

**District 2 Public Health**  
**Financial Management, Fees and Cash Handling Policy Procedures**  
**-Policy # 191**  
**Effective Sept. 1, 2012**

Revision Effective 5/22/13

*The Code of Federal Regulations (CFR) denotes the rules and regulations of the Office of Management and Budget under the Cost Principles for State, Local, and Indian Tribal Government within the county/district budget (2 CFR Part 225; OMB A-87).*

In order to comply with Federal Regulations, District 2 will adhere to the following policy:

Each month, all county funds generated by Fees for Service will be transferred, by check, into the District's County or Program budget. Funds collected will be used to expand, improve, or offset the cost of county or program service delivery system as documented by Federal Program Report.

**OBJECTIVES FOR COUNTY AND PROGRAM INCOME**

To have a fee collections system that is sensitive to the needs of the client, increases revenues, complies with federal (Title X) and state guidelines, and is supported by all staff. The Policies and Procedures governing the fee system will be administered in a manner that protects the privacy and dignity of the individual. They should also insure that the client understand his/her rights within the system.

The District Office, in collaboration with the local county health departments, shall determine how the generated program income will be utilized within each program. Program income from the previous SFY, may be included in the program budget submitted annually to the State Office. Each Program has specific rules; please see the specific Program Annex for the rules pertaining to the program you are working with.

The District Office should allocate Program grant funds to the county through the programs budget. Individual program county budgets can be established for the sole purpose of accounting for the programs income. All Program income budgets are managed at the District Office.

**District Level Program Income Accounting**

All program income managed at the District level must be reported separately through its own Program name and designated account number. All Programs and their budgets must be loaded into the Uniform Accounting System (UAS). The final GIA program budgets that the District submits to the State office must be aligned with the information in the UAS.

Any amendment to the budget during the SFY must be approved by the State Office and its appropriate Planning program. The program income may be carried over into the next fiscal year as prior year income within specific programs. – Specific program income may not be transferred to another program budget. Proposed expenditures of each of the programs income must be used for specific program services.

## **ESTABLISHMENT OF THE DISTRICT 2 PUBLIC HEALTH FEES POLICIES AND PROCEDURES MANUAL**

The District 2 PH Fees Committee will be responsible for recommending policies and procedures which are relevant to the District 2 Health Departments. The Management Team shall approve all changes to the manual prior to implementation. The committee shall meet annually to determine appropriate revisions. However, changes will be implemented as needed.

Every HD shall maintain the most current copy of the District 2 PH Financial Management, Fee and Cash Handling P & P Manual. The COM will be responsible for updating staff regarding changes.

### **AUTHORITY AND RESPONSIBILITY**

Routine decisions in accordance with this policy will be made by the COM and CNM. This includes the local management team’s ability to waive or discount fees as deemed appropriate. No changes will be made to these policies unless the directive for the change has been made in writing by the District Health Director. The IT Team is responsible for updating changes to the M & M Computer System and will notify all counties via the “Local Billing Committee”.

  
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David N. Westfall, MD., MPH., CPE.

  
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Date

**I. COMMONLY USED TERMS IN THE FEE COLLECTION PROCESS:**

The following definitions are set forth to insure there is no misunderstanding of commonly used terms or concepts and to provide definitions of key components of the fee system. **NOTE: Refer to specific programmatic guidelines in order to determine income utilized for fee collection.**

**A. CLIENT:** Any person who is receiving or requesting services provided by the County Boards of Health and Contract Agencies.

**B. DEPARTMENT:** District 2 Public Health.

**C. DECLARATION METHOD:** Acceptance of proof of income regarding the source and amount of his/her family's gross monthly or annual income or income verification, i.e. current check stubs, W-2 form, income tax return, or Statement of Earnings from employer.

**D. SELF-DECLARATION:** Allowing clients to attest to their income instead of submitting documents such as pay stubs or tax statements to prove their income. This method must be utilized in the Family Planning Program. See *Title X Family Planning Services Manual, November, 2006*. This method can also be utilized in other programs. See specific guidelines for reference.

**E. ABILITY TO PAY:** Determined by assessment of current Federal Poverty Income Guidelines using annual gross income and family size.

**F. FAMILY:** (a) One or more adults and children, if any, related by blood or law, and residing in the same household. Where adults, other than spouses, reside together, each may be considered a separate family.

Minors seeking Family Planning services without parental consent shall be considered one-person families. (b) Emancipated Minor: adolescent is self-supporting, income would be handled the same as for an adult.

**G. Household:** Income of all persons combined that lives in the household. This income is utilized in the WIC Program. Refer to WIC Program Guidelines for specifics. This income is NOT utilized to determine any other program income in the Health Department.

**H. ANNUAL GROSS INCOME:** The sum of income, available to an individual or family on an annual basis, prior to any deductions or discounts. Sources of gross annual income follow:

- 1) **WAGES OR SALARY:** Total monetary earnings received for work performed as an employee, including wages, salaries, Armed Forces pay, commissions, tips,

piece-rate payments and cash bonuses, earned before deductions are made for taxes, bonds, pensions, union dues, and similar purposes.

- 2) **CHILD SUPPORT:** An allowance contributed by a parent to assist in meeting the child's needs.
- 3) **ALIMONY:** An allowance made to a spouse for maintenance and support, pending or subsequent to, legal separation or divorce.
- 4) **UNEMPLOYMENT COMPENSATION:** Compensation received from Government Unemployment Insurance Agencies or private companies during periods of unemployment and any strike benefits received from union funds.
- 5) **WORKER'S COMPENSATION:** Compensation received periodically from private or public insurance companies for injuries incurred at work. The cost of this insurance must have been paid by the employer and not by the person.
- 6) **VETERAN'S PENSION:** Money paid periodically by the Veteran's Administration to disabled members of the Armed Forces or to survivors for education and on-the-job training, as well as so-called "Refunds" paid to ex-servicemen as GI insurance premiums.
- 7) **SOCIAL SECURITY:** Social Security pensions and survivor's benefits, permanent disability insurance payments made by the Social Security Administration prior to deductions for medical insurance, and Railroad Retirement Insurance checks from the U.S. Government.
- 8) **PENSIONS (PRIVATE/GOVERNMENT) OR ANNUITIES:** Pensions or retirement benefits paid to a retired person or his/her survivors by a former employer or by a union, either directly or through an insurance company, and periodic receipts from annuities or insurance.
- 9) **DIVIDENDS, INTEREST (ON SAVINGS OR BONDS), INCOME FROM ESTATES OR TRUSTS, NET RENTAL INCOME OR ROYALTIES:** Dividends from stockholding or membership in associations, interest on savings or bonds, periodic receipts from estates or trust funds, net income from rental of a house, store, or other property to others, receipts from boarders or lodgers, and net royalties.
- 10) **NET INCOME FROM NON-FARM SELF-EMPLOYMENT:** Gross receipts minus expenses from one's own business, professional enterprise, or partnership. Gross receipts include the value of all goods sold and services rendered. Expenses include cost of goods sold and services rendered. Expenses include cost of goods purchased, rent, utilities, depreciation charges, wages and salaries paid, business taxes (not personal income taxes), and similar costs. The value of saleable

merchandise consumed by the proprietors of retail stores is not included as part of net worth. Deficit or negative income from non-farm self-employment should be considered as a negative number when computing all applicable sources of income.

**11) NET INCOME FROM FARM SELF-EMPLOYMENT:** Gross receipts minus operating expenses from the operation of a farm by a person on his own account, as an owner, renter, or sharecropper. Gross receipts include the value of all products sold, government crop loans, money received from the rental of farm equipment to others, and incidental receipts from the sale of wood, sand, gravel, and similar items. Operating expenses include cost of feed, fertilizer, seed, and other farming supplies, cash paid to farmhands, depreciation charges, cash rent, farm taxes (not state and federal income taxes), and similar expenses. The value of fuel, food, or other farm products used for family living is not included as part of net income. Deficit or negative income from farm self-employment should be considered as a negative number when computing all applicable sources of income.

**12) PUBLIC ASSISTANCE OR WELFARE PAYMENTS:** Public assistance payments such as Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), Optional State Supplementation (OSS), and general assistance (e.g., county assistance).

## **Fee Schedules**

District 2 Public Health utilizes guidelines and policies set forth by the Federal and State Programs and insurance companies to set fees. Programmatic fees are not regulated by the County Boards of Health, rather by the Programs. County purchased vaccine and other supplies are regulated by the county, i.e. flu and other county purchased vaccine, condoms, pregnancy tests, etc. Quest Labs is a local program. Fees are set according to what the Health Departments pay Quest Labs plus a draw fee. These labs are subject to change and waiver of fees is not permissible due to the cost to the local Health Department.

Note that the environmental health fee schedule lists the only approved amounts to be charged for services provided. These fees must be approved by both the County Board of Health and the county governing authority (i.e. the County Commissioners). These amounts may not be changed by anyone without prior approval of both the Board of Health and the county governing authority.

## **Sliding Fee Schedule**

A fee can and will be assessed using the sliding fee schedule for the specific program service being sought. The only allowable fees for clients, regardless of income level, are the fees

established on the sliding fee schedules. Each Program will update the sliding fee schedule based on the cost of the program for providing specific services and in accordance with federal regulation for charging fees for those services. The District will incorporate the revised sliding fee schedule when it is distributed from the state office on an annual basis.

## **Fee Collections**

All persons seeking program services must be assessed a fee in accordance with the DHHS approved sliding fee schedule, which is updated annually. Services for clients holding valid Medicaid cards must be billed to the Division of Medical Assistance. Each Program will post its fee schedule in a public area, with a notation that discounts are available based upon need, or a notice will be posted that such information is available at the front desk of the clinic. It is not allowable to have a general policy of no fees, flat fees or a minimum fee for the provision of services.

A residency requirement is sometimes allowable depending on the service being sought. Programmatic services **MUST** be provided to any person wanting and needing them. Some services cannot be denied because of inability to pay or failure to provide proof of household income or individual income. If a client requests confidentiality, no bill will be mailed. Balance can be given at next visit. A fee will be assessed using the sliding fee schedule. The only allowable fees for clients, regardless of income level, are the fees established in the Sliding Fee Schedules.

Payment is expected at the time of service for all services provided. The method of payment may include cash, personal check (except as described below), credit card and debit card. Under **NO CIRCUMSTANCE** should a Health Department accept a post dated check or hold a check past the date of service. An attempt is to be made to collect fees owed at the time of the client's visit.

1. Attempts should be made to collect any outstanding balances when clients return for a new service. If the client states they cannot pay the outstanding balance, an effort should be made to initiate a payment plan.
2. An attempt to collect payment for debts, i.e. a returned check and/or any outstanding balance within the current or last fiscal year, should be made at the same time the payment for any new service is collected.
3. Personal Checks should not be accepted for one-time services, such as travel clinic visits or immunizations (adult) unless deemed appropriate by local management staff.
4. **NOTE:** Any outstanding balance should be noted in VHN under the "ALERTS" section in VHN.

## **Guidelines for Income Assessment**

In order to comply with programmatic state and federal regulations, proof of income may be requested but will not be required in order to receive some of the different program services. Each client must have their income assessed and documented in the record at least annually. This should be accomplished per HIPAA compliant guidelines. Most programs follow specific regulations for income verification and fee collections. See specific program manual for regulations.

Many clinic services are provided on a sliding fee scale. In order to determine the client's percent pay level and discount, income and family size are required or requested per program guidelines. The District 2 Confidential Discount Eligibility Form should be used to determine eligibility for discounts. Some programs will allow clients to receive discounted fee services by self-declaring their income. In self declaring income, the patient enters the information regarding employment and income. There will be no copy of a check stub in the record. There is no need to document "self declared" on the progress notes. See specific programs financial management policy and procedures for regulations. (**Note: Environmental Health fees are not discounted.**)

Clients may receive discounted fee services by self-declaring their income. In self declaring income, the patient enters the See Policy # 178 for specific Family Planning Financial Management Policies and Procedures.

For all other services, proof of income is required in order to obtain a discount. If proof of income is not provided, all fees are to be billed at the 100% level. Follow program guidelines.

Teens are charged based on their (the teen's) income. However, if the parent comes with the teen and knows the teen is being seen for Family Planning services, the parent's income can be requested.

### **Documents that can be utilized to perform the financial assessment:**

- Monetary compensation for services, including wages, salary, commission, or fees
- Net income from farm and non-farm self employment
- Dividends or interest on savings or bonds, income from estates or trusts, or net rental income
- Public assistance or welfare payments
- Unemployment compensation
- Government civilian employees' or military retirement, pension, or veterans' payment
- Private pension or annuity payments
- Alimony payments
- Regular contributions from person(s) not living in the household
- Basic Allowance for Subsistence (BAS) is cash payment added to base pay and is counted as part of all cash income for military families ONLY
- Net royalties

- Other cash income including, but is not limited to, cash amounts received or withdrawn from any source that would be taxable including investment and trust accounts

### **Income Exclusions**

- Bank loans
- Student loans/Scholarships
- Child Support
- Food Stamps
- Social Security benefit and/or Supplemental Security Income
- Any other Non-taxable receipts

Clients without documents proving their income must be allowed to self declare by entering their information regarding employment and income on the Discount Eligibility Form.

Documentation of income is a particularly difficult requirement for low-income individuals and families whose work is often informal and episodic.

### **Immunization Services:**

There are federal rules and regulations regarding waiving fees for VFC vaccine. VFC eligibility takes place with each immunization to ensure that eligibility status has not changed. If the parent states an ability to pay the VFC administration fee, proceed with usual fee process. If the parent states an inability to pay the VFC administration fee, waive this fee utilizing code # 848. Is it necessary to verify a parent's ability to pay? Per VFC, the Health Department will not verify by checking income – Meaning, we take the person's word for it. If the parent/client states they can bring the money back when they get paid, then take the money when they return and add it to the appropriate account. But in no way, should the amount be on the account as "owing" for the vaccine. Reference: State of Georgia Immunization Program

### **Assignment of Benefits**

Each HD accepts assignment of benefits from Medicaid, Medicare, and certain private commercial insurance companies. For insurance companies that we are not allowed to bill, a receipt is given to each patient that contains the appropriate information in order for clients to bill their insurance companies.

### **Financial Accountability**

The process of determining the income level, family size and discount group is the first step in the clinical visit. Usually, the type of visit will be known upon the client's arrival at the clinic. No client will be charged a clinic registration. It is against Federal regulation to charge some program clients clinic registration or any other fees in addition to or in lieu of fees based on the that particular programs sliding fee schedule.



- The client should be informed of the specific programs fee system which is being sought at the time the client makes an appointment. Some programs are based on family size and income; while other programs may not.
- Many Services cannot be denied because of inability to pay or provide proof of household income or individual income at the time of the visit.
- If the client requests confidentiality, no bill will be mailed. Balance can be given at next visit.
- Every attempt should be made to collect the fee at the time of the visit.

### **Denial of service**

No client shall be denied any service or have services rescheduled because of a true inability, as opposed to unwillingness, to pay, regardless of their credit standing. A statement must be posted which states that no one will be denied services because of inability to pay. County Health Departments are required to serve all those who request services without regard to length of county residency, number of times a service has been provided, prior approval by a physician, a true inability to pay, or other limitation unrelated to the need for a specific service.

If evidence indicates that the client has the ability to pay, but they refuse to do so, service can be denied due to unwillingness to pay.

**Note: Federal guidelines must be followed for federal programs.**

### **INSURANCE BILLING**

Billing is one of the most important components of a Health Department's responsibility in order to maintain fiscal viability. It is recommended that all third party payment billing be performed weekly, no less than monthly, or on a schedule which guarantees timely payment and assures re-billing payments. Third party insurance billing is negotiated by the Department of Public Health. Updates are sent as new rates and services are negotiated. IT distributes this list as received to the "Local Billing Committee".

### **MEDICAID BILLING**

General guidelines regarding Medicaid:

All Health Departments are Medicaid providers and all policies and procedures set forth by Medicaid must be followed. Medicaid manuals are available on the GHP web portal at [www.mmis.georgia.gov](http://www.mmis.georgia.gov) and are updated frequently. Please visit these websites in order to download / print the most current versions.

- Payment for a Medicaid billable service cannot be required.
- Medicaid/CMO eligibility must be verified at time of service.
- Eligibility must be documented in VHN for every visit.
- Patients cannot be balance billed for a Medicaid billable service.

## **STATEMENT PROCEDURES**

Statements of outstanding balances should be mailed monthly, if possible, but at least once a quarter. Only one statement should be sent for outstanding balances of \$5.00 or less, whereas three statements should be sent for outstanding balance greater than \$5.00. (See Section IV.A.3. for collection of debts prior to the client obtaining new services.) Do not send statements for a “No Contact” patient.

## **AGING OUTSTANDING ACCOUNTS RECEIVABLE**

Bad debts may be written-off annually. Balances must be kept for the current and last fiscal year. Any balances incurred prior to the previous fiscal year may be written off if the client has not received any services in the current or last fiscal year. Notes regarding all debts written off must be entered into the “Alert” section of the client’s computer record. Set the priority as “1” and leave the program ending date fields blank. Enter the amount of bad debt written off in the comment section.

If the client returns to the clinic and makes a payment toward the debt that has been written off, payment will be accepted. The adjustment code 781 (recover write-off) is to be used, and the original amount written off. This will add the balance back. The payment received is then to be posted as usual. Remove the “Alert” from the patient’s record.

## **RETURNED CHECKS**

Every effort should be made (by telephone, in-person, or by mail) to contact the individual who wrote an NSF check in order to determine when funds will be available for the Health Department. See the attachment for an example of a letter to be sent regarding NSF checks. The individual should commit themselves to a specific date (within ten days, per GA law) for re-deposit or to exchange cash for the check. A \$30 penalty will be charged for returned checks by the Health Department. The code for an NSF check is AHLU 125. This code will add the \$30.00 charge into their billing record. If the NSF check is for CH, then the code should be CHLU125.

Magistrate Court processes bad checks. Bad checks cost merchants hundreds of thousands of dollars. There are both civil and criminal remedies available to a person or business that has received a bad check.

Both the civil and criminal remedies are provided by statute and must be strictly complied with in every instance. The Court may have to deny a person or business a remedy to which they should be entitled because of failure to follow statutory procedures.

In criminal cases, failure to comply with any of the statutory procedures requires the Court to deny the warrant or citation. By following the format set forth in the Code, there should be no

problem meeting the bad check criteria. The new Bad Check Citation mechanism allows the Magistrate Court, together with the Solicitor's office, Sheriff's Department and Police Department to help you protect your rights and collect the sums of money that relate to criminal bad checks. However, this is a criminal proceeding and you have the burden of proof beyond a reasonable doubt to make your case. The Code Section(s) present the mechanism(s) for you to follow to make your case to meet that burden. In the event, however, there is a failure to set out sufficient grounds for a criminal prosecution, you may always file a civil suit against the maker of a check for the dollar amount due you, plus service charges and Court costs.

**Note: refer to [www.ncourt.com](http://www.ncourt.com) , choose your county, choose frequently asked questions on the bottom left hand side, then choose Bad Check FAQ. Some counties in our District are not represented. Please call your local magistrate court for instructions.**

Each county's Magistrate Court policies on bad checks may vary. Visit your local Magistrate Court to determine what process your Health Department should follow. The Civil Procedure/letter only is included in this fee manual.

## **PATIENT RECORD CHARGES**

The Official Code of Georgia Unannotated, Code 31-33-3 allows a charge for search, retrieval, and other direct administrative costs related to copying and mailing patient records.

Official Code of GA 31.33.3

(a) The party requesting the patient's records shall be responsible to the provider for the costs of copying and mailing the patient's record. A charge of up to \$25.88 may be collected for search, retrieval, and other direct administrative costs related to compliance with the request under this chapter. A fee for certifying the medical records may also be charged not to exceed \$9.70 for each record certified. The actual cost of postage incurred in mailing the requested records may also be charged. In addition, copying costs for a record which is in paper form shall not exceed \$.97 per page for the first 20 pages of the patient's records which are copied; \$.83 per page for pages 21 through 100; and \$.66 for each page copied in excess of 100 pages. All of the fees allowed by this Code section may be adjusted annually in accordance with the medical component of the consumer price index. The Office of Planning and Budget shall be responsible for calculating this annual adjustment, which will become effective on July 1 of each year. To the extent the request for medical records includes portions of records which are not in paper form, including but not limited to radiology films, models, or fetal monitoring strips, the provider shall be entitled to recover the full reasonable cost of such reproduction. Payment of such costs may be required by the provider prior to the records being furnished. This subsection shall not apply to records requested in order to make or complete an application for a disability benefits program. (b) The rights granted to a patient or other person under this chapter are in addition to any other rights such patient or person may have relating to access to a patient's records;

however, nothing in this chapter shall be construed as granting to a patient or person any right of ownership in the records, as such records are owned by and are the property of the provider.

**This is the original Code of Georgia as written. It is updated by the Office of Planning and Budget annually. Charges listed on page 14 are current.**

## **FINANCIAL DEPARTMENT GUIDELINES**

### **Cashing Checks and Making Change**

Personal checks, traveler's checks and credit/debit cards will be accepted for the payment amount only (See IV.A.2. for instances in which a personal check should not be accepted). No one is permitted to give cash back from checks or credit cards. Cashing checks of any kind is not permitted. If a personal check is accepted, driver's license number should be written on the front of the check.

### **Daily Money Report and Balancing**

The total cash, checks, and credit card slips must be reconciled and balanced on a daily basis. Money kept in the cash drawer should be counted after making each deposit to ensure that there are no overages or shortages. The person who prepares the Daily Money Report should sign off as preparer and then the report should be reviewed for accuracy and completeness and signed off by their supervisor.

### **Procedures for Partial or Non-Payments**

If a client or guardian fails to pay their bill, the County Office Manager (COM) or designee should discuss the situation with the responsible party to determine the reason for non-payment. Clients and guardians should always be encouraged to discuss bills and fees openly. If a client leaves the facility without making any payment and without making arrangements for payment, a Statement of Account is to be sent to that client, stating the amount due, payable within 30 days or prior to their next visit. These statements should be sent at least monthly for all clients and visits. **NOTE: A no contact client SHOULD NOT be sent a statement.**

If full payment cannot be made by a specific date, an installment plan should be established and documented in the client's medical record. If the program requires a copy of their proof of income, when provided, a copy should be kept in the medical record for documentation.

### **Use of Fees Collected**

- All monies collected as the specific program fees (including from third party payers such as Medicaid or primary Insurance payments).

- Fees collected must be used to expand, improve, or offset the cost of the Program service delivery system as documented revenues MUST be retained by the Program services provider.
- Programmatic system as documented by the programs agencies Annual Report (PAR).
- Monies received from fees collected are considered additional resources for the operation of the specific programs clinics and MUST be used for this.

### **Charges**

Charges should be based on a cost allocation plan that shows the reasonable cost of providing services (42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3). A Schedule of Discount should be developed and properly implemented (42 CFR 59.5 (a) (8); Title X Guidelines: Section 6.3).

This includes:

1. Eligibility of discount is documented in client's financial record (Title X Guidelines: Section 6.3)
2. Schedule of Discount has sufficient, proportional increments to ensure some of the programs income is not a barrier to service (Title X Guidelines: Section 6.3)
3. Schedule of Discount is used for family incomes between 101-250% of Federal Poverty Level (FPL) [42 CFR 59.5 (a) (8)]
4. Eligibility for discount for minors who receive confidential services in some programs is based on the income of the minor (42 CFR 59.2–Definition; OPA 97-1)
5. A mechanism is in place to allow County Nurse Managers and County Office Managers to waive fees for individuals who, for good cause, are unable to pay but not qualify for the Schedule of Discount within certain programs.(42 CFR 59.2 – Definitions: Guidelines: section 6.3)
6. For some programs clients at or below 100% of FPL are not charged for Title X services (title X Statute, Section 1006; 42 CFR 59.5(a)(7)
7. Certain Programs require that the clients income is re-evaluated annually
8. For some programs there is no evidence clients are denied services or are subjected to variation in quality of services because of inability to pay. (Guidelines: Section 6.3)

### **Billing**

At the time of services, “depending on which program service being sought” clients responsible for paying are given bills directly.

1. Bills to clients show the total charges, as well as any allowable discounts
2. Where a third party is responsible, bills are submitted to all third parties.
3. Where appropriate, third party authorization for clients at or below 100% FPL should be properly billed.
4. Bills to third parties show total charges without applying any discount unless there is a contracted reimbursement rate that must be billed per the third party agreement.
5. Medicaid clients who have been certified for Medicaid are told the cost of services will be covered by Medicaid. The Medicaid eligibility status is entered on the clients'

record. Provider agencies should bill Medicaid for the full cost of services provided to each Medicaid client. All Medicaid financial activity must be recorded in the fee for service system. If a Medicaid service is denied for payment as ineligible, the fee for this service should revert to the patient fee system with the appropriate discounts applied.

**Legal Authority:** This policy is based on Title X regulations (January, 2001) sections 6.3 and 8.0, as well as program requirements found in each of the specific program Manuals.

**References:** A complete explanation of state statues and Title X Guidelines can be accessed at <http://www.hhs.gov/opa>

### **Client Fee Refunds**

Process for client fee refunds:

- Refund requests must be processed on the FEES REFUND REQUEST FORM (3/2011). This form must be placed on county health department letterhead.
- The patient's name and address must be listed.
- The reason for the return must be given.
- The amount and what the original payment was for must be given.
- A transaction list for the client from VHN must be attached.
- The employee requesting the refund must sign the request along with supervisor or another witness.
- Absolutely NO CASH refunds are to be given.
- Send the Request Form and transaction list to the District Accounts Payable Department or your local county office manager for processing. A check will be sent to the individual within 7 – 10 working days.
- When the client uses a credit/debit card, an immediate refund can be issued by reversing the charges through the credit card system. Please note this on your fee re-cap report.

### **Violation of Title X Law and Regulations:**

The following actions are violations of Title X law and could result in paying back funds and/or an audit. District/Contract Agencies cannot:

- Some programs are not allowed to require any type of ID in order to receive services (Photo, driver's license, birth certificate, etc.)
- Some programs do require proof of the following:
  - o Citizenship
  - o Residency in county where service occurs
  - o Income, including tax statement, pay stubs, letters from employers

- Certain programs are not allowed to charge full fees when clients do not bring proof of income or proof of insurance. Some program clients must be allowed to self-declare income.
- Certain programs cannot reschedule appointments when clients do not bring documents proving income, residency, etc.
- Specific Programs cannot charge minimum fees. Those program fees must slide to zero.
- No program can require a donation for services.

When the client uses a credit/debit card, an immediate refund can be issued by reversing the charges through the credit card system. Please note this on the fee re-cap report.

**Donation Guidelines:**

- Voluntary donations from clients are permissible and encouraged from program clients.
- Display notice regarding acceptance of donations is permitted.
- Donations may be accepted from clients who fall in the no fee category (zero pay) as well as clients in all other pay categories.
- Donations must NEVER be a prerequisite to the provision of services or supplies.
- Clients must NEVER be pressured or coerced to make donations.
- Donation amounts should NOT be suggested.
- Donations from clients do not replace or serve to waive the billing/charging requirements or the client’s responsibility for payment of fees.
- Donations should be used to expand, improve, or offset the costs of the specific Program service sought.
- All donations must be documented as such in the client’s financial record.
- Clinic staff should provide a receipt to the client with “donation” and the amount donated noted on the receipt.
- Clinic staff should turn in donation and copy of receipt to Administrative/ Financial staff.
- Financial information shall be reviewed as part of the District Q&A activities.

District 2 utilizes the following script regarding program donations: (Has been translated into Spanish)

“Today, you received \$\_\_\_\_\_ in \_\_\_\_\_ services. Based upon your income and family size, you are \_\_\_\_\_% pay, which means you will pay \_\_\_\_\_ for your services. The \_\_\_\_\_ program accepts donations for the program if you would like to donate.

Note: The patient will be given a detailed receipt for services received that day which will specify services given and cost. If the patient chooses to make a donation, a hand written receipt will be given to the patient.

## Security

All fees collected must be secured in a locked drawer. Deposits must be taken to the bank at least twice a week. Additionally, on any day when the total amount of cash in the Health Department equals or exceeds \$500.00, a deposit is to be made by the close of business if possible, but no later than 2:00 p.m. of the next working day. As an additional security measure, a single person should not accept payments, reconcile the money drawer, prepare the deposit, and take the deposit to the bank. At least two staff members will be involved throughout this process. This will include one member of management along with the staff member who is in charge of the cash drawer.

## Processing County Cash Receipts

1. Delinquent receivables are reviewed.
2. Individuals who post cash receipts to the receivables sub ledger cannot:
  - Review the receivables aging trial balance.
  - Authorize write-offs of delinquent accounts.
  - Independently investigate receivables discrepancies.
  - Maintain or authorize receivables adjustments.
  - Edit the accounts receivable master file.
  - Process customer service calls and complaints.
  - Investigate discrepancies or issues related to revenue.
  - Open the mail or copy checks received.
  - Prepare deposits.
  - Deposit cash receipts.
  - Reconcile bank accounts.
3. Pre-numbered receipts or cash registers are effectively used and controlled.
4. A responsible person (preferably a member of management) will maintain a second key to each cash drawer within the safe, other than the cash register operator (cashier):
  - Maintains custody of the key to the cash register tape compartment.
  - Takes periodic readings of the register and or daily computer ledgers and compares the readings with the contents of the cash register.
5. Daily cash register reconciliation forms are used, a copy of the daily closeout tape(money report) is attached to the form, and tape totals are compared to the reconciliation form and deposited by an appropriate person.
6. Cashier funds are counted and reconciled at the end of each shift, or by an appropriate closing time depending on what that department does. At which time a secondary



member of management within the health department will count and verify ending drawer balances and initial the daily count log along with the cashier. A supervisor will review reconciliations and will investigate unusual reconciling items.

7. A list of daily cash receipts is compared to postings to customer and other accounts, contribution records, and deposits by a person independent of the cash receipts and accounts receivable functions.
8. The government has a formal deposit policy that limits (establish an amount of cash on hand) the government's allowable deposits and addresses the specific types of risk to which the government is exposed.
9. Individuals opening the mail prepare pre-numbered cash receipts and attach remittance data to the cash receipts prior to forwarding the documentation to accounting.
10. Cash receipts are deposited intact promptly or stored in a secure location.
11. Cash receipts are reconciled to general ledger postings daily by a secondary person, who does not take in cash, prepare checks or has authority to void entries.
12. Cash funds on hand are stored in a secure location and kept independent of mail receipts.
  - The entity uses a lockbox, along with keeping the box locked inside a drawer at all times.
  - Lockbox receipts are compared to remittances.
13. Adjustments of cash accounts are approved by the appropriate level of management or another appropriate person.
14. Bank reconciliations are prepared and reviewed monthly by a separation of duties, verified and approved of by management.
15. Individuals who open mail or records checks received cannot:
  - Prepare deposits.
  - Deposit cash receipts.
  - Reconcile bank accounts.
  - Investigate discrepancies or issues related to cash.
  - Maintain the cash receipts journal.
  - Post journal entries to the general ledger.
16. Individuals who deposit cash receipts cannot:
  - Reconcile bank accounts.
  - Investigate discrepancies or issues related to cash.
  - Maintain the cash receipts journal.

- Post journal entries to the general ledger.
17. Individuals who reconcile bank accounts cannot:
- Investigate discrepancies or issues related to cash.
  - Maintain access to cash.
  - Maintain the cash receipts journal.
  - Post journal entries to the general ledger
18. Individuals who investigate discrepancies or issues related to cash cannot:
- Maintain the cash receipts journal.
  - Post journal entries to the general ledger.
  - Monitor suspense or clearing accounts usage.
  - Edit transactional data.
  - Approve edits of transitional data.

### **Processing Disbursements – Accounts Payable and Accruals**

1. The computer system rejects duplicate entry of an invoice from a vendor.
2. Purchase order, receiving report, and invoice are matched prior to payment.
3. The District Administrator, who reviews checks, cannot:
  - Initiate checks for expenditures
  - Prepare checks
  - Mail checks
  - Edit the vendor master file
  - Open the mail or copy checks received
4. Checks are pre-numbered, the sequence is accounted for regularly, and unissued checks are controlled and kept in a secure location.
5. Purchasing documents are pre-numbered, the sequence is accounted for, and unissued forms are controlled.
6. Disbursements that require special approval of funding sources or the governing body are properly documented.
7. Bank reconciliations are prepared and reviewed in a timely fashion by an Accounting Paraprofessional.
8. All journal entries, including nonstandard/non-routine entries, have adequate supporting documentation and are reviewed and approved independently prior to posting.

### **Aging Process - Accounts Receivable**

1. A delinquent accounts receivable report, showing 30, 60, 90+ days overdue, should be reviewed by the County Office Manager monthly. Bad debts should be written-off annually. Balances must be kept for the current and last fiscal year. Any balances incurred prior to the previous fiscal year may be written off if the client has not received any services in the current or last fiscal year. Notes regarding all debts written off must be entered into the “Alert” section of

the client's computer record. Set the priority as "1" and leave the program ending date fields blank. Enter the amount of bad debt written off in the comment section.

2. If the client returns to the clinic and makes a payment toward the debt that has been written off, payment will be accepted. The adjustment code 781 (recover write-off) is to be used, and the original amount written off should be posted. This will add the balance back. The payment received is then to be posted as usual. Remove the "Alert" from the patient's record.

### **Processing Payroll**

1. Expenditures are compared to budget and prior periods at an appropriate level of detail.
2. Bank reconciliations are prepared and reviewed in a timely fashion.
3. Access to data and/or transaction files is appropriately restricted. Kay and Teresa
4. Payroll register is reconciled to the general ledger.
5. The payroll system automatically calculates the journal entry, which accounting them manually posts to the general ledger.
6. The payroll system calculates the payroll using database files holding employee information.
7. Standard programmed algorithms perform significant payroll calculations.
8. The payroll system master file change log, showing all changes made to payroll information, is reviewed by the payroll department and by human resources to ensure it reflects accurate and complete information.
9. The appropriate level of management or Budget Specialist periodically reviews the allocation of payroll costs to accounts, funds, and programs quarterly.
10. Position Action Requests are completed by the program managers or county supervisors to determine whether individuals are employees or independent contractors and the appropriate tax forms are prepared.
11. Current payroll amounts are compared with previous payroll amounts and variances are investigated and documented.
12. Payroll registers are reviewed after processing, reconciled to control totals, and approved by an appropriate level of management.
13. Individuals who prepare payroll checks cannot:
  - o Sign payroll checks.

- Authorize electronic payroll disbursements.
  - Disburse payroll checks.
  - Control unclaimed paychecks.
  - Resolve employee payroll inquires.
  - Edit the payroll master file.
  - Open mail or copy checks received.
  - Initiate changes to the payroll master file.
  - Resolve employee payroll inquires.
14. Current payrolls are compared with previous payrolls and variances are investigated and documented.
15. Payroll registers are reviewed after processing, reconciled to control totals, and approved by an appropriate level of management.

### **Maintaining the Employee Database Master File**

1. Access to data and/or transaction files is appropriately restricted.
2. The payroll system calculates the payroll using database files holding employee information.
3. The payroll system master file change log, showing all changes made to payroll information, is reviewed by the payroll department and by human resources to ensure it reflects accurate and complete information.
4. Individuals who determine salary and wage rates cannot:
  - Approve changes to salary and wage rates.
  - Define the financial closing and reporting process.

## **Frequently Asked Questions**

### **Can fees ever be waived?**

Clinics must have a policy for each program to waive fees when the client, as determined by the clinic manager or designee, is unable for good cause to pay for the programs services. For instance, a client may have a family income above 250% of poverty, but the family has no health insurance and a family member has a catastrophic illness resulting in large debts.

### **What is the definition of a family?**

A family is one or more adults and children, if any, related by blood or law and residing in the same household. Where adults other than spouses reside together, each may be considered a separate family.

### **How are minors charged for services?**

When considering charges to minors for services, several conditions must be taken into account. If the minor is emancipated and the provision of confidential services is not a concern, the family's income must be considered in determining the charge for services. When a minor requests confidential services, without the involvement of a principal family member in specific programs, charges for services must be based on the minor's income. It is not permissible to have a general policy of no fees, flat fees or a minimum fee for the provision of services to minors. Eligibility for discounts for minors who receive certain confidential program services must be based on the income of the minor. In most instances, the minor's fee will be minimal or slide to zero.

### **Talking with Clients about Fees**

Knowledge of the fee system is every clinic employee's responsibility. The client may ask any staff member a question regarding fees, and all Program staff should be able to answer basic questions. The clerk or other designated person who has initial contact with the client, either in person or by phone, may be asked questions about payment. These staff members who make initial contact with potential clients often hold the key to the success or failure of the fee collection system. Regardless of what the client asks, there are several important points to remember. Clients are affected by:

- The way information is given
- The amount of information that is given
- The tone of voice used to ask or give information
- The non-verbal communications, such as facial expressions, displayed by staff
- Staff should provide the same clear, consistent message to all clients

For inquiries about specific program eligibilities and the fees associated with each, either in person or on the phone, the following information should be conveyed:

- If you are receiving Medicaid, or have some other insurance, please bring your card to the appointment.
- Discounts for services are available within each different program, some programs fees/charges are based on income and number of family members in the household.
- Please bring (specify income documents ) with you so we can figure your fee.
- Our clinic does not accept (e.g., checks). We accept credit cards (specify) and cash only.

For inquiries about specific charges, provide information on what the full fee for the visit would be. For example:

“The full fee for the first visit which includes the exam and lab tests is about \$ \_\_\_\_\_ There may be additional fees. For instance, the full price for a pack of birth control pills is \$ \_\_\_\_\_ Most of our clients are eligible for a discount depending on their income and family size. The staff will discuss this with you before your visit.”

The overall message should be the following: “The clinic does charge fees but discounts may be available depending on the program, income, and family size. Some programs may require you to bring documents (specify) to verify your income.” Staff must be able to communicate effectively with clients and must understand that under certain programs no client will be denied service because of inability to pay. Include the following three points in an explanation of the fee system:

1. For example the Family Planning Program receives money from State and Federal sources. It is a Title X Federal regulation that fees must be based on a sliding scale.
2. Fees collected allow clinics to continue to provide and possibly expand services.
3. Some program fees charged are based on several factors and will vary for each individual. Some program Fees are based on the number in the family, the family income and the services received at the clinic. Use the current fee schedule for the specific program being sought when discussing fees with clients.

The following dialogue between clinic staff and client is an **example** of discussing fees with a client:

“Ms./Mr. \_\_\_\_\_ your fee today will be based on a sliding scale. Both your income and family size will be used in helping to determine your fee. Do you currently receive Medicaid?”

If the reply is yes, follow with:

“Medicaid will cover the cost of the services you receive today. May I see your Medicaid card so I can record your number in order to bill Medicaid?”

If the reply is no, follow with:

“Do you currently have any health insurance?”

If the reply is yes, follow with:

“Your health insurance may cover all or part of the cost of the services you received today. May I see your insurance card so I can record your information in order to bill your insurance company?”

If the reply is no, follow with:

“We use a sliding fee scale to determine the amount each client must pay to cover the cost of clinic services. This means that the fees our clients pay are determined on an individual basis. The scale is based on income, the family size and the services and supplies received in the clinic. What is your total annual income (gross)?”

### **Estimating Cost of Fees**

“Are you here for your first exam today, a yearly check-up, medical problem visit, or to pick up supplies?”

(Based on the above information, the clerk can determine what fee might be charged by using the sliding fee schedule. The fee will be collected at the end of the visit.)

“Because the fee will vary according to the service and supplies you receive, your exact fee will be given to you at the end of your visit.”

If the client asks “about how much,” give an example, using the fee chart. This will give the client some idea and will ease the client’s mind if he/she seems anxious or upset. The client should be told that the full fee is expected at that time, however, a payment plan can be worked out if the full fee cannot be paid today.

When the clinic visit is completed, the client will pay at check out. The charges will be based on services and supplies provided. It is important for all clients to know the fee for their services before any discount was applied, in addition to their discounted fee. For example, if the patient received an annual exam the clerk might say:

“I see you had an annual exam today and received 4 packs of pills, Ms.\_\_\_\_\_. The services you received today cost \$\_\_\_\_\_, but because of where you fall on the sliding fee scale, your discounted cost is \$\_\_\_\_\_. I will give you a receipt. Please be aware that we do accept donations if you would like to give one in addition to your payment.”

OR

“Ms. \_\_\_\_\_ the services you received today cost \$ \_\_\_\_\_, but because of where you fall on the sliding fee scale, there will be no charge. However, we do accept donations if you would like to give one.”

Success in collecting fees varies from clinic to clinic. Much of this success will be determined by the manner in which a clerk interacts with clients. Speak politely, but with firmness, indicating that payment in full, if possible, is expected today.

Avoid saying, "Your charge is" or "You owe us." Instead, say "The full cost of your services is \$ \_\_\_\_\_, "or "The portion which you need to pay is \$ \_\_\_\_\_." Be positive and firm when explaining the charge. Do not embarrass or harass the client. Again, the voice tone, facial expression and manner in which the staff gives this information are all important.



SAMPLE TEMPLATE  
PATIENT INFORMATION AND INCOME DECLARATION

Today's Date: \_\_\_\_\_

Guardian's or  
Parent's Name: \_\_\_\_\_  
(if applicable)

Patient's Name: \_\_\_\_\_  
Last First Maiden

Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

HOW CAN WE CONTACT YOU? Check all that apply:

Mail Home Phone Work Phone Cell Phone I do not wish to be contacted

Date of birth: \_\_\_\_\_ Male Female

Married Never Married Divorced Widowed Separated

RACE/ETHNICITY:

White Non-Hispanic White Hispanic Black Non-Hispanic Black Hispanic

Asian Native American Hawaiian/Pacific Islander Multi-Racial

Medicaid: Yes  No  PeachCare: Yes  No

Medicare: Yes  No  Private Insurance: Yes  No

NOTE: Some programs offer reduced fees based on income. To apply for a reduced fee, please provide the following information:

Number of family members in household: \_\_\_\_\_

Total family income: \$ \_\_\_\_\_ per: Week Month Year (Circle one)

## County Health Department Cash Handling Procedures – Policy # 191

1. All Checks, Cash, Cashier Checks, Name Stamps, State Stamps along with any and all recordable records paper will be placed in a safe by two people for overnight security until the next business day.

2. At the beginning of each business day one member of management along with any staff member who handles and or possesses a cash drawer during the day will both be present when the cash drawer is pulled.

- The Cash drawer will not leave the presence of both parties until that drawer is counted and verified and initialed on a cash count sheet by one member of management, (If a member of management is not available at the time a second staff member may be used as long as that person does not handle cash during day to day business or who does not do any of the following under section on page #8 **Processing County Cash Receipts**
- If the cashier must walk through any open area within the Health Department two people must walk to the secure area before the cashier is able to secure the drawer into a locked space for daily use.
- During day to day business, cashiers shall keep their cash drawers, name stamps and valuable forms or papers locked and area doors closed to prevent loss and unauthorized access.

3. **If change is needed during the day:** Cashiers will not exchange funds between different departments without management present. Cashiers may only exchange funds when management is present and watching between other cashiers and or departments.

- For additional funds needed cashiers will fill out a change slips and placed into a money bag, and management will be notified.
- Management will walk to the cashiers with the appropriate person or persons who make the deposits to retrieve the change order. Or that change order is placed inside of the safe for overnight storage.
- At no time will cashiers carry a change bag to another department or outside of their area without being accompanied by a member of management.

4. When funds are returned by the person who was responsible for going to the bank. Two people will count out that change and initial the change order form.

### **Mid-Day procedures for departments who close out at 2:00pm.**

1. Cashiers will take turns closing out their drawers in 15 minute intervals. So patrons are not inconvenienced. The department manager will always be the last to close out a drawer if they hold a cash drawer.
2. Cashiers will pull their own daily ledgers and reports and wait for a second person not within their own department to walk with them to a disclosed location away from patrons and others to count the cash drawer together.
  - Each person will count the amount of the deposit first and place that amount with the appropriate documents.
  - On that document the second person will place that days date, time and initial and write the amount down that they counted as part of the deposit. It will not be necessary to count the checks at that point just the cash.
  - The change for the next day will be counted into an envelope and initialed by both parties. The Deposit will be placed into the cash drawer and locked and placed back into the cashier's desk drawer until each staff member has had their drawers counted and verified.
  - All Cashiers will call for management in the front to either come walk with all of them or they may be joined by a second person to walk together to the safe area. No person is to walk alone to the safe.
  - Management and cashiers or cashier will both be present when the safe is opened. Management will instruct each cashier to open their locked drawer or lockbox and to pull their deposit. While in the presence of the cashier management will look at and verify that two people have counted each deposit. Each deposit is then placed in a single Locked cash bag for the next day deposit and then placed in the safe. There shall be a safe sheet that shall be initialed by each person watching.