UCHC POLICY / PROCEDURE MEMORANDUM

Check Which Applies: ☒ **Corporate Policy / Procedure**
☐ **Departmental Policy / Procedure**

TO: **Controller, Operations Manager Division One, Operations Manager Division Four, EDP/Billing Supervisor, Financial Analyst, Reception Supervisor, Registration & Call Center Supervisor**

SUBJECT: **Credit and Collection Policy, August 2016**

POLICY#:

DATE ISSUED: **8/5/2016**

EFFECTIVE DATE: **Immediate**

SUPERCEDES / REVISES: **Revises Credit and Collection Policy, March 2015**

WRITTEN BY: **Project Manager**

APPROVED BY: **CEO**

INTRODUCTION: **It is the policy of Upham's Corner Health Center to provide affordable health care. The policy attached describes how the health center ensures affordable care for all patients.**

POLICY: **Policy described below.**

PROCEDURE: **Procedure described below.**

APPLICABILITY:

EXCEPTIONS: **None**

CC:

Department Heads and Supervisors are responsible for making the appropriate staff members aware of this policy / procedure.

Upham's Corner Health Center
Credit and Collection Policy
Revised August 2016

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1. General Filing Requirement *613.08(1)(c*

1.1 The Upham's Corner Health Center will electronically file its Credit & Collection Policy with the Health Safety Net (HSN) Office within 90 days of adoption of amendments to this regulation that would require a change in the Credit & Collection Policy; when the health center changes its Credit & Collection Policy; or when requested by the HSN Office .

2. General Definitions *613.02*

2.1 Emergency Services – N/A

2.2 The Urgent Care Services Definition used to determine allowable Bad Debt under *613.06 is:* Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

3. General Collection Policies & Procedures *613.08(1)(c)2 and 613.04(6)(c)3*

3.1 Standard Collection Policies and Procedures for patients *613.08(1)(c)2a*

(a) The health center makes reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. The center's staff request proof of insurance from all first-time patients. The health center registers and records all patient information including proof of insurance electronically. Patients who are uninsured or who have an inactive insurance are instructed to visit the Benefits Office for Mass Health, Health Safety Net Trust Fund, or Sliding Scale eligibility in order to avoid receiving a bill for the full amount of the visit. See attachment #1 for Sliding Scale Fee Schedule. The patient will also be instructed to bring necessary documentation, such as proof of residency and proof of income, to this screening. The Benefits Office staff members are directed to counsel and/or enroll eligible patients into the most appropriate health insurance program to meet their needs.

A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer. Health center staff ask returning patients, at the time of visit, whether there have been any changes in their income or insurance coverage status. If there has been a change, the new information is recorded in the center's practice management system and the patient advised or assisted to inform MassHealth of the change.

(b) The health center undertakes the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available:

(1) an initial bill is sent to the party responsible for the patient's financial obligations;

(2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality are sent;

(3) efforts to locate the patient or the correct address on mail returned as an incorrect

address are documented, and

(4) a final notice is sent by certified mail for balances over $1000, where notices have not been returned as an incorrect address or as undeliverable.

(c) Cost Sharing Requirements. Health center staff inform patients who are responsible for paying co-payments in accordance with 101 CMR 613.04 (6)(b) and deductibles in accordance with 101 CMR 613.04(6)(c), that they will be responsible for these co-payments.

(d) Low Income Patient Co-Payment Requirements. The health center requests co-payments of $1 for antihyperglycemic, antihypertensive, and antihyperlipidemic generic prescription and $3.65 for generic and brand-name drugs from all patients over the age of 18, with the exception of pregnant or postpartum women, up to a maximum pharmacy co-payment of $250 per year.

(e) Health Safety Net - Partial Deductibles/Sliding Fees: For Health Safety Net - Partial Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL, the health center determines their deductible (40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL). If any member of the PBFG has an FPL below 150.1 % there is no deductible for any member of the PBFG. The Patient is responsible for 20% of the HSN payment for all services, with the exception of pharmacy services, provided up to this Deductible amount. Once the Patient has incurred the Deductible, the patient is no longer required to pay 20% of the payment. Only one Deductible is allowed per PBFG approval period.

3.2 Policies & Procedures for Collection Financial Information from patients

613.08(1)(c)2b

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth/Connector Care Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 515.000.

(a) Determination Notice. The Office of Medicaid or the Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.

(b) The Division's Electronic Free Care Application issued under 101 CMR 613.04(2)(b)(3) may be used for the following special application types:

a. Minors receiving Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process.

613.04(3)a

b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address.

613.04(3)b

Presumptive Determination. An individual may be determined to be a Low Income Patient for a limited period of time, if on the basis of attested information submitted to the health center on the form specified by the Health Safety Net Office, the Provider determines the individual is presumptively a Low Income Patient, The health center will submit claims for Reimbursable Health Services provided to individuals with time-limited presumptive Low Income Patient determinations for dates of service beginning on the date on which

the Provider makes the presumptive determination and continuing until the earlier of: a. The end of the month following the month in which the Provider made the presumptive determination if the individual has not submitted a complete Application, or b. The date of the determination notice described in 101 CMR 613.04(2)(a) related to the individual's Application. *613.04 (4)*

3.3 Emergency Care Classification - NA

3.4 Policy for Deposits and Payment Plans *613.08(1)(c)2d*

The health center's billing department provides and monitors Deposits and Payment Plans as described in **Section 5** of this policy for qualified patients as described in 101 CMR 613.08. Each payment plan must be authorized by the Controller.

3.5 Copies of Billing Invoices and Notices of Assistance *613.08(1)(c)2e*

(a) Billing Invoices: The following language is used in billing statements sent to low income patients: "**Financial assistance may be available. Please call (617) 825-9205 Extension 10, 11, or 19 for additional information regarding health safety net insurance**."

(b) Notices: The Health center provides all applicants with notices of the availability of financial assistance programs, including MassHealth, subsidized Health Connector Programs, HSN and Medical Hardship, for coverage of services exclusive of personal convenience items or services, which may not be paid in full by third party coverage. The center also includes a notice about Eligible Services and programs of public assistance to Low Income Patients in its initial invoices, and in all written Collection Actions. All applicants will be provided with individual notice of approval for Health Safety Net or denial of Health Safety Net once this has been determined. The following language is used in billing statements sent to low income patients: "If you are unable to pay this bill, please call (617) 825-9205 Extension 10, 11, or 19 for additional information regarding health safety net insurance." The Health center will notify the patient that the Provider offers a payment plan if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(c) Signs: The Health center posts signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance and programs of public assistance and the location of the Benefits Office to apply for such programs. Signs will be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices are posted in English, Spanish, and Portuguese.

3.6 Discount/Charity Programs for the Uninsured *613.08(1)(c)2f*

The health center offers Sliding Fee Discounts to patients who are ineligible for the Health Safety Net. For these patients, the health center offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 150.1% of the FPIG.

It is standard protocol to first determine if a patient is eligible for MassHealth, Commonwealth Care or Health Safety Net (or other applicable coverage type options). The Sliding Fee Scale eligibility is only used in cases when a patient is not eligible for other subsidized insurance types. In addition, in cases when a patient goes to the Benefits Department and is unable to obtain immediate eligibility determination/coverage, the patient

is assessed charges for that day's visit based on the sliding fee scale. The sliding fee scale is based on the patient's "income" and "family size" using the board-approved definitions of each. Please see Page 15-16 for current sliding fee scale.

3.7 Hospital deductible payment option at HLHC – NA

3.8 *Full or 20% Deductible Payment Option for all Partial HSN Payments at HLCH Satellite or Student Health Center – NA*

3.9 Community Health Center (CHC) charge of 20% of deductible per visit to all partial HSN patients *613.04(6)(c)5a*

The health center charges HSN-Partial Low Income Patients 20% of the HSN payment for each visit, to be applied to the amount of the Patient's annual Deductible until the patient meets the Deductible.

3.10 Direct Website(s) (or URL(s)) where the provider's Credit & Collection Policy, Provider Affiliate List (if applicable) and other financial assistance Policies are posted

Uphams.org

3.11 Provider Affiliate List effective the first day of the acute hospital's fiscal year beginning after December 31, 2016 - NA

4. Collection of Financial Information *613.06(1)(a)*

4.1 Inpatient, Emergency, Outpatient & CHC Services: *613.06(1)(a)1* The Health center makes reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.

4.2 Inpatient Verification - NA

4.3 Outpatient/CHC Financial Verification *613.06(1)(a)2b*

The Health center makes reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:

1. Verification of gross monthly-earned income is mandatory. When possible this is done through electronic data matching using the eligibility procedures and requirements under 130 CMR 502 or 516. If the information received is not compatible or is unavailable, the following are required:

a. Two recent pay stubs;
b. A signed statement from the employer; or
c. The most recent U.S. tax return.

2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:

a. A copy of a recent check or pay stub showing gross income from the source;
b. A statement from the income source, where matching is not available;
c. The most recent U.S. Tax Return.

3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

5. Deposits and Payment Plans *613.08(1)(f)*

5.1 The health center does not require pre-treatment deposits from Low Income patients. *613.08(1)(g)1*

5.2 Deposit Requests for Low Income Patients: The Health center does not require a deposit from individuals determined to be Low Income Patients *613.08(1)(g)2*

5.3 Deposit Requirement for Medical Hardship Patients: The Health center does not require a deposit from patients eligible for Medical Hardship. *613.08(1)(g)3*

5.4 Interest Free Payment Plans on Balances less than, and greater than, $1000 The Health center will offer payment plans to Low Income and Medical Hardship patients with balances interest-free payment plans with monthly payments of no more than $25. If the balance is less than $1000, this will be for one year; if it is greater than $1,000 it will be for two years. . *613.08(1)(g)4*

6. Populations Exempt from Collection Action *613.08(3)& 613.05(2)*

6.1 MassHealth, Emergency Aid to the Elderly, Disabled, and Children EAEDC enrollees: The health center does not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, except that the health center may bill patients for any required co-payments and deductibles. The Health center may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Health center will cease its collection activities. *613.08(3)(a)*

6.2 Participants in Children's Medical Security Plan (CMSP) with Modified Adjusted Gross Income (MAGI) under 300% FPL: are also exempt from Collection Action. The Health center may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Health center will cease all collection activities. *613.08(3)(b)*

6.3 Low Income Patients except Dental-only Low Income Patients.

Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income equal or less than 150.1% of the FPL, are exempt from Collection Action for any Eligible Services rendered by the Health center during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. The Health center may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. *613.08(3)(c)*

6.4 Low Income Patients with HSN Partial

Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 200.1% and 300.1% of the FPL are exempt from Collection Action for the portion of their bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 101 CMR 13.04(6)(b) and (c). The Health center may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated. *613.08(3)(d)*

6.5 Low Income Patient Consent to billing for non-reimbursable services: The Health center may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed in writing to be responsible. 613.08(3)(e)
6.6 Low Income Patient Consent Exclusion for Medical Errors, including Serious Reportable Events (SRE
The health center will not bill low income patients for claims related to medical errors occurring on the health center's premises. *613.08(3)(e)1*
6.7 Low Income Patient Consent Exclusion for Administrative or Billing Errors The health center will not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error. *613.08(3)(e)2*
6.8 Low income Patient Consent for CommonHealth one-time deductible billing. At the request of the patient, the health center may bill a low-income patient in order to allow the patient to meet the required CommonHealth one-time deductible as described in 130 CMR 506.009. *613.08(3)(f)*
6.9 Medical Hardship Patient & Emergency Bad Debt Eligible for Medical Hardship: The Health center will not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. *613.08(3)(g*).
6.10 Provider Fails to Timely Submit Medical Hardship Application
The health center will not undertake a collection action against any individual who has qualified for Medical Hardship with respect to any bills that would have been eligible for HSN payment in the event that the health center has not submitted the patient's Medical Hardship documentation within 5 days. *613.05(2).*

7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt *613.06(1)(2)(3) and (4)*
The Health center makes the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications.

The minimum requirements before writing off an account to the Health Safety Net include:
7.1 Initial Bill: The health center sends an initial bill to the patient or to the party responsible for the patient's personal financial obligations. *613.06(1)(a)3bi*
7.2 Collection action subsequent to Initial Bill: The health center will use subsequent bills, phone calls, collection letters, personal contact notices, and any other notification methods that constitute a genuine effort to contact the party responsible for the bill. 6*13.06(1)(a)3bii*
7.3 Documentation of alternative collection action efforts: The health center will document alternative efforts to locate the party responsible or the correct address on any bills returned by the USPS as "incorrect address" or "undeliverable." *613.06(1)(a)3biii*
7.4 Final Notice by Certified Mail: The health center will send a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable" *613.06(1)(a)3biv*
7.5 Continuous Collection Action with no gap exceeding 120 days: The health center will document that the required collection action has been undertaken on a regular basis and , to the extent possible, does not allow a gap in this action greater than 120 days. If, after reasonable

attempts to collect a bill, the debt for an Uninsured Patient remains unpaid for more than 120 days, the health center may deem the bill to be uncollectible and bill it to the Health Safety Net Office. *613.06(1)(a)3bv*

7.6 Collection Action File The health center maintains a patient file which includes documentation of the collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made. *613.06(1)(a)3d*

7.7 Emergency Bad Debt Claim and EVS Check – NA

7.8 HLHC Bad Debt Claim and EVS Check – NA

7.9 CHC Bad Debt Claim and EVS Check. The health center may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

(a) The services were provided to:

1. An uninsured individual who is not a Low Income Patient. The health center will not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. The health center will not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or

2. An uninsured individual whom the health center assists in completing a MassHealth application and who is subsequently determined into a category exempt from collection action. In this case, the above collection actions will not be required in order to file.

(b) The Health center provided Urgent Services as defined in 101 CMR 613.02 to the patient. The Health center may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.

(c) The responsible provider determined that the patient required Urgent Services. The health center will submit a claim only for urgent care services provided during the visit.

(d) The Health center undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and

(e) The bill remains unpaid after a period of 120 days. 613-06(4)

8. Available Third Party Resources *613.03(1)(c)3*

8.1 Diligent efforts to identify & obtain payment from all liable parties: The health center will make diligent efforts to identify and obtain payment from all liable parties. *613.03(1)(c)3*

8.2 Determining the existence of insurance, including when applicable motor vehicle liability:

In the event that a patient seeks care for an injury, the health center will inquire as to whether the injury was the result of a motor vehicle accident; and if so, whether the patient or the owner of the other motor vehicle had a liability policy. The health center will retain evidence of efforts to obtain third policy payer information. *613.03(1)(c)3a*

8.3 Verification of patient's other health insurance coverage: At the time of application, and when presenting for visits, patients will be asked whether they have private insurance. The health center will verify, through EVS, or any other health insurance resource available to the health center, on each date of service and at the time of billing. *613.03(1)(c)3b*

8.4 Submission of claims to all insurers: In the event that a patient has identified that they have private insurance, the health center will make reasonable efforts to obtain sufficient information to file claims with that insurer; and file such claims. *613.03(1)(c)3c*

8.5 Compliance with insurer's billing and authorization requirements: The health center will comply with the insurer's billing and authorization requirements. *613.03(1)(c)3d*

8.6 Appeal of denied claim. The health center will appeal denied claims when the stated purpose of the denial does not appear to support the denial. *613.03(1)(c)3e*

8.7 Return of HSN payments upon availability of 3rd-party resource: For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the health center will promptly report the recovery to the HSN. *613.03(1)(c)3f*

9. Serious Reportable Events (SRE) *613.03(1)(d)*

9.1 Billing & collection for services provided as a result of SRE: The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services provided as a result of a SRE occurring on premises covered by a provider's license, if the provider determines that the SRE was: a. Preventable; b. Within the provider's control; and c. Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (c). *613.03(1)(d)1*

9.2 Billing & collection for services that cause or remedy SRE: The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 120.332 for services directly related to: a. The occurrence of the SRE;
b. The correction or remediation of the event; or c. Subsequent complications arising from the event as determined by the Health Safety Net office on a case-by-case basis. *613.03(1)(d)2*

9.3 Billing and collection by provider not associated with SRE for SRE-related services: The health center will submit claims for services it provides that result from an SRE that did not occur on its premises *613.03(1)(d)3*

9.4 Billing & collection for readmission or follow-up on SRE associated with provider: Follow-up Care provided by the health center is not billable if the services are associated with the SRE as described above. *613.03(1)(d)4*

10. Provider responsibilities *613.08(1)(a)(b) & (h)*

10.1 Non-discrimination: The health center shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status. 613.08(1)(a)

10.2 Board Approval Before seeking legal execution against patient home or motor vehicle. Before seeking legal execution against a low-income patient' s home or motor vehicle, the health center requires its Board of Directors to approve such action on an individual basis. *613.08(1)(b)*

10.3 Advise patient on TPL duties and responsibilities: The health center will advise patients of the responsibilities described in 101 CMR 613.08(2) at the time of application and at subsequent visits. *613.08(1)(h)*

11. Patient Rights and Responsibilities *613.08(1)(2)*

11.1 Provider Responsibility to advise patient on right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship: The health center informs all patients of their right to apply for MassHealth, Health Connector Programs, HSN, and Medical Hardship. *613.08(2)(a)1*

11.2 Provider responsibility to provide individual notice of eligible services and programs of public assistance during the patient's initial registration with the provider. The health center informs all Low Income Patients and patients determined eligible for Medical Hardship of their right to a payment plan as described in 101 CMR 613.08(1)(f). *613.08(1)(e)2a*

11.3 Provider responsibility to provide individual notice of eligible services and programs of public assistance when a provider becomes aware of a change in the patient's eligibility for health insurance coverage: The health center provides patients with individual notices of eligible services and programs of public assistance when we become aware of a change in the patient's eligibility for health insurance coverage. *613.08(1)(e)2c*

11.4 Provider responsibility to advise patient of the right to a payment plan: The health center advises patients of their right to an payment plan. 613.08(2)(a)2

11.5 Provider responsibility to advise patient on duty to provide all required documentation: The health center advises patients of their duty to provide all required documentation. *613.08(2)(b)1*

11.6 Provider responsibility to advise patient of duty to inform of change in eligibility status and available third party liability (TPL): The health center informs all patients that they have a responsibility to inform the health center and/or MassHealth when there has been a change in their MassHealth MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.04(1), insurance coverage, insurance recoveries, and/or TPL status. *613.08(2)(b)2*

11.7 *Provider responsibility to* advise patient on duty to track patient deductible: At the time of application, Low Income Partial patients are advised that it is their responsibility to track expenses toward their deductible and provide documentation to the health center that the deductible has been reached when more than one family member has been determined to be a Low Income Patient or if the patient or family members receive Eligible Services from more than one provider. *613.08(2)(b)3*

11.8 Provider responsibility to inform the HSN Office or MassHealth of a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to inform the HSN Office or MassHealth of a TPL claim/lawsuit as well as to: *613.08(2)(b)4*

11.9 Provider responsibility to advise patient on duty to file TPL claims on accident, injury of loss: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to file TPL claims.*613.08(2)(b)4a.*

11.10 Provider responsibility to inform patient on Assigning the right to recover HSN payments from TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to assign the right to recover HSN payments from the TPL proceeds. *613.08(2)(b)4bi*

11.11 Provider responsibility to inform patient to provide TPL claim or legal proceedings information: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to provide TPL claims or legal proceedings information. *613.08(2)(b)4bii*

11.12 Provider responsibility advise patient to notify HSN/MassHealth within 10 days of filing a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim,

the health center advises the patient that they are responsible to notify HSN/MassHealth of it within 10 days. *613.08(2)(b)4biii*
11.13 Provider responsibility to advise patient of duty to repay the HSN for applicable services from TPL Proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible for repaying the HSN for applicable services from TPL proceeds. *613.08(2)(b)4biv*
11.14 Provider responsibility to provide individual notice of financial assistance during the patient's initial registration with the provider: The health center provides individual notice of financial assistance during the patient's initial registration. 613.08(1)(e)1a
11.15 Provider's responsibility to provide individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage: The health center provides individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage. *613.08(1)(e)1c*
11.16 Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that recovery from TPL payments is limited to the HSN expenditures for eligible services. *613.08(2)(c)*

12. Signs *613.08(1)(f)*
12.1 Location of the signs The Health center has posted signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and the health center location at which to apply for such programs. *613.08(1)(f)1*
12.2 Size of the Signs: The signs are large enough to be clearly visible and legible by patients visiting these areas. *613.08(1)(f)1*
12.3 Multi-lingual signs when applicable: All signs and notices have been translated into the languages spoken by 10% or more of the residents in our health center's service area. These are: English, Spanish, and Portuguese. *613.08(1)(f)1*
12.4 Wording in Signs: The health center signs notify patients of the availability of financial assistance and of programs of financial assistance. *613.08(1)(f)1*

Wording of signs: "For more information and assistance with insurance coverage options, please contact the UCHC Benefits Office, located at: 415 Columbia Road, 2nd Floor. Phone: 617-287-8000, extension: 8135, 8205, 8002." See Page 12 for complete sign.

12.5 Providers must make their Credit & Collection Policy and provider affiliate list, if applicable, available on the provider's website. 613.08(1)(f)2

Website: Uphams.org

13. Sample Documents & Notices on Availability of Assistance *613.08(1)e) & (f)*
13.1 Sample of Assistance Notice on Billing Invoice Attached Page 13 *613.08(1)(e)1b*

13.2 Sample of Eligible Services and programs of assistance – notice on billing invoice.– Attached Page 13-14*613.08(1)(e)2b [attach}*

13.3 Sample of Assistance notice in collection actions (billing invoices) – Attached Page 13 *613.08 (1)(e)3*

13.4 Sample of Payment plan notice to Low Income or Medical Hardship patients – Attached Page 13-14 *613.08(1)(e)4*

13.5 Sample of Posted Signs –attached Page 12 *613.08(1)(f)*

Authorized Signature: _____

Jagdeep Trivedi, Chief Executive Officer/CEO

As a 330-Supported Health Center, We Promise To:

- ✓ **Serve all patients**
- ✓ **Offer discounted fees for patients who qualify (Sliding Fee Scale)**
- ✓ **Not deny services based on a person's:**
  - Race
  - Color
  - Sex
  - National Origin
  - Disability
  - Religion
  - Sexual orientation
  - Inability to Pay
- ✓ **Accept insurance, including:**
  - Medicaid
  - Medicare
  - Children's Health Insurance Program (CHIP)

For more information and assistance with insurance coverage options, please contact the UCHC Benefits Office, located at: 415 Columbia Road, 2nd Floor.
Phone: 617-287-8000, extension: 8135, 8205, 8002, 8107

Como apoyo de 330 centro de salud, nos comprometemos a:

- ✓ **Servir a todos los pacientes**
- ✓ **Oferta con descuento para los pacientes que califican (escala de tarifa)**
- ✓ **No negar servicios basados en una persona:**
  - Raza
  - discapacidad
  - Color
  - Religión
  - Origen nacional
  - Sexo
  - Orientación Sexual
  - imposibilidad de pagar
- ✓ **Aceptar seguro, incluyendo:**
  - Medicaid
  - Medicare
  - salud infantil
  - Programa de seguro (CHIP)

Para más información y ayuda con opciones de cobertura de seguro, por favor póngase en contacto con la oficina de beneficios de UCHC, ubicado en: 415 Columbia Road, 2nd piso.
Teléfono: 617-287-8000 extension: 8135, 8205, 8002, 8107

Como um centro de saúde de 330-suportes, nós prometemos:

- ✓ **Servir a todos os pacientes**
- ✓ **Oferecer descontos para pacientes que qualificao (taxa de escala)**
- ✓ **Não negar serviços baseados em pessoas com as seguinte caracteristicas:**
  - Raca
  - Cor
  - Sexo
  - Origem nacional
  - Deficiência
  - Religião
  - Orientação Sexual
  - Incapacidade de pagamento
- ✓ **Aceitar seguro, incluindo:**
  - Medicaid
  - Medicare
  - saúde infantil
  - Programa de seguro (CHIP)

Para mais informações e assistência com a cobertura do seguro medico, por favor entre em contato com O escritório de benefícios UCHC, localizado em: 415 Columbia Road, 2nd piso.
Telefone: 617-287-8000, extensão: 8107, 8135, 8205, 8002

Attachment 2

Upham's Corner Health Center

Upham's Corner Health Commitee, Inc.
500 Columbia Road
Dorchester, Massachusetts 02125
Appointments: (617) 287-8000
Business: (617) 825-9205

- MEDICAL CARE
- DENTAL CARE
- HOME HEALTH CARE
- EYE CARE
- MENTAL HEALTH

PATIENT STATEMENT

MAKE CHECKS PAYABLE TO:
Upham's Corner Health Center
IRS #237-211-732

AMOUNT ENCLOSED $_____

ALL CHARGES ARE DUE AND PAYABLE UPON RECEIPT. CHARGES AND PAYMENTS MADEAFTER THE SATEMENT DATE WILL SHOW ON NEXT MONTH'S STATEMENT.

STATEMENT DATE	ACCOUNT NUMBER	

☐ PLEASE INDICATE ANY ADDRESS, NAME OR INSURANCE CHANGE ON THE REVERSE SIDE.

* DETACH HERE AND RETURN THIS STUB WITH PAYMENT

ATE OF SERVICE	DESCRIPTION	AMOUNT CHARGED	AMT. PD. / ADJ.	AMOUNT DUE	ENCOUNTER NO

FINANCIAL ASSISTANCE MAY BE AVAILABLE. PLEASE CALL (617) 825 -9205 EXTENTIONS 10; 11; OR 19 FOR ADDITIONAL INFORMATION REGARDING HEALTH SAFETY NET INSURANCE.

Upham's Corner Health Center
500 Columbia Road
Dorchester, MA 02125

PAYMENT NOTICE

July 22, 2009

Dear Patient,

As of July 1, 2009, if you do not have insurance or if your insurance does not cover the cost of the visit, you will be charged for your next visit according to a Sliding Fee Scale that will be used to determine the amount. Please bring one of the following to your next visit:

1. Proof of your income which can be the last 3 pay stubs from your employer or if you have more than one job from each employer,

or

2. A copy of your W-2 form or a copy of your last year's tax return.

A member of our Benefits Office will determine the fee to be paid that day based upon your proof of income.

The Sliding Fee Scale proof of income system applies to all visits in Urgent Care, Primary Care, Behavioral Health, Home Care, Dental and the Teen Clinic.

If you do not have insurance, the Benefit Office staff will be happy to assist you with applying for Medicaid or Commonwealth Care insurance. The Benefits Office is located on the 2nd floor of the Clinic at 415 Columbia Road. If you have any questions, feel free to contact a member of the Benefits Office at 617-287-8000 Ext. 8205 or Ext. 8002.
Sincerely,

Edward Grimes
Executive Director
Upham's Corner Health Center

UPHAM'S CORNER HEALTH CENTER

617-287-8000

500 COLUMBIA ROAD **DORCHESTER, MA 02125**	**415 COLUMBIA ROAD** **DORCHESTER, MA 02125**	**636 COLUMBIA ROAD** **DORCHESTER, MA 02125**

SLIDING SCALE FEE SCHEDULE

NAME:_____ **CHART/ACCOUNT:** _____

Welcome to the Upham's Corner Health Center:

The Upham's Corner Health Center will bill your insurance company for your visit today. However, if you do not have insurance, or your medical insurance does not cover the service(s) that you are receiving today, a sliding scale of fees is used.

If you cannot afford to pay for care, the health center has a number of government plans that may assist you. These plans are described on the reverse side of this sheet, and a staff person in the Benefits Office will be happy to explain them to you. In order to be eligible for these plans, you must complete the sliding scale below.

A staff person in the Benefits Office will determine the amount you may have to pay based on your proof of income (i.e., W-2 form or tax return form of prior year) and the number of people in your family. For example, if your income every two weeks is $1,000 and there are 3 people in your family, the discounted fee for each visit will be $35.00 per person. This charge will be waived if you are eligible for one of the programs described on the reverse side of this form.

Lab and ancillary charges generated at UCHC will be discounted by the same rate as your visit. If your lab test is sent to an outside lab, you will receive a bill directly from that lab at their prevailing rate. Massachusetts's law requires every resident to have health insurance

Category	**A**	**80%**	**C**	**D**	**E**	**F**
Poverty level	**100%**	**133%**	**150%**	**185%**	**200%**	**>200%**
Discount	**100% Min. fee**	**80%**	**60%**	**40%**	**20%**	**0%**
Charge	**$25**	**$35**	**$70**	**$105**	**$140**	**$175**
Family size						
Single	$0 to $457	$458 to $608	$609 to $685	$686 to $845	$846 to $914	$915 to $1,828
Two in family	$0 to $616	$617 to $819	$820 to $924	$925 to $1,140	$1,141 to $1,232	$1,233 to $2,465
Three in family	$0 to $775	$776 to $1,031	$1,032 to $1,163	$1,164 to $1,434	$1,435 to $1,551	$1,552 to $3,102
Four in family	$0 to $935	$936 to $1,243	$1,244 to $1,402	$1,403 to $1,729	$1,730 to $1,869	$1,870 to $3,738
Five in family	$0 to $1,094	$1,095 to $1,455	$1,456 to $1,641	$1,642 to $2,024	$2,025 to $2,188	$2,189 to $4,375
Six in family	$0 to $1,253	$1,254 to $1,667	$1,668 to $1,880	$1,881 to $2,318	$2,319 to $2,506	$2,507 to $5,012
Seven in family	$0 to $1,413	$1,414 to $1,879	$1,880 to $2,119	$2,120 to $2,613	$2,614 to $2,825	$2,826 to $5,651
Eight in family	$0 to $1,573	$1,574 to $2,092	$2,093 to $2,359	$2,360 to $2,909	$2,910 to $3,145	$3,146 to $6,291
Nine in Family	$0 to $1,733	$1,734 to $2,079	$2,080 to $2,304	$2,305 to $2,339	$2,340 to $2,599	$2,600 to $6,931

I, the undersigned, attest that all the information I have submitted on this form is true and I agree to pay for my health care, or the health care of my family, if needed, at the rate determined by this form. The amount I agree to pay is $_____ per visit, per person.

Date: _____ Signature: _____

UPHAM'S CORNER HEALTH CENTER
617-287-8000

500 COLUMBIA ROAD
DORCHESTER, MA 02125

415 COLUMBIA ROAD
DORCHESTER, MA 02125

636 COLUMBIA ROAD
DORCHESTER, MA 02125

SLIDING SCALE FEE SCHEDULE

NOTICE OF AVAILABILITY OF UNCOMPENSATED CARE

The Upham's Corner Health Center is required by law to give a reasonable amount of its services without charge or at a reduced charge to eligible persons who cannot afford to pay for care. The Upham's Corner Health Center's uncompensated services are limited to ambulatory obstetrical, gynecological, adult medicine and pediatric care.

The Upham's Corner Health Center will make a written conditional or final determination of your eligibility for no charge or reduced charge services within 2 working days after your request OR no later than the end of the next billing cycle if you make your request after you have received services.

COMMONWEALTH OF MASSACHUSETTS REDUCED CHARGES/HEATH SAFETY NET PROGRAM

A person is eligible for reduced charges/health safety net program under the guidelines set forth by the Commonwealth of Massachusetts Reduced Charge Program (MGL c. 118F) if they fall under 200% of the federal poverty income guidelines. They may also be eligible if they fall between 200% and 400% if they face undo medical hardship. If you feel you may fall in these categories, please speak to the receptionist or representative in the Benefits Office (located on 2nd floor of 415 Columbia Rd. Phone: 617-287-8000 X 8205 or 8002). To qualify for this plan you must submit the required financial information.

Family Size	Full Health Safety Net up to These Income Levels	Partial Health Safety Net up to These Income Levels
1	$23,761	$47,520
2	$32,041	$64,080
3	$40,321	$80,640
4	$48,601	$97,200

* Above income standards are effective March 1, 2016 – February 28, 2017