar es considerado un grupo de dos o más personas quienes comparten una residencia común, son relacionados por sangre, matrimonio, adopción o se presentan como familiares y comparten costos y responsabilidades de soporte y sustento del grupo).

Por favor escriba todos los miembros del hogar, incluyendo a usted mismo.

	Nombre	Relación	Fecha de Nacimiento		Nombre	Relación	Fecha de Nacimiento
1.				5.			
2.				6.			
3.				7.			
4.				8.			

V. Información de Ingresos del Hogar

Por favor indique abajo todas las formas de ingreso de todos los adultos en el hogar, incluyéndose usted mismo (Ingresos incluye, salarios, beneficios de desempleo, SSI, SSDI, asistencia pública, pagos de veterano, beneficios de sobreviviente, pensiones y retiro, pensión alimenticia, y manutención). Prueba de ingresos incluye (1) Los últimos dos talones de pago, (2) la última declaración de impuestos, (3) prueba de ingresos de agencias afiliadas, (4) carta del empleador con el membrete, (5) Declaración personal (Circunstancias especiales, ver al contador para razones como usar esta forma). Adultos son las personas de 18 años de edad o más.

Esta aplicación debe ser devuelta con pruebas de ingreso para ser considerada para nuestro programa de descuento.

Nombre	Relación	Fuente de Ingreso	Cantidad/ Frecuencia	Total al Año

Sólo para uso oficial		
Qualified	*Sliding Fee Scale*	*% FPG*
☐	*A – 100% Discount*	*< 100%*
☐	*B – 80% Discount*	*101-138%*
☐	*C – 60% Discount*	*139-170%*
☐	*D – 50% Discount*	*171-200%*
Not Qualified		
☐	*E – 0%Discount*	*201-250%*
☐	*F – 0% Discount*	*251-300%*
☐	*0% Discount*	*> 300%*

_____

Fecha Nombre Firma Relación (si no es el aplicante)

Aceptado Por: _____ Título: _____ Fecha: _____

Nombre Firma

**Elegibilidad retroactiva puede ser dada bajo aprobación*

Solano County Family Health Services

Solicitud Para Tarifa Escalada

Proceso de apelación: Entendemos que es posible que no esté de acuerdo con la decisión tomada con respecto a su elegibilidad para el Programa de descuento de escala móvil de tarifas. Si desea apelar la determinación de elegibilidad para el Programa de Descuento de Tarifa Escalada, envíe una nueva solicitud a Servicios de Salud Familiar. Puede ingresar a una de las clínicas que se enumeran a continuación y pedir hablar con un empleado de contabilidad, o puede llamar al 707-784-2010 y pedir hablar con un empleado de contabilidad.

Si no califica para un descuento debido a sus ingresos y tamaño familiar, aún puede calificar para un acuerdo de plan de pago o, en ciertas circunstancias, una exención de tarifas. Llame al 707-784-2010 y pida hablar con un empleado de contabilidad con respecto a su cuenta. **En ningún momento se le negarán servicios a un paciente debido a la incapacidad de pagar.**

Fairfield Adult Primary Care Clinic – 2201 Courage Drive, Fairfield, CA 94533

Fairfield Pediatric and Dental Clinic – 2101 Courage Drive, Fairfield, CA 94533

Vacaville Adult, Pediatric and Dental Clinic – 1119 East Monte Vista Avenue, Vacaville, CA 95688

Vallejo Adult, Pediatric and Dental Clinic – 365 Tuolumne Street, Vallejo, CA 94590

Solano County Family Health Services

PAYMENT PLAN AGREEMENT

FAIRFIELD	**FAIRFIELD**	**VACAVILLE**	**VALLEJO**
2201 Courage Dr.	2101 Courage Dr.	1119 E. Monte Vista	365 Tuolumne St.
707-784-2010	707-784-2010	707-784-2010	707-784-2010

PATIENT'S NAME: _____ PATIENT'S DOB: _____

DATE: _____ CURRENT BALANCE ON ACCOUNT: _____

I understand that I am responsible for the outstanding balance and agree to the following:

☐ I agree to notify this health center if any changes occur in family size, income, medical insurance status or address.

☐ I agree to pay $_____ each month until paid in full.

☐ I agree to pay $_____ every two (2) weeks until paid in full.

NOTES: _____

_____

I certify that the information given by me on this form is true in all respects. My signature below certifies that I have read and understand to the best of my knowledge the information on this form and have been given an opportunity to ask questions regarding any issues that I might have regarding the sliding fee-scale.

PLEASE NOTE: **If payment is not made as agreed upon above, your account may be transferred to the Collection Agency.**

You may call us at the above number if you have any questions regarding your statement.

_____

Date Print Name Signature Relationship (if not self)

Approved by: _____ **Date:** _____

Health Center Representative - Name / Signature Title

Solano County Family Health Services

Acuerdo de Plan de Pagos

FAIRFIELD	**Fairfield**	**VACAVILLE**	**VALLEJO**
2201 Courage Dr.	2101 Courage Dr.	1119 E. Monte Vista	365 Tuolumne St.
707-784-2010	707-784-2010	707-784-2010	707-784-2010

Nombre del Paciente: _____ Fecha de Nacimiento: _____

Fecha: _____ BALANCE ACTUAL EN LA CUENTA: _____

Yo entiendo que yo soy responsable por cualquier balance debido y acuerdo a lo siguiente:

☐ Yo acuerdo en notificar a este centro de salud de cualquier cambio en miembros de la familia, ingresos y estado de cualquier seguro médico o dirección.

☐ Yo acuerdo en pagar $_____ cada mes hasta cubrir el total.

☐ Yo acuerdo en pagar $_____ cada dos (2) semanas hasta cubrir el total.

Notas: _____

_____

Yo certifico que la información dada por mí en esta forma es verdadera en todos los aspectos. Mi firma abajo certifica que yo he leído y entendido según mi conocimiento la información en esta forma y que he tenido la oportunidad de hacer preguntas relacionado con la tarifa escalada de descuentos.

POR FAVOR ENTIENDA: **Si los pagos no son hechos como acordó arriba, su cuenta puede ser reportada a una agencia de cobros.**

Usted puede llamar a los números de arriba si tiene alguna pregunta sobre su factura.

_____

Fecha Nombre Firma Relación (Si no es el paciente)

Aprobado por: _____ **Fecha:** _____

Representante del Centro de Salud – Nombre / Firma Titulo

Solano County Family Health Services

FEE WAIVER REQUEST

FAIRFIELD	**FAIRFIELD**	**VACAVILLE**	**VALLEJO**
2201 Courage Dr.	2101 Courage Dr.	1119 E. Monte Vista	365 Tuolumne St.

PATIENT'S NAME: _____ PATIENT'S DOB: _____

DATE: _____ ENCOUNTER#_____

If you are currently experiencing a financial hardship and would like Family Health Services to consider you for a one-time fee waiver for the requested encounter, please provide the reason for your request below:

_____

_____

_____

_____

_____

_____

_____

_____

By signing below, I certify that the information given by me on this form is true in all respects. My signature below certifies that I have read and understand to the best of my knowledge the information on this form and have been given an opportunity to ask questions regarding the fee waiver request. I acknowledge that my fee waiver request must be approved and signed by either the Practice Manager or Revenue Cycle Manager before it can be assigned to me and my signature below is not a guarantee of approval.

_____

Patient's Signature Date

Processed by:_____ **Date:**_____

Health Center Representative – Name/ Signature Title

Approved by: _____ **Date:** _____

Health Center Manager – Name / Signature Title

Solano County Family Health Services

Solicitud de Exención de Pago

FAIRFIELD	**FAIRFIELD**	**VACAVILLE**	**VALLEJO**
2201 Courage Dr.	2101 Courage Dr.	1119 E. Monte Vista	365 Tuolumne St.

Nombre del Paciente: _____ Fecha de Nacimiento: _____

Fecha: _____ Visita#_____

Si usted en este momento está teniendo dificultad financiera y quisiera que el Centro de Salud lo considere para una exención de la visita requerida, por favor dé una explicación abajo:

_____

_____

_____

_____

_____

_____

_____

_____

Por mi firma abajo, Yo certifico que la información que estoy dando en esta forma es verdadera en todo sentido. Mi firma abajo certifica que yo he leído y entendido en mi conocimiento la información en esta forma y que se me ha dado la oportunidad de hacer preguntas acerca de la solicitud de exención de pago. Yo reconozco que mi solicitud de exención debe ser aprobada y firmada por el gerente del Centro de Salud o el Administrador de Finanzas antes de que esta exención se me otorgue y mi firma no es una garantía de aprobación.

_____

Firma del Paciente Fecha

Procesado por:_____ **Fecha:**_____

Representante del Centro de Salud - Nombre / Firma Titulo

Aprobado por: _____ **Fecha:** _____

Gerente del Centro de Salud - Nombre / Firma Titulo