I. POLICY ON THE SLIDING SCALE PROGRAM

1. Only patients who meet eligibility standards for the San Francisco County Sliding Scale Program will be eligible for sliding scale fees for services provided by the Community Health Network providers.
   - San Francisco General Hospital Medical Center
   - Castro/Mission Health Center
   - Maxine Hall Health Center
   - Silver Avenue Family Health Center
   - Chinatown Public Health Center
   - Ocean Park Health Center
   - Potrero Hill Health Center
   - Southeast Health Center
   - Tom Waddell Health Center
   - Cole Street Health Center
   - Larkin Street Health Center
   - Balboa Teen Clinic
   - North of Market Senior Center

2. Patients will be eligible for sliding scale fees only for medically necessary services, as defined by Medi-Cal program guidelines.

3. Only patients with verified incomes below one hundred percent (100%) of the Federal Poverty Level will be eligible for free care.

4. Patients will be asked to complete an application and provide verifications in order to qualify for the sliding scale. The application may take place at the point of pre-registration, registration or at a later date when appropriate. The patient must provide all information required by the eligibility worker.

5. **Eligibility Requirements**
   All of the requirements listed below (A - F) must be met to qualify for the San Francisco County Sliding Scale Program.
A. **IDENTIFICATION**
The patient must provide acceptable identification.

Acceptable Documents include:

Drivers License  
California or other State ID  
Military ID  
Permanent Resident or Employment Authorization card  
Employment Picture ID  
Student Picture ID  
Credit Union Picture ID  
Credit Card with Picture  
Passport  
Other forms of positive ID

B. **SAN FRANCISCO RESIDENTS**
The patient must provide acceptable verification of San Francisco residence.

Acceptable verifications of San Francisco residence include:

California Driver’s License  
California ID  
Rental agreement  
Property Tax Bill  
Current Utility Bill  
Current Bank Statement  
Affidavit of support from a friend or relative who provides one of the above or other acceptable verifications of address.

Situations in which the residence requirement will be considered unmet

Bad Addresses:
If a bill is returned to the CHN Business Office as “undeliverable,” the case will be flagged on the registration screen. At the next episode of service, the Eligibility Worker will discuss the returned bill with the patient and request current address verification before considering the patient for the sliding scale.

Tourists:
A person who has entered the US on a tourist visa (B-1 or B-2) and is holding an INS Form I-94 showing current status as a tourist is not eligible for the sliding scale.

C. **INCOME**
The patient must declare and provide verification of prior gross monthly income of under 500% of the Federal Poverty Level.

Acceptable verifications of income include:

- Wage stubs (recent)
- Tax return (mandatory if requested by the EW)
- Award letters Social Security, SSI, State Disability, UIB
- Pension check
- Employer verification
- Affidavit of support from a friend or relative.

D. **ASSETS**
The patient must have financial resources within Medi-Cal guidelines for real and personal property. (Revised periodically by the Medi-Cal program) To qualify for the Sliding Scale program for inpatient services the patient’s liquid assets must also be within Medi-Cal guidelines. For Outpatient and Emergency services the patient’s liquid assets must not exceed an amount equal to one hundred percent of the Federal Poverty Level. For the purposes of the sliding scale program, liquid assets are considered to be: cash; checking accounts; savings accounts; money market funds; certificates of deposits; annuities; stocks, bond or mutual funds that are not part of an Employer sponsored retirement account.

Acceptable verifications include:

- Bank statements
- Bank books
- Letters from a bank
- Financial statements
- Stock certificates
- Medi-Cal application verifications.

E. **COOPERATION**
The patient must fully cooperate with pursuing other sources of reimbursement, which could reasonably be expected to pay for the services provided. Cooperation includes providing all required
information on other coverage, pursuing third party liability, and applying for any programs for which he or she is potentially eligible.

6. Length of Enrollment
Upon completion of enrollment requirements, eligible patients will be enrolled in the program for ninety days. The patient’s eligibility for the sliding scale may be terminated at an earlier date if the patient becomes eligible for other sources of payment or there is a change in residence income or assets that would disqualify the patient from participation.

7. Charity Care
Patients who do not qualify for discounts under the terms of the Sliding Scale program may request reductions to their bills through the Charity Care policies of each participating location.

II. PROCEDURES FOR SLIDING SCALE FEES.

1. Minimum verification requirements:

**SFGH Emergency Department**

Identification
Completion of sliding scale screening process

**CHN Outpatient Clinics**

Identification
Address verification
Completion of sliding scale screening process
Verification of income and assets

**Inpatient Emergency Admissions**

Identification
Address verification
Completion of sliding scale screening process
Verification of income and assets (brought in during Hospitalization or sent to eligibility worker within 5 days of discharge)
Elective Admissions, Come and Go, Special Procedures

Identification
Address verification
Completion of sliding scale screening process
Verification of income and assets prior to scheduling of services.

CHN Business Office

Identification
Address verification
Completion of sliding scale screening process
Verification of income and assets.

In all areas, unsponsored indigent patients will be assigned a self pay financial class when they are not able to complete the sliding scale screening process or present verifications if requested. Eligibility workers will advise patients of the appropriate procedure for providing the verifications later for possible adjustment of the bill.

2. Other coverage deductibles

If a patient has verified active third party coverage which does not fully cover the charges, and there is a deductible or co-pay amount owed by the patient, the sliding scale may be applied to the balance if the patient is otherwise eligible. This applies to MediCare deductibles, insurance deductibles and Medi-Cal shares of cost.

3 Adjustments of bill to the sliding scale

If the patient has received a full bill or needs an eligibility re-evaluation for any reason, he or she may be evaluated for the sliding scale by the CHN Business Office within thirty (30) days of receipt of the bill. After that time, the bills may be sent to collection agencies.

When the patient meets the financial criteria for the sliding scale, but another potential source of payment has been identified, the bill may be adjusted to a sliding scale fee by Eligibility or Business Office staff at a later time under the following conditions:
There is verification that the patient has applied for a program and been found ineligible for reasons other than non-cooperation or in the case of Medi-Cal excess real or personal property.

or

Other coverage has not reimbursed, for example, insurance denies payment for a pre-existing condition.

4. Collection agencies

Once a bill has been transferred to an agency for collection, the patient will be directed to work out a payment plan with the agency.

5. Continuation of care

San Francisco residents who have outstanding bills will continue to receive services and will be encouraged to work out payment plans with the CHN Business Office or collection agencies.

III. CHN ELIGIBILITY, BILLING AND COLLECTION POLICIES

1. Eligibility Determinations

Eligibility staff will conduct an eligibility screening of all patients presenting for services. The screening may take place before or after services are provided.

Based on information from the patient or family members, the eligibility worker will identify all sources of coverage for services. and will determine if patients are potentially eligible to apply for any reimbursement programs.

Eligibility staff will advise patients of the CHN eligibility/billing policies and procedures that apply to their cases.

Eligibility staff will request patient cooperation in providing any required information and applying for reimbursement programs.

Unsponsored patients who decline to provide information required for an eligibility determination will be billed in full.

2. Billing/Collection Policies
A. Elective Admissions, Come and Go, Come and Stay, and Special Procedures.

**Third Party Reimbursement**
Patients who have been referred for pursuit of third party reimbursement will be responsible for providing eligibility staff with the required information, for example, Medi-Cal Benefits Identification Card, copies of applications, notices of approval or denial of benefits, insurance information, names of attorneys for lawsuits, etc. before services are scheduled.

Patients who fail to cooperate with pursuit of third party reimbursement will be asked to make full payment in advance. If the advance payment is waived for medical urgency, the patient will remain liable for full charges.

**Non SF residents/HMO members**
Unsponsored out of county patients and members of health maintenance organizations will be denied non emergency services, unless there is authorization for payment from the county or health plan, or the patient makes advance payment of estimated full charges.

**Self Pay Patients**
Self pay patients who are scheduled for cosmetic procedures or non-urgent procedures will be asked for full payment in advance.

In most cases, services will be deferred until full payment is made. Exceptions based on medical urgency can be made by Utilization Review Admitting Nurse.

**Sliding Scale Patients**
The eligibility worker will ask patients to pay the full amount of the sliding scale fee in advance of scheduling procedures.

**Waiver of Deposit**
Patients may request a waiver of deposit if they are unable to pay. The decision to waive the deposit will be made by the Eligibility Manager and the Utilization Review Admitting Nurse based on the circumstances of the case and the degree of medical urgency. Patients will be responsible for payment of the sliding scale fee after the procedure.

In some cases, services may be deferred until the patient is able to pay the deposit.

B. Emergency Admissions
Third Party Reimbursement
Patients who have been referred for pursuit of third party reimbursement will receive bills. They will be responsible for providing Eligibility Worker or Business Office staff with the required information, for example, Medi-Cal Benefits Identification Card, copies of applications, notices of approval or denial of benefits, insurance information, names of attorneys for lawsuits, etc.

Patients who fail to provide information necessary for billing a third party or making an eligibility determination will be responsible for full charges.

Unsponsored non San Francisco residents
Unsponsored persons who are not residents of San Francisco will be billed in full.

Patients who are unsponsored residents of other California counties will be transferred to the appropriate county facility for non-emergency services or for follow-up care after emergency treatment at SFGH unless it is medically contraindicated.

HMO Members
Whenever possible, patients who are members of health maintenance organizations that do not contract with CHN will be transferred to the appropriate facility for non emergency care.

SFGH will bill the HMO directly whenever possible. Otherwise patients will be billed in full and be responsible for obtaining reimbursement from the HMO.

Payment Plans
Patients who are billed in full or on the sliding scale will be responsible for arranging payment plans with the CHN Business Office.

C. Outpatient Clinics and Emergency Room

Third Party Reimbursement
Patients who have been referred for pursuit of third party reimbursement will receive interim bills. They will be responsible for providing Eligibility Worker or Business Office staff with the required information, for example, Medi-Cal Benefits Identification Card, copies of applications, notices of approval or denial of benefits, insurance information, names of attorneys for lawsuits, etc.

Patients who fail to cooperate with the process will be responsible for payment in full.
Unsponsored out-of-county residents
Unsponsored persons who are not residents of San Francisco will be billed in full for emergency services, and will be referred to their own counties for non-emergency care unless they can make payment in full in advance.

Payment Plans
Patients who are billed in full or on the sliding scale will be responsible for arranging payment plans with the CHN Business Office.

D. Business Office

Third Party Liability Cases
If the Business Office is notified that a patient has failed to cooperate with pursuit of third party reimbursement, the patient will be responsible for payment in full.

Adjustments
If a patient did not complete the sliding scale screening process at the time of service, he/she will be asked to provide verifications to determine eligibility for adjustments of bills to sliding scale fees.

Refunds
If a patient has made any payment the Business Office will not make refunds unless all the active patient accounts together show a credit. If an insurance later makes a payment or a procedure is canceled, the patient’s payment will be applied to any outstanding balance on other accounts.

3. Special Situations

Spend Down of excess assets for Medi-Cal

If a patient has excess assets that make him or her ineligible for Medi-Cal, the eligibility worker will explore the possibility of a spend down of assets to qualify for Medi-Cal. In many cases this will be the best course, because the patient may need extensive ongoing treatment and be clearly linked to Medi-Cal by a disability. Generally, the patient will be expected to spend down the assets during the month of service to qualify for Medi-Cal or be billed in full.

Refusal to apply for Medi-Cal

Occasionally a patient who is otherwise qualified for Medi-Cal, may not wish to apply for Medi-Cal, upon the determination by an Eligibility Supervisor that the patient has a valid reason to refuse Medi-Cal and after
the patient has been counseled regarding Medi-Cal, such patients may be given a sliding scale fee. This will not apply to inpatient, come and go, or come and stay procedures.

4. Eligibility for tertiary care

   A. CHN staff will authorize payment of county funds for tertiary care at the University of California, San Francisco Medical Center for patients who meet the following criteria:

      1) Age 21 through 64.
      2) Has no current coverage for the services.
      3) Has pursued and exhausted all other reimbursement programs.
      4) Meets sliding scale eligibility requirements.
      5) Is a current CHN patient referred to UCSF by an CHN physician, with approval by CHN Utilization Review.

   All other CHN patients referred to UCSF for non-emergency specialty care will be directed to apply for Medi-Cal or other reimbursement programs, or to make other financial arrangements with UCSF.

   B. The scope of tertiary care services for which the CHN will authorize payment will be limited to specific medically necessary services which are unavailable through CHN and which are designated by CHN as covered services under a contract with UCSF, or services which have been approved by CHN Utilization Review on a case by case basis.

5. Charity Care

Due to limited resources only residents of the City and County of San Francisco may receive benefits under the Sliding Scale and Charity Care Programs. Residents of other counties may be considered for assistance under the Charity Care Program, but will have a lower priority than residents of the City and Country of San Francisco.

- Charity Care allowances will be considered only when the patient is unable to obtain any other source of assistance.
• Charity care is distinguished from bad debt which results from an unwillingness to pay.

• The use of Charity Care allowances will take into account
  The amount owed by the patient/guarantor in relation to his/her total means
  The medical status of the patient and/or guarantor
  Other factors which demonstrate that payment of the full amount owed would create a catastrophic hardship for the patient or guarantor.

• Applicant must comply with verification requirements

• Charity Care allowances require the approval of PFS managers as detailed in the regulations of the Charity Care Program.