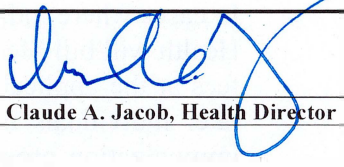




SAN ANTONIO METROPOLITAN HEALTH DISTRICT
DEPARTMENTAL MANUAL
Claude A. Jacob, Health Director

DM 8.11	EFFECTIVE: 10/1/2022	 _____ Claude A. Jacob, Health Director
	REVISED:	
SUBJECT: Financial Assistance		
REFERENCES:		
PHAB:		PAGE: 1 of 4

8.11 FINANCIAL ASSISTANCE POLICY

The provisions of this Financial Assistance Policy are applicable to all participating City of San Antonio Metropolitan Health District clinics and programs (collectively referred to herein as "Metro Health") that provide health care services and other prevention and self-management programs authorized to charge fees consistent with the provisions of Section 15-2 of the San Antonio City Code.

8.11.1 Purpose

Metro Health is committed to providing high-quality health care services to the public. Metro Health strives to ensure that the financial situation of individuals who need services does not prevent them from seeking or receiving care.

In accordance with Texas Health and Safety Code, Section 121.006, and Section 15-2 of the San Antonio City Code, Metro Health, by San Antonio City Council adoption, may charge fees for public health services; however, Metro Health will not deny public health services to an individual because of their inability to pay for the services and will provide for the reduction or waiver of a fee for an individual who cannot pay for services in whole or in part.

Metro Health will provide services to individuals regardless of their financial situation without discrimination.

8.11.2 Policy

All patients and clients receiving health services, including low-income, uninsured, and underinsured, will be treated fairly and with respect before, during, and after service delivery, regardless of their ability to pay. The granting of financial assistance shall be based on individualized determination of financial need and, consistent with the City's nondiscrimination policy, shall not consider, color, religion, national origin, sex, sexual orientation, gender identity, veteran status, age, or disability, unless exempted by state or federal law.

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a. Eligibility Criteria

In cases where individuals are covered by Medicaid or private insurance, Metro Health will bill Medicaid or the individual's private insurance company for clinic fees at the applicable Medicaid or private insurance company's reimbursement rate. Individuals not covered by Medicaid, private insurance, or a qualified immunization program, may be assessed fees on a sliding scale based on the patient's family income. No patient otherwise qualified to receive health clinic services will be denied said services based on an ability to pay the established fee. Patients and clients indicating their inability to pay will not be denied services and will be provided with a reduction or waiver of fees in whole or in part. Furthermore, Metro Health does not collect on past due accounts. Once a patient has been determined to be eligible for financial assistance, that patient shall not receive any future bills based on undiscounted gross charges.

b. Eligibility Determination

Metro Health personnel may ask patients to provide employment status, insurance status, number of people that live in the household, household income, and state of residence at time of service.

A patient who requests a discounted payment, charity care, or other assistance in meeting their financial obligation to Metro Health, may be asked to provide Metro Health with income and health benefits coverage documentation and/or may be asked to sign an acknowledgement attesting to their inability to pay for services. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need and may include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

c. Community Notification

Information about Metro Health's Financial Assistance Policy shall be made available through posted notices in registration areas, clinics, and on the Metro Health website. In addition, written notice shall be provided to potentially eligible patients at time of service, or as soon as possible thereafter, and during the payment collection process. This information shall be provided in English and Spanish and translated for patients in other languages as necessary, including American Sign Language.

d. Regulatory Requirements

Applicable local, state, and federal regulatory requirements were considered in the development of this policy.

8.11.3 Definitions

For the purpose of this policy, the terms are defined as follows:

Charity care: A provider's policy to provide free or discounted services to individuals who meet the established criteria without expectation for standard payment for services rendered.

Family: Using the Census Bureau definition, a group of two or more people who reside together and are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for the provision of financial assistance.

Family income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:
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;

Excludes noncash benefits (such as food stamps and housing subsidies);
Determined on a before-tax basis;
Excludes capital gains or losses; and
Includes the income of all family members who live together (Non-relatives, such as housemates, do not count).

Federal Poverty Level (FPL): The applicable household income thresholds established periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C.~9902(2).

Gross charges: The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

Medically necessary: As defined by Medicare, services or items reasonable and necessary for the diagnosis or treatment of an illness or injury.

Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed his or her financial abilities.

Uninsured: The patient has no level of insurance or third-party assistance to assist with meeting his or her payment obligations.

8.11.4 Policy Authority

For claims, appeals, interpretations, resolution of problems, and special situations,

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contact:

Calling 210-207-8730 Monday through Friday, 7:45 a.m. to 4:30 p.m. (Central Time)

or

Mailing a written request to City of San Antonio, 100 W Houston, 14th Floor, San Antonio, TX, 78205