



## SLIDING SCALE FEE PROGRAM AGREEMENT

**NOTE:** Anyone applying for this program is asked to review this document thoroughly and return it, signed and dated, along with completed program application and supporting documents to any CASA-Trinity location or mail to CASA-Trinity, Inc. Billing Department, 45 Maple Street, Dansville, NY 14437.

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CASA-Trinity, Inc. offers a “Sliding Scale Fee Program” based on a person’s ability to pay for services and does not discriminate based on age, gender, race, sexual orientation, creed, religion, disability, or national origin. In order to qualify for a “Sliding Scale Fee Program” the client must have had previously applied for insurance and got denied or have no behavioral health benefits with their current coverage. The program is based on Federal Poverty Guidelines which can be found online at <http://aspe.hhs.gov/poverty>. No one will be denied service based on financial means.

### The following guidelines are to be followed in providing the Sliding Scale Fee Program.

#### NOTIFICATION:

CASA-Trinity, Inc. informs patients about the “Sliding Scale Fee Program” upon admission. Information can also be accessed in the front lobby area or with front desk staff. Assistance in filling out the form is available and all applications are confidential.

#### REQUEST FOR DISCOUNT:

Requests to participate in the “Sliding Scale Fee Program” may be made by patients, family members, social services staff or others who are aware of existing financial hardship. Discounts are offered based on family size and annual income. This form must be completed every 12 months and when a financial income change occurs. The discount applies to clinic services except for services or equipment purchased externally such as laboratory testing and medications.

#### ADMINISTRATION:

Participation in the “Sliding Scale Fee Program” is administered through the CASA-Trinity Billing Department.

#### ALTERNATIVE PAYMENT SOURCES:

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

#### COMPLETION OF APPLICATION:

The patient/responsible party must complete the "Sliding Scale Fee Program" application in its entirety. Assistance in filling out the application is available if needed, upon request.

- By signing the program application, persons authorize CASA-Trinity, Inc. access in confirming income as disclosed on the application form.
- Providing false information will result in all Sliding Scale Fee Program discounts being revoked and the full balance of the account(s) restored and payable immediately.
- If an application is unable to be processed due to the need for additional information, the applicant has two weeks from the date of notification to supply the necessary information without having the date on their application adjusted.
- If a patient does not provide the requested information within the two-week time period, their application will be re-dated to the date on which they supply the requested information.
- Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the program.

#### ELIGIBILITY:

Eligibility is based on income and family size only, based Census Bureau definitions of each.

- Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family.
- Income includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. \*\*\*Noncash benefits (such as food stamps and housing subsidies) do not count.

#### INCOME VERIFICATION:

Applicants must provide one of the following:

- 3 current pay stubs
- SSI, SSD Bank Accounts
- or Form 4506-T (if W-2 not filed) if self employed

Self-employed individuals will be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income, and why (s)he is unable to provide independent verification. This statement will be presented to CASA-Trinity's CEO or his/her designee for review and final determination as to the

sliding fee percentage. Self-declared patients will be responsible for 100 percent of their charges until management determines the appropriate category.

#### DISCOUNTS:

Patients who qualify based on the latest federal poverty guidelines will be charged according to the attached sliding fee schedule. The “Sliding Scale Fee Program” will be updated during the first quarter of every calendar year with the latest federal poverty guidelines, <http://aspe.hhs.gov/poverty>.

#### NOMINAL FEE:

Patients with incomes at or below 100% of poverty will be assessed a \$10 nominal charge per visit. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

#### APPLICANT NOTIFICATION:

Program determination will be provided to the applicant(s) in writing, and will include the percentage of “Sliding Scale Fee Program” write off, or, if applicable, the reason for denial. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. Applicant is required to notify the agency when there have been significant changes in family income. If a sliding scale participant fails to notify, the sliding scale arrangement may be revoked. When the applicant reapplies, the look back period will be the lesser of one month or the expiration of their last Sliding Scale Fee Program application.

#### RECORD KEEPING:

Information related to “Sliding Scale Fee Program” decisions will be maintained by the Billing Department and preserved in an electronically archived centralized confidential file.

#### COLLECTIONS:

Clients are billed for any outstanding account balance monthly. Upon discharge, the client will be given 30 days to pay off their account. If we do not receive payment or a payment agreement request, the client will be issued a 30-day collection letter. If still no response after 30 days, the client will be sent to collections

#### POLICY & PROCEDURE REVIEW:

Annually, the amount provided will be reviewed by the CEO/CFO. The “Sliding Scale Fee Program” Policy will be updated based on the current Federal Poverty Guidelines. Pertinent information comparing amount budgeted and actual community care provided shall serve as a guideline for future planning. This will also serve as a discussion base for reviewing possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.

I understand this policy and I have read and understand the terms of this agreement.

\_\_\_\_\_  
**Client Name – Please Print**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

**FOR INTERNAL USE ONLY**

\_\_\_\_\_  
**Billing Supervisor Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**CFO Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Clinical Supervisor**

\_\_\_\_\_  
**Date**