Bitterroot Valley Education Cooperative

CSCT PROGRAM
PO Box 187
Stevensville, MT 59870
Phone: (406) 777-2494 FAX: (406) 777-2495

SLIDING FEE POLICY

Policy

It is the policy of Bitterroot Valley Cooperative (Co-op) to provide essential services regardless of the client's ability to pay. No one is refused service because of a lack of financial means to pay. Discounts are offered depending upon household income and size. Discounts will be based on income and family size only. Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Income includes: earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Noncash benefits (such as food stamps and housing subsidies) do not count.

A sliding fee schedule is used to calculate the basic discount and is reviewed by BVEC leadership and updated each year using the federal poverty guidelines (See attached table used to calculate eligibility and applied discount). The sliding fee option is advertised in our program flyer and posted on our website. Signage is posted at all CSCT sights including stating that the practice serves all patients regardless of ability to pay. All potential clients are also informed of the sliding fee application process and offered an application at the time of the intake assessment meeting. Clients without insurance that have not submitted a sliding fee application will be sent an application with monthly statements. Once a completed application and supporting documentation is reviewed and approved, the discount will be honored for twelve months, after which the client must reapply.

Those with incomes below 100% of poverty will receive a full 100% discount. Those with incomes above 100% of poverty, but at or below 400% of poverty, will be charged a monthly fee according to the attached sliding fee schedule ($25-$150 based on income and family size). The sliding fee schedule will be updated during the first quarter of every calendar year with the latest Federal Poverty Guidelines.

Discount Application Process

The Sliding Fee Discount Program procedure will be administered through the Business Manager / Billing Clerk or his/her designee. Information about the Sliding Fee Discount Program policy and procedure will be provided and assistance offered for completion of the application. Dignity and confidentiality will be respected for all

who seek and/or are provided discounted services. All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal and State programs. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required to qualify for the sliding fee scale.

The client/parent must complete the Sliding Fee Discount Program application in its entirety. By signing the Sliding Fee Discount Program application, persons authorize BVEC access in confirming income as disclosed on the application form. Providing false information on a Sliding Fee Discount Program application will result in all Sliding Fee Discount Program discounts being revoked and the full balance of the account(s) restored and payable immediately.

Applicants may need to provide one of the following: prior year W-2, two most recent pay stubs, letter from employer, or Form 4506-T (if W-2 not filed). Self-employed individuals may be required to submit detail of the most recent three months of income and expenses for the business. Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may only be used in special circumstances. Specific examples include participants who are homeless. Patients who are unable to provide written verification must provide a signed statement of income.

Applicant Notification

The Sliding Fee Discount Program determination will be provided to the applicant(s) in writing, and will include the percentage of Sliding Fee Discount Program write off, or, if applicable, the reason for denial. If the application is approved for less than a 100% discount or denied, the patient and/or responsible party must establish payment arrangements with BVEC. Sliding Fee Discount Program applications cover outstanding patient balances for six months prior to application date and any balances incurred within 12 months after the approved date, unless their financial situation changes significantly. The applicant has the option to reapply after the 12 months have expired or anytime there has been a significant change in family income. When the applicant reapplies, the look back period will be the lesser of six months or the expiration of their last Sliding Fee Discount Program application.

Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Business Manager or Billing Clerk’s office, to preserve the dignity of those receiving discounted care.

Payment

If a client qualifies for less than 100% discount or is denied discount on the sliding fee scale the patient will receive monthly billing in writing regarding their payment obligations. If the client does not make effort to pay within 60 days, BVEC will explore options including offering the client a payment plan. BVEC will not turn in clients to collections for outstanding debt.

Bitterroot Valley Education Cooperative

CSCT PROGRAM
PO Box 187
Stevensville, MT 59870
Phone: (406) 777-2494 **FAX: (406) 777-2495**

Application for Discounts

Please complete the following information and return to the therapist or Co-op office to determine if you or members of your family are eligible for a discount.

Client Name: _____

Parent/Guardian Name:

Address: _____

_____

The discount will apply to all services provided through our CSCT program in your child's school.

Number of persons living in your household: _____

Total household income: (complete one column for each household member)

Household Member	Annual	Monthly	Bi-Weekly	Weekly
Self				
Spouse				
Relatives				
Others				
Total				

NOTE: Include income from all persons in household and income from all sources, including gross wages, tips, social security, disability, pensions, annuities, veteran's payments, net business or self employment, alimony, child support, military, unemployment, public aid, and other.

I certify that the household size and income information shown above is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

_____ _____ _____
Parent/Guardian Name (Print) Parent/Guardian Signature Date

FOR OFFICE USE ONLY
Discounted Fee _____ **Approved By** _____