CHAPTER 2

CLINICAL SERVICES

CLINICAL SERVICES
Table of Contents

A. PATIENT REGISTRATION/INCOME ASSESSMENT

PURPOSE:
The purpose of this form is to provide basic identification and demographic data for patient care; direct and third party billing; computerized data entry; and documentation for standardized assessment of income and family size to determine eligibility for and percentage of charge, if applicable, for all Health Department services. Documentation may be based upon a declaration, except for WIC eligibility. For WIC eligibility, proof of identity, residence, and income is required and is documented by entering the type of proof document in PHALCON prior to Food Instrument issuance. See the WIC Procedure manual for explanation of proof requirements.

PATIENTS SHOULD NOT BE DENIED SERVICE FOR FAILURE TO PRESENT DOCUMENTATION EXCEPT FOR WIC.

The Income Assessment is an essential tool for implementation of the Fee System. County health departments charge fees on a sliding scale based on family size and income which is captured on the income assessment.

The Income Assessment:

- provides documentation of income assessment;
- records income and family size;
- determines eligibility for all applicable health department services;
- determines percentage of charge for services; and
- is completed at each client's first visit to the clinic, when a client volunteers an update and annually thereafter except WIC. Income assessments are completed at each WIC certification or recertification.

All sections of the CHR-2 must be completed.

Fees are charged based upon the last annual income assessment. A new income assessment must be completed if the last assessment is more than 12 months from the date of the signed declaration or the client declares a change in status.

Family size and income must be documented to validate the percentage of charge. ***Income assessments without this information are audit exceptions.*** The client/parent/legal guardian/legal custodian/proxy signature signifies client understands his/her rights and responsibilities.

- **Determining Percentage of Charge**
  Family size and income from the income guidelines determine if the percentage of charge will be either 100%, 75%, 50%, 25% or 0%. The percentage of charge identifies the client's payment category and the fee amount. Medicaid eligible clients are exempt from fee charges for covered services.

Status of Medicaid eligibility must be checked at every Child Health, Family Planning, Maternity, and Care Coordination visit using the Medicaid swipe card, web-eligibility verification, or eligibility screen (MSIQ), with the fee based upon the last income assessment.

PROCEDURE

1. **PHALCON label:** Place a PHALCON label here.

2. **Country of Birth:** Complete if patient is from another country.

3. **Limited English Proficiency (LEP):** Indicate if patient's native or dominant language is not English and if an interpreter is required. Specify language spoken.

4. **Contact Person/Phone:** Enter name and phone number of a parent, guardian, relative or friend to be notified in case of emergency. Indicate if patient refuses information. Other information such as mother's name and social security number may be documented in the space below "Directions to Home" and above the double, bold lines.

5. **Employer Name/Address/Phone:** Enter information, if applicable.

6. **Health Care Provider:** Enter name of physician, if applicable.

7. **Directions to Home:** Enter directions to home and/or place of employment, if applicable. May be completed in pencil.

8. **Patient Declaration:** Patient/parent/legal custodian/legal guardian, or proxy must read to ensure he or she understands the rights and responsibilities. When necessary read the declaration to the patient/parent/legal custodian/legal guardian. The signature of one of these individuals is required. **In the case of an infant of a WIC mother (Nutrition Risk Code 701)**; the proxy may sign in the signature space. The assessor will indicate in the box provided, "parent not here today, proxy signature".

9. **Signature and Title of Assessor/Witness:** The assessor/witness (Health Department staff completing this form) signs and dates his/her section after the patient or parent/guardian has signed. The assessor and witness may be the same person.

   The patient's fee ledger card (if applicable) should be securely placed in an envelope in back on the left side of the patient's CHR folder. Ledger cards may be filed alphabetically in a secure location. Refer to the Fee System Manual for detailed instructions of the fee ledger card.

10. **Family Size:** The following guidelines are to be used to verify family size and income in order to: 1) assign a fee for Family Planning and Other Clinical Programs; and 2) to determine WIC eligibility. The WIC Program does not charge fees to clients for services.

    A. Family Planning and Other Clinical Programs, excluding WIC:
    Family refers to a person or persons related or non-related by blood, marriage (including common law), or adoption living under one roof. Dependents away at school are also included. The income of all these persons should be counted to calculate the total income of the family.

- Examples of one member families:
  - A single person living alone
  - A person living with her/his parents who is not legally responsible for her/him

  < Exceptions to the one member family unit:
    - A foster child is considered a family size of one
    - A single teenager living with parents and in need of confidential services is considered a family size of one

- Examples of two or more member families:
  - A couple with or without children
  - A single parent with one or more children
  - A couple with or without children living with and being supported by a family unit of relatives all living in the same house
  - A pregnant women expecting to deliver one child is considered a family of two
  - A pregnant woman expecting twins, a family of three; and, expecting triplets, she is considered to be a family of four

- Other examples:
  - A child is counted in the household size of the parent or guardian with whom she/he lives.
  - In joint custody cases, consider the income of the household of the parent who initiates the service for the child. Fees are to be based on the income of the parent who initiated the service.
  - A child/student residing in a school or an institution and being supported by the parent, guardian, or caretaker is counted in the household size of the parent, guardian, or caretaker.
  - An adopted child, or a child for whom a family has accepted the legal responsibility, is counted in the household size with whom he/she resides.
  - If an adolescent has parental consent for contraceptive services, the fee should be based on family income.

B. WIC – Family Size:

A family is defined as a group of related or non-related individuals who are living together as one economic unit which may consist of an adult and his/her spouse, (including common law), and children/dependents under 18 (or under 21 if in school) related by blood, marriage, or adoption who are residing in the same household. A member of this economic unit temporarily out of the home, e.g., attending school but returning for holidays and vacations or hospitalized, continues to be considered a part of the family.

Note: There may be several economic units sharing a household, but only count and document the income for the economic unit requesting or applying for services. Often there may be situations in which the assessor must make a judgment because living arrangements vary considerable from household to household.

The following should be used when determining family size for WIC:

- **Single Client**
  - with or without children living alone.
  - with or without children supporting relatives, i.e., father, mother, brother, sister.
  - non-wage earner applying for herself or for a child, living with and being supported by the economic unit of relatives all living in the same house. Count all income of the economic unit when assessing income eligibility.

- **Single Wage Earner**
  - living with parents and not supported by parents, should be classified as a family of one and only his/her income should be counted.

- **Married or Cohabitating Couple**
  - with or without children.
  - with or without children supporting relatives, i.e. father, mother, brother, sister.
  - with or without children living with and being supported by a family unit of relatives all living in the same house. Count all the income of this family unit when assessing for income eligibility.

- **Pregnant Woman**
  - expecting to deliver one child is considered to be a family of two.
  - expecting twins, she is considered to be a family of three.
  - expecting triplets, she is considered to be a family of four.
  - when admitting the child of a pregnant woman, the unborn child/children are also counted as family members.

- **WIC Applicants** living in institutions including incarcerated pregnant women and homeless women/individuals
  - The family size of an institutionalized person or unit of related persons, e.g., a mother and her children in a temporary shelter for battered women, does not include other residents of the shelter. Income of the institutionalized person is also separate from the income of other residents and general revenues of the institution.

- **WIC Applicants with Military Spouse**
  - Military personnel serving overseas or assigned to a military base and temporarily absent from the home should be considered members of the household and counted when determining family size.

- **Exceptions to the Basic Family Unit Include**
  - Foster child is considered a family unit of one.

11. Medicaid Assessment:

Indicate "no" if the client does not have Medicaid benefits and complete the income assessment.

Indicate "yes" if the patient is eligible for Medicaid benefits. The assessor should ask for proof of Medicaid eligibility (i.e., plastic Medicaid card and/or eligibility letter). To verify current Medicaid eligibility, the clinic MUST swipe the Medicaid card, check Web Eligibility verification or call the 1- 800-number on the card. Indicate "No" or "Yes" to document verification, date and initial. An application should be taken if indicated and check the box indicating "applied for".

For WIC only, MSIQ can be used to verify current Medicaid eligibility. Medicaid eligible patients are exempt from fee charge for covered services. Patients who are Medicaid eligible automatically quality for all family health service programs.

Indicate "self" or "family member" to denote who is receiving Medicaid benefits.

NOTE: For WIC, Medicaid adjunctive income eligibility applies to the patient who receives Medicaid (indicate self in PHALCON) or to the patient who is a member of a family in which a prenatal or infant receives Medicaid (indicate family member in PHALCON).
The self-declared income of all adjunctively income eligible (Medicaid Food Stamps, Family Assistance) WIC participants must be entered in PHALCON at certification/ recertification.

If after a Medicaid Status check is completed and the patient is no longer eligible for Medicaid, complete a new income assessment. If the patient is on WIC and the new income assessment shows that the patient is no longer eligible for WIC, the patient and any other participating family members must be terminated from WIC and given a Notification Form (WIC-119). Patients applying for the Plan First Program will be provided services eligible under the Family Planning Waiver without charge. During the application process, patients should be informed that if it is determined they are not eligible for the Family Planning Waiver, they will be responsible for any bills since the time of the application.

NOTE: On subsequent visits if the patient does not yet have a Medicaid card, status of Medicaid eligibility must be checked. If the application is still pending, continue to treat the patient without charge and enter the services in PHALCON. If it has been more than 45 days since the initial visit, check with the Medicaid eligibility worker to determine the status of the application. As long as the application is pending, continue to treat the patient without charge. If the patient is shown as "Medicaid Application Denied", treat the patient on a fee for services basis and charge for services rendered since the time of the application.

SPECIAL PROCEDURES FOR FOSTER CHILDREN: For Medicaid-eligible foster children, the foster parent should present the child's Medicaid card during intake. For non-Medicaid-eligible foster children, an income assessment must be completed. To comply with Department of Human Resources (DHR) guidelines, the DHR social worker must complete and sign the income assessment and other documents for both Medicaid-eligible and non-Medicaid eligible foster children at the Health Department except for WIC certification. Foster parents may sign the income assessment for WIC certification only.

12. Family Assistance:

Indicate "No" if the patient does not receive assistance.
Indicate "Yes" if the patient receives family assistance.

The assessor must see the copy of the Family Assistance Notice of Eligibility. Certification dates are listed on the notice. Document on the WIC Proofs screen in PHALCON.

13. Food Stamps:

Indicate "No" if the patient does not receive food stamps.
Indicate "Yes" if the patient receives food stamps.

The assessor must see the Notice of Action sent to the family/household by the Alabama Food Stamp Program to determine current participation. Document on the WIC Proofs screen in PHALCON.

14. Private Insurance:

Indicate "No" if the patient has no private health insurance coverage.
Indicate "Yes" if the patient has any type of private health insurance.

15. American Indian/Alaskan Native:

Indicate "no" if the patient is not American Indian/Alaskan Native.
Indicate "yes" if the patient (parent or guardian) states that they are American Indian or Alaskan Native.

Indicate "Yes" if the patient is an unaccompanied minor for FP without insurance information.

16. Vaccines for Children (VFC) Eligibility Requirements:

Nothing in this section is to be marked. It is to be used to provide an at-a-glance indication of children eligible for vaccine provided by VFC using the information obtained in the Medicaid, Private Insurance, and American Indian/Alaskan Native questions. Note that children 0 through 18 years of age are eligible for vaccines furnished by VFC if they are on Medicaid, have no health insurance, or are American Indian or Alaskan Native. Children who are on Medicaid **and** have private insurance may be given VFC vaccine.

For those counties with a fee bill, there is a fee cap of $14.26 **per dose** of vaccine for these children. Counties with a charge of $15 per visit may continue to charge this if more than one vaccine is given.

17. **Explanation of Services: All** applicable health services must be explained and offered to all clients, regardless of the program. WIC participants eligible for other programs such as Food Stamps, Family Assistance (formerly TANF), or Medicaid must be referred to the appropriate agency. Indicate after health services are explained.

18. **Required Education:** Three of the required education topics 1) WIC as Supplemental Food, 2) WIC Foods for Participant, and 3) Using WIC Identification Folder may be explained to WIC participants by clerical staff according to clinic procedure and documented here. Indicate after the Required Educations Topics are explained. See WIC Procedure Manual page VI – 10e. (1).

19. **Notice of Ineligibility:** When a client is ineligible to receive certain program benefits, indicate in the appropriate space whether VERBAL or WRITTEN notification was given. This shows that the client was informed of ineligibility and how to appeal as specified in the specific program protocols and procedure manuals. **The WIC Program requires that written notification be given.**

20. **Income:** Assess income status based on program protocol requirements.

    This section **MUST BE COMPLETED**. If not, this will be considered an audit exception.

    A. <u>Family Planning and Other Clinical Programs:</u>
    - Income refers to the gross annual income for all members of a household. Income eligibility must be determined annually. Income includes:
        1. Wages, salaries and tips received before deductions
        2. Net income from self-employment. Net income is determined by subtracting the self-employed individual's operating expenses from his/her gross receipts
        3. Social Security benefits such as widow's benefits or children's allowance.
        4. Alimony and child support received
        5. Dividends or interest on savings or bonds, income from estates or trusts, net rental income or net royalties
        6. Unemployment compensation
        7. Government, civilian, or military retirement, pensions or veteran's payments
        8. Private pensions or annuities
        9. Regular contributions from persons not living in the household
        10. Lump sum payments such as "new money" include gifts, inheritances, lottery winnings, worker's compensation for lost income, and severance pay

- Income does NOT include:
    1. Food, rent or other non-cash items received in lieu of wages
    2. Food stamps received
    3. Withdrawal from savings
    4. Money received from sale of personal possessions
    5. Loans received
    6. Student loans or grants received for school expenses
    7. Earnings of children under 14 received
    8. Settlements for legal damage
    9. Maturity payments on insurance policies received

- Determination of Income:
    1. Income is by self-declaration and is documented as an annualized income.
    2. Consider the income of the household during the past 12 months (annual income) and the family's current rate of income to determine which income more accurately reflects the family's current status.
    3. Count income of all members of the household who are employed, or have other sources of income (e.g., unemployment, pension, etc).
    4. If an individual declares zero income, ask for information as to how they obtain food, shelter, clothing, medical care, etc. The information must be recorded in the client's file.

- Reassessment of Income - Income must be reassessed annually and when a client has a change in income status.

B. <u>WIC</u>

Current income is defined as gross cash income from all sources before deductions for income taxes, employees social security taxes, insurance premiums, bonds, etc. which the client, spouse and all other members of the family unit (included in Medicaid Eligibility) are earning or receiving at the time of the assessment.

- WIC Eligibility:
    - Income eligibility must be determined at certification/recertification prior to issuance of benefits (food instruments, formula). Infants born to mothers who participated in WIC as a prenatal patient must be income eligible. Income eligibility must be determined at certification/recertification. This includes certifications conducted at a clinic, a hospital or during home visit. Proof of income is required for WIC and the type of proof document must be entered in PHALCON at each certification/ recertification.
    - The WIC Program will use the same Income Guideline Chart used by other programs in the Health Department. All programs will implement changes in the income schedule at the same time. WIC participants cannot exceed 185% of poverty, unless there is proof of current participation in Medicaid, Food Stamps, or Family Assistance. Self-declared income, annual amount, and source must be documented.

- **Sources of Income**: Documentation must include the name of the place of employment, company, or business. Income should be given as an annual amount and include:
  - Alimony
  - Annuities
  - Business Profits
  - Child Support
  - Help from relatives and non-relatives not living in the household
  - Lump sum payments
    - < Gifts
    - < Inheritances
    - < Lottery winnings
    - < Severance pay
  - Military pay should include all forms of pay except on or off-base military housing allowance payments and Family Substance Supplemental Allowance (FSSA). Basic Allowance for Subsistence (BAS), hazardous duty, jump, separation, etc. must be counted with Base Pay.
  - Net earnings from self-employment
  - Net investment income (rent, interest, dividends)
  - Net royalties and any other cash income including received or withdrawn from savings, investments, trusts, or other resources
  - Sick pay
  - Workman's compensation
  - Pension or retirement payment
  - Regular contributions from persons not living in the household
  - Salaries (must document the name of the place of employment, company, or business)
  - Social security cash benefits such as widow's benefits or children's allowance
  - Tips
  - Unemployment compensation
  - Veteran's benefits
  - Wages

- **Sources <u>not</u> counted as Income**:
  The following non-inclusive listings of reimbursements, payments, assistance, or allowances is NOT counted as income:
  - Bank loans
  - Student loans
  - Earned Income Tax Credit
  - Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
  - Home Energy Assistance Act
  - Title I (VISTA and others) and Title II (RSVP, foster grandparents and others) of the Domestic Volunteer Services Act of 1973
  - Small Business Act (SCORE and ACE)

- Job Training Partnership Act
- National School Lunch Act
- Child Nutrition Act or 1966
- Food Stamp Act of 1977 (food Stamp benefits)
- Statutes related to certain claims settled with various Indian tribes
- Student financial assistance received from any program funded under Title IV which includes:
  - < The Pell Grant
  - < Supplemental Education Opportunity Grant
  - < BYRD Honor Scholarship Programs
  - < Any other Title IV programs
- Child care payments made under Section 402(g)(1)(E) of the Social Security Act
- Any at-risk block grant child care payments made under Section 5081, gPub.101-508
- Any child care provided or paid for under the Child Care and Development Block Grant Act.

For additional federal assistance programs that can be excluded from being counted as income, see USDAWIC Regulations, Section 246.7(d)(2)(iv).

▪ Migrants

A migrant farm worker or logger is defined as an individual:

- Whose principal employment is in agriculture on a seasonal basis;
- Who has been employed in agriculture within the last 24 months, and;
- Who establishes, for the purposes of employment, a temporary abode or home.

Principal employment means over 5 percent of the migrant farm worker's job in agriculture. Agriculture means all activities which include:

- Cultivation and tillage of the soil;
- Cultivation, growing, and harvesting of any commodity grown in or on the land;
- Or as an adjunct or part of a commodity grown in or on the land including logging or harvesting of trees.

When determining income for migrants at certifications, annual income is often more reliable and more easily obtained than current income.

The migrant farm worker family who presents expired VOC cards/letters indicating that income eligibility was accomplished within the previous 12 months do not need income reassessed. They are considered income eligible.

21. Income Self-Declared – Self-declared income (annual amount) and sources of income must be entered. (For WIC, verification of self-declared income is not required if patient qualifies due to adjunctive eligibility).

Indicate "No" if the income is not self-declared.
Indicate "Yes" if the income is self-declared.

22. Payment Bracket: After calculation of annual income and family size, the income percentage is written in this section to indicate the payment class for fees (100%, 75%, 50%, 25%, or 0%). The Income Schedule is located in the Fee Manual. Income schedules are updated annually and counties must use the most recent schedule.

No fee is charged to clients receiving services under WIC, STD, and TB programs, (excluding job-related skin tests or x-rays) or service covered by Medicaid.

23. Student/School:

Indicate "NO" if client is not a student.
Indicate "YES" if client is a student and list the name of the school attended.

24. Special Circumstances: At times there will be special circumstances which impact a client's ability to pay. The Income Assessment should include questioning about special circumstances. Examples include extreme medical expenses, temporary layoffs, unemployment or layoff for an extended period followed by recent unemployment.

Family Planning

- Fees must be waived for individuals with family incomes above the amounts shown in the schedule who, as determined by the assessor/supervisor, are unable for good cause, to pay for family planning services.
- The county health department Administrator or Area/Clinic supervisory staff is required to approve waived fees for services as recommended by intake assessor. The approver is to initial in the Special Circumstances box.
- This is self declared information. Proof of cause is <u>not</u> required (example: hospital bill).
- Fees may be waived for services and/or supplies when the client meets any one or more, but not limited to other reasons deemed reasonable, of the following definitions of "Good Cause".
  - *Recent layoff from employment
  - *Recent Funeral Costs of immediate family member (**)
  - *Recent Medical/Hospital Costs
  - Extraordinary ongoing monthly prescription costs
  - Recent Bankruptcy
  - Recent Natural Disaster Loss (uncompensated costs for fire, flood, tornado, etc.)

* Recent is defined as no more than six months from the date of the event.

** Immediate family for this purpose includes spouse, children, parents, step parents, parent-in-law, grandchildren, grandparents, brothers, sisters, and stepchildren.

WIC - when calculating income for WIC, special circumstances cannot be allowed.

25. Interim Visits:

Medicaid - Indicate "NO" if client is not receiving Medicaid benefits. Indicate "YES" if client is receiving Medicaid benefits. Status of Medicaid eligibility must be checked at every Child Health, Immunization, Family Planning, Maternity, and Care Coordination visit using the Medicaid swipe card, Web Eligibility verification or 1-800 number on the card, with the fee based upon the last income assessment. If after a Medicaid status check is completed and the patient is no longer eligible for Medicaid, complete a new assessment. NOTE: If the most recent Income Assessment indicates that the patient is no longer eligible for WIC services, the client and any other participating family members shall be terminated and a WIC 119, Notifications Form given. If the assessment indicates that the client has been classified incorrectly for fees, correct fees shall be charged.

26. VFC Eligibility – VFC eligibility must be verified every visit where the client is age appropriate for VFC (up to the 19th birthday).

Indicate "NO" if the patient is not VFC eligible.
Indicate "YES" if patient is VFC eligible. If "Yes" the qualifier should be circled.

Enter the initials and date of the person verifying information.

INCOME SCHEDULE

THE INCOME SCHEDULE:

- with the Client Registration/Income Assessment (Form CHR-2) assesses each client income eligibility.
- determines the percent of fees, if any, will be charged to a client for Family Planning and other clinic services.
- is released each spring from the Department of Health and Human Services (DHHS).
- is based on DHHS poverty guidelines.
- is effective for use upon receipt at county health department.
  - Date stamp Income Schedule immediately when received for audit purposes.
- shows the percent of fee to charge for services based on family size and income.

PERCENT OVER MAXIMUM AMOUNT OF POVERTY INCOME	PERCENT TO CHARGE FOR SERVICES
250% OVER	100%
200% - 250%	75%
150% - 200%	50%
WIC = 185% AND UNDER	**AUTOMATIC ELIGIBILITY**
100% - 150%	25%
PLAN FIRST = 133% AND UNDER	**AUTOMATIC ELIGIBILITY**
100% AND UNDER	0%

The current Income Schedule should be used with the Form CHR-2 to assess each client's income eligibility.

PATIENT REGISTRATION/INCOME ASSESSMENT

1

2 Country of Birth ____________________

3 Limited English Proficiency (LEP) ____ No ____ Yes

4 Contact Person ____________________ Phone ____________________

Employer Name, 5 ____________________

Address, Phone 6 ____________________

Health Care Provider ____________________

Directions to Home 7 ____________________

____

____

8 **PATIENT DECLARATION:** I certify that the information I will provide on this form in order to determine my eligibility for services of this agency, as well as to determine the amount which I will pay for the services I receive, is true and correct to the best of my knowledge. I understand that Social Security information is used for identification purposes only and is not required for me to obtain services. I understand this assessment is being made in connection with the receipt of Federal and State subsidized services and/or assistance. Officials of this agency have my permission to verify this information, and I will cooperate fully by providing documentation of my income if requested by this agency. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State Agency, in cash, the value of the food benefits improperly issued to me and subject me to civil or criminal prosecution under State and Federal law.

9

Signature of Patient (or Parent/Guardian)	Signature & Title of Assessor/Witness	Date

☐ Parent not here today, proxy signature

Family Size 10 ____________

MEDICAID 11 ____ No ____ Yes ____ Self ____ Family Member

Verified ____ No ____ Yes

____________________ Date/Initials

Applied for ☐

Family Assistance ____ No ____ Yes 12

Food Stamps ____ No ____ Yes 13

Private Insurance ____ No ____ Yes 14

American Indian/Alaskan Native ____ No ____ Yes 15

Vaccines for Children Eligibility Requirements: Medicaid "Yes", Private Insurance "No", or American Indian/Alaskan Native "Yes" FP-unaccompanied minor without insurance "Yes" 16

Explanation of Services 17 **Required Education** 18

Notice of Ineligibility _____ Verbal _____ Written 19

INCOME 20 (Source) (Annual Amount)

	(Source)	(Annual Amount)
Patient	____________	$ ____________
Spouse	____________	$ ____________
Other	____________	$ ____________
	Total	$ ____________

Income Self-declared ____ **No** ____ **Yes** 21

Payment Bracket 22 ____________

Student ____ **No** ____ **Yes** 23

School ____________________

Special Circumstances (circle) 24

Waive Fee Medical Expenses Temporary Layoff/Hardship

Other ____________________

Interim Visits 25

Medicaid ____No ____ Yes VFC Eligibility ____No ____ Yes 26	**If VFC "Yes" circle eligibility qualifier** Medicaid "Yes" Private Insurance "No" American Indian/Alaskan Native "Yes" FP-unaccompanied minor without insurance "Yes" Verified____________(Date/Initials)
Medicaid ____No ____ Yes VFC Eligibility ____No ____ Yes	**If VFC "Yes" circle eligibility qualifier** Medicaid "Yes" Private Insurance "No" American Indian/Alaskan Native "Yes" FP-unaccompanied minor without insurance "Yes" Verified____________(Date/Initials)
Medicaid ____No ____ Yes VFC Eligibility ____No ____ Yes	**If VFC "Yes" circle eligibility qualifier** Medicaid "Yes" Private Insurance "No" American Indian/Alaskan Native "Yes" FP-unaccompanied minor without insurance "Yes" Verified____________(Date/Initials)
Medicaid ____No ____ Yes VFC Eligibility ____No ____ Yes	**If VFC "Yes" circle eligibility qualifier** Medicaid "Yes" Private Insurance "No" American Indian/Alaskan Native "Yes" FP-unaccompanied minor without insurance "Yes" Verified____________(Date/Initials)

FAMILY HEALTH SERVICES

CANCER DETECTION

A. SERVICE CODE 114 - INITIAL AND ANNUAL VISIT

An evaluation of a new or established client requiring the establishment or update of medical records, comprehensive history, and appropriate counseling. These clients are generally no longer childbearing and the focus of the visit is breast and cervical cancer screening.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 114	$83	$62	$41	$20	$0

B. SERVICE CODE 116 - REVISIT

An evaluation of a client with a new or existing problem or condition. These clients are generally no longer childbearing and are eligible for the Alabama Breast and Cervical Cancer Program, however, it may be utilized to assess a woman who is less than 40 years of age who presents with a breast complaint and is not eligible or does not desire FP services enrolled in the Family Planning program.

Examples of visits include:

- Evaluating breast problems
- Repeating necessary lab work such as Pap smear or hemoglobin
- Counseling only visit regarding abnormal Pap smear or other identified problems.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 116	$33	$25	$16	$8	$0

C. Documentation Procedure for Alabama Breast and Cervical Cancer Clients:

Counties with a fee bill and an approved fee schedule for cancer detection services would normally assess fees for cancer detection services. These counties should complete the income assessment as normal (including family size, income, and payment bracket.) "Waive Fee" should be circled at the bottom of the income assessment form and "Eligible for BCCP" should be indicated. This will identify the services that will be paid for through the Breast and Cervical Cancer Program (BCCP). The services would be listed on the day sheet with the gross charges at the 100% amount and the net charges would be 0.00, since the fee is waived. The BCCP client never actually pays for any BCCP services.

For counties without a fee bill or with no approval to charge cancer detection services, there would be no entry on the day sheet for a BCCP eligible client who receives services, and the client would not pay for any BCCP services received.

D. Charging Procedure:

Assess client for Medicaid or Breast and Cervical Cancer Program (BCCP) eligibility. Clients not eligible for Medicaid or BCCP benefits are charged based on their annual income assessment. The charge includes all services and laboratory work provided during this visit.

The fees listed above are suggested fees. Counties with a local fee bill for these described services are to utilize their local fee schedule.

CHILD HEALTH

A. SERVICE CODE 118: INITIAL AND PERIODIC VISITS

Initial Screening indicates the first time a well child screening is performed on a client.

Periodic Screenings are well child checkups performed based on a periodicity schedule. The ages to be screened are by 1month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually beginning on or after the child's third birthday.

Services include a comprehensive family/medical history, physical examination, immunization status, developmental assessment, nutritional assessment, anticipatory guidance, health education and procedures per protocol - measurements, hearing/vision/dental evaluation, laboratory tests, and counseling per protocol.

Percentage Fee	**100%**	**75%**	**50%**	**25%**	**0%**
Service Code 118	$163	$122	$82	$40	0

B. SERVICE CODE 120: INTERPERIODIC VISITS

Interperiodic visits are considered problem-focused and abnormal. These visits may be performed before, between, or after a periodic screening if medically necessary. Interperiodic screenings may also occur in the case of children whose diagnosed illness/condition (physical, mental or developmental) has become more severe or has changed sufficiently so that further examination is medically necessary. A referral to others or a self-referral may be issued for problems identified during the visit. Interperiodic screenings will have an abnormal diagnosis.

Percentage Fee	**100%**	**75%**	**50%**	**25%**	**0%**
Service Code 120	$163	$122	$82	$40	0

C. SERVICE CODE 122: SINGLE SERVICE VISIT

A single service visit when only one service is provided to a child during the visit. Services provided depend upon the nature of the illness or problem which requires the specific service. Examples of services include:

- Head lice checks
- Repeat PKU tests
- Lead screening
- Hemoglobin re-check

Percentage Fee	**100%**	**75%**	**50%**	**25%**	**0%**
Service Code 122	$20	$15	$10	$5	0

D. CHARGING PROCEDURE:

- Status of Medicaid eligibility must be checked at each visit with the fee based on the last annual income assessment. Clients not eligible for Medicaid benefits are charged based on their **parent's or guardian's** ability to pay prior to receiving services. The charge includes all services and laboratory work provided during this visit.
- The fees listed above are suggested fees. Counties with a local fee bill for these described services are to utilize their local fee schedule.
- **NOTE**: The DHR social worker **must** complete and sign the income assessment for both Medicaid and non-Medicaid eligible foster children.

FAMILY PLANNING

I. **PROGRAM PHILOSOPHY** - All family planning clients must be given the opportunity to make two fundamental choices: the choice of participation and the choice of contraceptive method.

II. **PROGRAM REQUIREMENTS**

The following guidelines are designed to comply with the federal Title X regulations which require a sliding scale fee assessment based on the client's self declared income and family size. The full fee rate is to be charged at 250% of the federal poverty level. All clients are to be income assessed as described in this manual and informed that services will not be denied based on inability to pay.

The fees described in this section are applicable to the Family Planning Program and are set at the state level only. The county cannot change the Family Planning service descriptions or amounts when providing these services.

The following are program mandates:

A. Provide services without regard to religion, race, color, national origin, creed, disability, sex, number of pregnancies, marital status, age, contraceptive preference, or inability to pay.
B. Target services to low-income individuals with priority in the provision of services be given to persons from low-income families.
C. Provide services without subjecting individuals to any coercion to accept services or employ or not to employ any particular methods of family planning. Services must be provided solely on a voluntary basis and not be made a prerequisite or eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant. Project personnel must be informed that they may be subject to prosecution under Federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure.
D. Provide services in a manner which protects the dignity of the individual.
E. Assure client confidentiality and provide safeguards of individuals against the invasion of personal privacy as required by the Privacy Act. If requested, the client has the option of not being contacted at home by phone or mail for billing purposes.
F. No charge for services provided to any persons from a low-income family except to the extent that payment will be made by a third party authorized to or under legal obligation to pay this charge.
G. Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except charges to persons from families whose annual income exceeds 250 percent of the most recent Poverty Guidelines will be made in accordance with a schedule of fees designed to recover reasonable cost of providing services.

FAMILY PLANNING

III. **INCOME DETERMINATION** – Income determination is based on family size and household income. Determination of income is by self-declaration and is documented as annualized income. See next chapter for instructions on assessment of family size and income.

IV. **INTAKE PROCESS**

A. Inform client of the financial assessment process including the sliding fee scale.

B. Complete an income assessment based on client's self-declared income and family size as outlined in this manual.

C. If client is eligible for Medicaid, initiate the application process or verify Medicaid status. For additional information, see section below for Charging Fees.

D. If non-Medicaid client, inform her of her pay category and that services will be provided regardless of inability to pay.

E. The charging of applicable services should ideally be done following completion of service(s); however, counties should set up the system that works best for their setting. For example, a county can opt to charge established clients for a supply visit at the beginning, however, new clients who have not chosen a birth control method may be charged at the end of the visit.

F. Inform the client of the applicable charges incurred today and ask how much she/he can pay on the bill. Enter the service on the day sheet for all non-Medicaid clients.

G. Print the receipt/invoice and review with client. For those with a remaining balance, the clerk can provide the client with a self-addressed envelope to send back with a payment at a later date.

V. **CHARGING FEES**

B. All non-Medicaid family planning clients will be assessed a fee depending on their family size, declared income, and type of visit or service.

C. Fees are determined by the ADPH by performing a cost analysis of the services provided statewide. Fees are assessed locally by applying the schedule of discounts to the total charges based on the client’s Federal Poverty Level.

D. If a client comes in for one type of visit and it is determined that another type of visit is needed at the same time, (e.g. in for GYN problem and it is determined that emergency contraception is indicated), the client should be billed for only one (1) visit, as well as any other billable services that were provided.

FAMILY PLANNING

E. Should a client be deemed ineligible for Medicaid (example, over the income criteria), the fee for this service should be charged to the client.

If the client appears eligible for Medicaid, and the application process has been initiated, do not charge the client for services provided on that date of service. If client is denied Medicaid, county is to charge fees appropriately, including all visits/services provided since the application was taken. These visits/services are to be recorded on the E-Daysheet and the client billed as appropriate. If the application remains pending after 45 days, HD will send a bill to all eligible clients. (See VI. Billing/Collection section).

F. Clients whose income falls at or below 100% of the federal poverty level will fall into a zero % pay category. All non-Medicaid clients will have services recorded on the E-Daysheet, including those in the zero % pay category. The transaction will generate an invoice/receipt for the client which will show the gross charge, net charge, amount paid and current balance. All clients are to be given this statement.

G. Clients who indicate they do not know their income, or decline or refuse to declare income will be charged at the 100% pay category. Clerk is to document this on the Income Assessment such as "Client refused to disclose income, or client waived sliding fee scale".

H. Fees charged to any client for services must be in accordance with the ADPH approved Fee Schedule.

I. No client will be refused service or be subjected to any variation in quality of services based on inability to pay.

J. Clients who return to the clinic for lost, misplaced or otherwise missing contraceptive packets of pills, patches or rings will be charged as specified on the Family Planning Fee Schedule.

K. The county Health Department Administrator or Area/Clinic supervisory staff may waive the fee for an individual "for good cause."

< Definition of "Good Cause" - Fees may on occasion need to be waived due to unusual circumstances for clients who would be required to pay for services and/or supplies, based on their income and family size. However, these clients are unable to pay based on a temporary or one-time catastrophic financial event. The county health department Administrator or Area/Clinic supervisory staff may waive fees for services and/or supplies when the client meets any one or more, but not limited to other reasons deemed reasonable, of the following definitions of "Good Cause". This is self declared information. Proof of cause is not required (example: hospital bill)**:**

FAMILY PLANNING

- *Recent layoff from employment
- *Recent Funeral Costs of immediate family member (**)
- *Recent Medical/Hospital Costs
- Extraordinary ongoing monthly prescription costs
- Recent Bankruptcy
- Recent Natural Disaster Loss (uncompensated costs for fire, flood, tornado, etc.)

*Recent is defined as no more than six months from the date of the event.
** Immediate family for this purpose includes spouse, children, parents, step parents, parent-in-law, grandchildren, grandparents, brothers, sisters, and stepchildren.

VI. DONATIONS

Voluntary donations from clients are permissible. Clients must not be pressured to make donations, and donations must not be a prerequisite for the provision of services and supplies. Donations from clients do not waive the billing/charging requirements specified above. Donation amounts should not be suggested. It is acceptable to display notice regarding acceptance of donations.

The following is an example of requesting donations:

"There are no charges for your services today because it is based on your family size and income; however, we do accept donations. These donations are used to offset the expenses used to provide services to our clients. Would you be interested in providing a donation today?"

VII. BILLING/COLLECTING

A. The following information should be given to the client at the time the appointment is scheduled:
   - A fee may be charged for services and supplies.
   - Any fee will be based on income and family size.
   - Payment is due at the time of the service, however, services will not be denied based on inability to pay.
   - A fee may not be charged if client appears eligible for Medicaid and applies at the time of the visit (pending enrollment). If deemed ineligible, client will be charged appropriately from the time of the application as described in section IV. Charging Fees, D.
   - Clients deemed ineligible for billing based on confidentiality purposes, will not have mailings sent to their home.
   - A donation will be accepted.

B. At the time of services, each client must be given an invoice containing the following information:
   1. Name of Client
   2. Date of service

FAMILY PLANNING

3. Gross charges
4. Net charges
5. Amount paid this date
6. Current balance

C. Clients unable to pay in full at the time of service should be asked to make a partial payment.

D. Clients should be mailed an invoice for the unpaid balance of their bill. Clients who have requested confidential services must not be mailed an invoice or be contacted by phone unless an alternative address/contact # has been established.

VIII. THIRD PARTY BILLING

A. All clients must be asked about third party coverage (Medicaid or private insurance). The term "creditable coverage" is defined as:
   - A group health plan
   - Health insurance coverage - benefits consisting of medical care (providing directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.
   - Medicare
   - Medicaid (under any mandatory coverage group)
   - Armed forces insurance
   - A medical care program of the Indian Health Service (IHS) or of a tribal organization
   - A state health risk pool

   There are certain types of coverage that are <u>not considered creditable coverage</u>: Limited scope coverage such as those which only cover dental, vision, or long term care; coverage for only a specified disease or illness; indemnity policies that pay certain amounts for each day in the hospital.

B. Clerk must establish that billing third party insurance is not a breach of confidentiality for the client and if statements or bills can be received through mailings.

C. Private insurance providers must be billed on non-confidential clients with private insurance. (**Note:** Systematic changes are in development. Counties will be notified when the Third Party Private Insurance billing is ready to be implemented).

IX. AGING ACCOUNTS/ WRITE-OFF POLICIES

A. All service sites will implement a method for aging of outstanding account receivables.

FAMILY PLANNING

B. Service site accounts should be aged quarterly and aged as of the report run date. This allows the program to attempt collections from current customers while providing a mechanism to write-off accounts that are dormant/uncollectible.

C. Quarterly run the current balance (as of date run) and how old as of date run (for example, set to run automatically October 5, January 5, April 5 and July 5). Based on the totals and confidentiality, do the following (using calendar days):
If 0-30 days old, do nothing
If 31-60 days old, send a bill (county)
If 61-90 days old, send a bill (county)
If 91 days or greater, write off

D. Any payments received should go against any outstanding balance. A "Receipt/Current Invoice" should be created to provide clients.

E. If a client returns to the clinic after the account balance has been written off, the previous balance will be zero.

X. CHANGE FUNDS

Each service site will maintain a change fund to facilitate clients wishing to make payments by cash.

XI. RECORDS AND FORMS

Privacy Statement:

- Clients seen in service sites must be provided with a copy of the Alabama State Department of Health Privacy Statement.
- Contract agencies must develop and provide privacy statements in accordance with federal and state guidelines.

XII. MEDICAL RECORDS and CLIENT CONFIDENTIALITY

A. Family planning client records are confidential as required by medical ethics and by federal and state statutes. It is the responsibility of each service site and contract agency employee to maintain complete and total confidentiality of any and all client information collected, filed or stored by the service site or contract agency.

B. Contract agencies must develop and implement medical records policies and procedures to include obtaining authorization to release confidential information to agencies or other parties. These policies and procedures must be in compliance with federal and state guidelines.

FAMILY PLANNING

C. Measures to assure client confidentiality include:
- Providing privacy when requesting personal information (demographic profile or equivalent, health history, current problem, etc.)
- Never leave a client in a room with any client record.
- Place client record on desks or in holders so that the name cannot be seen.
- Never call out the client's full name in the waiting area.
- Records should be secured by lock when not in use.
- Mailing information is requested during the initial interview for privacy purposes and documented in PHALCON.
- No information obtained by personnel about individuals receiving services may be disclosed without the specific written consent of the individual and as outlined in ADPH HIPPA Policy.

FAMILY PLANNING

XIII. FEE SCHEDULE

Following are the eligible services and contraceptive methods to be utilized when charging Family Planning clients.

Service Description

Service Code	Service Description	Percentage of Fee Charge				
		A - 100%	B - 75%	C - 50%	D - 25%	E - 0%
100	Family Planning-Initial and Annual Visit	$182	$137	$91	$46	0
101	Family Planning-Periodic Revisit Resupply	$182	$137	$91	$46	0
102	Deferred Physical Visit	$182	$137	$91	$46	0
103	Extended Family Planning Counseling Visit	$182	$137	$91	$46	0
104	GYN Problem/Lab/Counseling Visit	$0	$0	$0	$0	0
107	Pregnancy Test Only Service	$12	$9	$6	$3	0

Contraceptive Method Fees*

Service Code	Method	A – 100%	B – 75%	C – 50%	D – 25%	E – 0%
106A	Pills - Monthly	$8	$6	$4	$2	$0
106B	Pills - Quarter	$32	$24	$16	$8	$0
106C	Pills - Annual	$112	$84	$56	$28	$0
106D	Injection - Quarter	$15	$11	$8	$4	$0
106E	Patch - Quarter	$67	$50	$34	$17	$0
106F	Ring - Quarter	$45	$34	$23	$11	$0
106G	Diaphragm	$19	$14	$10	$5	$0
106H	Spermicidal jelly	$9	$7	$5	$2	$0
106I	IUD/Paragard + Insertion	$271	$203	$136	$68	$0
106J	IUD/Mirena + Insertion	$470	$353	$235	$118	$0
106K	Implant +Insertion	$435	$326	$218	$109	$0
106L	Female Sterilization	$1000	$750	$500	$250	$0
106M	Male Sterilization	$300	$225	$150	$75	$0

- The fees listed above are based upon a cost analysis of the program services and supplies (10/2008).
- There is no charge for foam and/or condoms.
- For examples of circumstances when fees can be waived, see description of "Good Cause", earlier this section.

NOTE: If a client returns for a repeat BP reading following a routine FP visit, code the visit as a GYN Problem/Lab/Counseling Visit and only charge for applicable contraceptives provided if applicable.

FAMILY PLANNING

XIV. SERVICE CODES

A. SERVICE CODE 100 - INITIAL AND ANNUAL VISIT

An in-depth evaluation of a new or established client requiring the establishment or update of medical records, comprehensive history, complete physical examination, appropriate diagnostic laboratory tests and procedures, family planning counseling using PT+3 teaching method and contraceptive method as indicated.

Fees charged to the client include the visit and contraceptive method as appropriate. See fee schedule for current rates.
NOTE: If the physical exam is deferred see Service Code 102 below.

B. SERVICE CODE 101 - PERIODIC REVISIT

A follow-up evaluation of an established client with a new or existing family planning condition. These visits are available for multiple reasons such as contraceptive changes, issuance/ administration of supplies, or contraceptive problems (e.g. break through bleeding or the need for additional guidance). Fees charged to the client include the visit and contraceptive method as appropriate. See fee schedule for current rates.

C. SERVICE CODE 102 - DEFERRED PHYSICAL VISIT

An evaluation of a new or established client which requires the establishment or update of medical records, comprehensive history, contraceptive counseling and issuance/ administration of contraceptive supplies, while deferring the physical exam and labwork.

- Initial/Annual deferred visit involves the deferral of the Initial or Annual visit for up to 6 months. When the client returns for the Initial or Annual visit, as appropriate, the visit is charged as Service Code 100.
- Postpartum deferred visit involves the deferral of the physical exam/labwork following the six week postpartum exam from the client's private provider. The client must provide the health department's pre-printed prescription (as required by protocol) for her chosen method from her private provider. Supplies will be issued/administered until the due date of the Pap smear. At that time, or if the client's contraceptive needs change, the health department will assume the care of the client and arrange for her exam visit.

Fees charged to the client include the visit and contraceptive method as appropriate. See fee schedule for current rates.

See ADPH Clinic Protocol Manual visit standards for "Deferred Physical - Initial/Annual" and "Deferred Physical - Postpartum".

FAMILY PLANNING

D. SERVICE CODE 103 - EXTENDED FAMILY PLANNING COUNSELING VISIT

The Extended FP Counseling Visit is a separate and distinct service consisting of a minimum of 10 face-to-face minutes of extended contraceptive counseling using the PT+3 teaching method. The Extended FP Counseling visit is performed in conjunction with the 6 week postpartum visit in the office/clinic setting. The counseling services are those provided above and beyond the routine contraceptive counseling that is included in the postpartum visit. Family Planning services are not provided for clients who have received permanent sterilization. For bilateral tubal ligation clients and hysterectomy clients, see Service Code 112.

Fees charged to the client include the visit and contraceptive method as appropriate. See fee schedule for current rates.

E. SERVICE CODE 104 – GYN PROBLEM/LAB/COUNSELING VISIT

Brief visit for services which may include but are not limited to:

- Repeat BP reading (NOTE: if contraceptives are provided following repeat BP reading, charge client for applicable contraceptive only)
- Assessment of breast problem
- Repeat lab visit (repeat Pap smear; Hgb, etc.)
- Counseling only visit

F. SERVICE CODE 107 – PREGNANCY TEST ONLY SERVICE

Services include a pregnancy test only (regardless of result) with counseling and referral as appropriate.

G. CHARGING PROCEDURE FOR FAMILY PLANNING:

Assess client for Medicaid eligibility. Clients not eligible for Medicaid benefits are charged based on their annual income assessment. The charge includes all Family Planning services and laboratory work provided during the visit, and contraceptive method provided as appropriate. See current Fee Schedule.

MATERNITY

A. SERVICE CODE 112 - MATERNITY-POSTPARTUM VISIT

A follow-up evaluation typically performed about six weeks post delivery. This visit includes the update of medical records, comprehensive history, complete physical examination, appropriate laboratory tests and procedures, and counseling. These clients are generally no longer childbearing or have had surgery which prevents childbearing (bilateral tubal ligation or hysterectomy). Family Planning services are not provided at this visit.

If Family Planning services are provided see description for the Extended Family Planning Counseling Visit, Service Code 103.

Percentage Fee	**100%**	**75%**	**50%**	**25%**	**0%**
Service Code 112	$108	81	54	27	0

B. CHARGING PROCEDURES:

Assess client for Medicaid eligibility. Clients not eligible for Medicaid benefits are charged based on their annual income assessment. The charge includes all services and laboratory work provided during this visit.

The fees listed below are suggested fees. Counties with a local fee bill for these described services are to utilize their local fee schedule.

WIC

WIC is the Special Supplemental Nutrition Program for Women, Infants and Children to 5 years of age. There are no fees charged to participants receiving WIC services. Proof of income, identity and residence are required for each applicant in order to assess eligibility. A nutrition assessment is performed by the nutritionist/nurse to determine participation. See instructions regarding income eligibility assessment and procedures for documentation on the Client Registration/Income Assessment Form, CHR-2, earlier this chapter.