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Erene Soliman Psychologist, Inc
Sliding Fee Discount Program- POLICY
REVISED DATE: March 2, 2022
Updated: September 20, 2022

POLICY: To make available free or discounted services to those in need of healthcare services and do not have the ability to pay.

PURPOSE: All patients seeking healthcare services at Erene Soliman Psychologist, Inc are assured that they will be served regardless of ability to pay. No one is refused service because of lack of financial means to pay. This program is designed to provide free or discounted care to those who have no means, or limited means, to pay for their medical services (including the uninsured or underinsured).

Erene Soliman Psychologist, Inc will offer a Sliding Fee Discount Program to all who are unable to pay for their services. Erene Soliman Psychologist, Inc will base program eligibility on a person's ability to pay and will not discriminate on the basis of an individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity. The Federal Poverty Guidelines are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility. (See "Appendix C" *for the current Federal Poverty Guidelines scale. Use as reference when examining an applicant's application.*)

PROCEDURE:
The following guidelines are to be followed in providing the Sliding Fee Discount Program.

1. Notification: Erene Soliman Psychologist, Inc will notify patients of the Sliding Fee Discount Program by: • Payment Policy will be available to all patients at the time of service.
• Notification of the Sliding Fee Discount Program will be offered to each patient upon admission.
• Sliding Fee Discount Program application will be included with collection notices sent out by Erene Soliman Psychologist, Inc.
• Erene Soliman Psychologist, Inc places notification of the Sliding Fee Discount Program in the clinic waiting Area.

2. Request for discount: Requests for discounted services may be made by patients, family members, social services staff or others who are aware of existing financial hardship. The Sliding Fee Discount Program will only be made available for clinic visits. Information and forms can be obtained from the Front Desk.

3. Administration: The Sliding Fee Discount Program procedure will be administered through the Business Office Manager. Information about the Sliding Fee Discount Program policy and procedure will be provided to patients. Staff are to offer assistance for completion of the application. Dignity and confidentiality will be respected for all who seek and/or are provided healthcare services.

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4. Completion of Application: The patient/responsible party must complete the Sliding Fee Discount Program application in its entirety. Staff will be available, as needed, to assist the patient/responsible party with applications. By signing the Sliding Fee Discount Program application, persons are confirming their income to Erene Soliman Psychologist, Inc Clinic as disclosed on the application form.

5. Eligibility: Discounts will be based on income and family size only.

a. 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. Erene Soliman Psychologist, Inc will also accept non-related household members when calculating family size. b. Income includes: gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; public assistance; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

6. Income verification: Applicants may provide one of the following: current year W-2, two most recent pay stubs, letter from employer verifying employment, or IRS Form 4506-T (if W-2 not filed). Self-employed individuals will be required to submit details of the most recent three months of income and expenses for the business; this is not limited to but includes last three months bank statements and expense reports (if deemed applicable). Adequate information must be made available to determine eligibility for the program. Self-declaration of Income may be used. Patients who are unable to provide written verification may provide a signed statement of income.

7. Discounts: Those with incomes at or below 100% of poverty will receive a full 100% discount for healthcare services. Those with incomes above 100% of poverty, but at or below 200% of poverty, will be charged a nominal fee according to the attached sliding fee schedule. The sliding fee schedule will be updated during the first quarter of every calendar year with the latest FPL Guidelines.

8. Nominal Fee: Patients with incomes above 100% of poverty, but at or below 200% poverty will be charged a nominal fee according to the attached sliding fee schedule and based on their family size and income. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

9. Waiving of Charges: In certain situations, patients may not be able to pay the nominal or discount fee. Waiving of charges must be approved by the Erene Soliman Psychologist, Inc's designated official. Any waiving of charges should be documented in the patient's file along with an explanation.

10. 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, Erene Soliman Psychologist, Inc clinics will work with the patient and/or responsible party to establish

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payment arrangements. 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.

11. Refusal to Pay: If a patient verbally expresses an unwillingness to pay or vacate the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on the sliding fee schedule, a copy of the sliding fee discount program application will be sent with the notice. If the patient does not make an effort to pay or fails to respond within 60 days, this constitutes refusal to pay. At this point in time, Erene Soliman Psychologist, Inc clinics can explore options not limited to, but including offering the patient a payment plan, waiving of charges, or referring the patient to collections.

12. Record keeping: Information related to Sliding Fee Discount Program decisions will be maintained and preserved in a centralized confidential file located in the Business Office Manager's Office, in an effort to preserve the dignity of those receiving free or discounted care.

a. Applicants that have been approved for the Sliding Fee Discount Program will be logged in Erene Soliman Psychologist, Inc Clinic's practice management system, noting names of applicants, dates of coverage and percentage of coverage.
b. The Business Office Manager will maintain an additional monthly log identifying Sliding Fee Discount Program recipients and dollar amounts. Denials and applications not returned will also be logged.

13. Policy and procedure review: The SFS will be updated based on the current Federal Poverty Guidelines. Erene Soliman Psychologist, Inc clinics will also review possible changes in our policy and procedures and for examining institutional practices which may serve as barriers preventing eligible patients from having access to our community care provisions.

14. Budget: During the annual budget process, an estimated amount of Sliding Fee Discount Program service will be placed into the budget as a ***deduction from revenue.***

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ATTACHMENTS:

Appendix A-Patient Application for the Sliding Fee Discount Program
Appendix B- Patient Self Declaration Statement (template)
Appendix C- 2022 Sliding Fee Schedule
Appendix D- Erene Soliman Psychologist, Inc Data Tables

APPROVAL: _____
REVISED: _____
*REVIEWED BY:*_____

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Appendix A:

Erene Soliman Psychologist, Inc

Sliding Fee Discount Information

It is the policy of Erene Soliman Psychologist, Inc's to provide essential services regardless of the patient's ability to pay. Erene Soliman Psychologist, Inc offers discounts based on family size and annual income.

Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this clinic, but not those services or equipment purchased from outside, including reference laboratory testing, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 12 months or if your financial situation changes.

Name (Last, First):
Address:
Phone:
Email:

Please list all household members, including those under age 18.

	Name	**Date of Birth**	**Relationship**
Self			
Other			
Other			
Other			

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Please list all household income, including from those under age 18.

Source Self Other	**Total**
Gross wages, salaries, tips, etc.	
Income from business and self-employment	
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income	
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources	
Total Income	

I certify that the family size and income information shown above is correct.

Name (print):
Signature:
Date:

Office Use Only

Patient Name: _____ Approved Discount: _____
Approved by: _____ Date Approved _____

Verification	**Yes/ No**
Identification/Address: Driver's license, utility bill, employment ID, or other	
Income: Prior year tax return, three most recent pay stubs, or other	

Note: A Self-declaration of income may also be used.

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Appendix B:

SELF-DECLARATION

(ONLY USED WHEN NO OTHER VERIFICATION METHOD IS AVAILABLE)

To be completed by patient:

I am unable to provide written verification because

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My self-reported annual income is $_____ and I further attest this is true by signing below.

Patient Signature: _____ Date: _____

_____

Verified by: _____ Date: _____

Approved by: _____ Date: _____

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Appendix C:

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POVERTY GUIDELINES FOR 2022

The 2022 ANNUAL poverty guidelines are in effect as of January 13, 2022

2022 POVERTY GUIDELINES FOR THE STATE OF CALIFORNIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
1	$13,590
2	$18,310
3	$23,030
4	$27,750
5	$32,470
6	$37,190
7	$41,910
8	$46,630

For families/households with more than 8 persons, add $4,720 for each additional person. 8

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Appendix D:

Erene Soliman Psychologist, Inc Data Tables

Site Name:	
Site Address:	
Date Prepared:	
Prepared By:	

6-Month Reporting Period (from mm/yy to mm/yy): ___/_____/___ - ___/_____/___

Total Patients: _____ Total Patient Visits: _____

TABLE 1: PATIENTS AND VISITS BY PRIMARY INSURANCE TYPE

Complete data for "Number of Patients" AND "Number of Patient Visits"

Primary Insurance	**Number of Patients**	Percentage Of Patients (Patients)	Number of Patient Visits (Visits)
1. Medicare			
2. Medicaid			
3. Other Public/ Private Funds			
4. Private Insurance			
5. Sliding Fee Schedule			
6. Self-Pay (no insurance and not SFS)			
7. Total (Line 1-6)			

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TABLE 2: PATIENT SERVICE CHARGES, COLLECTIONS, AND ADJUSTMENTS

Payment Source	Full Charges (a)	Amount Collected (b)	Adjustments (c)
1.Medicare			
2. Medicaid			
3. Other Public/Private Funds			
4. Private Insurance			
5. Sliding Fee			
6. Self-Pay (Other than Sliding Fee)			
7. Total (lines 1-6)			

TABLE 3: PATIENT APPLICATIONS FOR SLIDING FEE SCHEDULE (SFS)

Patient Applications for the Sliding Fee Schedule	Number of Applications
1) SFS Applications Approved	
2) SFS Applications Not Approved	
3) Total SFS Applications Received	

TABLE 4: SERVICE SITE STAFFING

Personnel by Major Service Categories	FTE's
Medical Services	
1.General Practitioners	
2. Psychiatrists	
A. Total Physicians (lines 1-2)	
3. Nurse Practitioners/ Physician Assistants	
4. Certified Nurse Midwives	

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5. Nurses
6. Other Medical Support Personnel
B. Total Medical Services (lines 3-6)
Mental Health (MH) and Behavioral Health (BH) Services
7. Mental Health & Behavioral Health Specialists
8. Mental Health & Behavioral Health Support Personnel
9. Total MH & BH Services (lines 7-8)
GRAND TOTAL

Detailed Table Instructions

Table 1: Patients or Visits by Primary Insurance Type

This table reflects the number of patients and patient visits by primary insurance type and/or payer source for the reporting period. A patient may have coverage under more than one insurance plan, different coverage for different services and this coverage may change over the course of a year. When medical services are provided, report the patient's primary health insurance covering primary medical care, if any, as of the last visit during the reporting period. If medical services are not provided, report the patient's primary insurance, if any, for the services offered. Report the patient's primary health insurance even though it may not have covered the services rendered during the patient's last visit. Primary insurance is defined as the insurance plan or program that the site would bill first for services rendered.

Example: Report Medicare as the primary insurance if a patient has both Medicare and Medicaid because Medicare is billed before Medicaid. Report the employer plan as the primary insurance if a patient has both an employer plan and Medicare because the employer plan is billed first.

(Line 1) Medicare: patients whose primary insurance is a plan for Medicare beneficiaries including Rural Health Clinic (RHC), managed care, Federally Qualified Health Center (FQHC), and other reimbursement arrangements administered by Medicare or by a fiscal Intermediary.

(Line 2) Medicaid: patients whose primary insurance is a plan for Medicaid beneficiaries including RHC, managed care, FQHC, Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, Child Health Insurance Program (CHIP) and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary.

(Line 3) Other Public/Private Funds: patients with no insurance but who have categorical or other grant funds applied to their accounts for services rendered. *(Note: This also includes state or local indigent care or charity care programs that are earmarked to subsidize services rendered to uninsured patients, such as the Massachusetts Free Care Pool,*

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New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, New Mexico Tobacco Program, or Colorado Indigent Care Program.)

(Line 4) Private Insurance: patients whose primary insurance is a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers and others. Patients with health benefit plans purchased for government employees, retirees and dependents, such as TRICARE, the Federal Employees Insurance Program, state employee health insurance benefit programs, teacher health insurance, as well as workers compensation, and similar plans are to be classified as private insurance patients.

(Line 5) Sliding Fee Schedule (SFS): patients participating in the site's sliding fee discount program who do not have other coverage. NHSC sites are expected to make services available through the use of a sliding fee discount schedule or other documented means of eliminating financial barriers for those at or below 200 percent of the Federal Poverty Guidelines (FPG). All Sliding Fee Discount Programs must include the following elements:

• Applicable to all individuals and families with annual incomes at or below 200 percent of the most current FPG
• Provide a full discount for individuals and families with annual incomes at or below 100 percent of the FPG, with allowance for a nominal charge only, consistent with site's policy; and
• Adjust fees (partial sliding fee discount) based on family size and income for individuals and families with incomes above 100 percent and at or below 200 percent of the FPG. View the most current HHS Poverty Guidelines. The data reported here should be based upon the number of patients making use of the sliding fee discount policy as their primary source of coverage.

(Line 6) Self-Pay (no insurance and not on SFS): patients without any health insurance and not participating in the site's sliding fee discount program are to be classified as self pay.

(Line 7) Total: the sum of lines 1-6.

Table 2: Patient Service Charges, Collections, and Adjustments

This table shows the patient service charges, receipts, and sliding fee discounts by payment source for all related activity of all providers at the site to which the NHSC provider is assigned. See the General Instructions for a definition of the scope of activity to be reported. Report in whole dollars.

Charges and collections are to be reported in six pay classes: Medicare, Medicaid, Other Public/Private Funds, Private Insurance, Sliding Fee Schedule, and Self-Pay. Charges and receipts are to be identified with the payer, which is the responsible party. For instance, Medicare receipts are attributable to Medicare even though the receipts were made by an intermediary such as Blue Shield. Similarly, charges and receipts for which a Medicare beneficiary is personally responsible, such as deductibles and copayments, are self-pay
rather than Medicare charges and receipts.

(Column a) Full Charges: the gross charges as established by the site for the services rendered during the reporting period. Charges are reported at their full value for all services prior to any adjustments. Fee-for-service charges are uniformly reported at the full charge rate from the site's fee schedule. Sites with capitation contracts or who are reimbursed on a cost based flat fee, such as an RHC rate or FQHC rate, are to report the normal full charge from the site's fee schedule rather than the negotiated visit capitation or contract rate.

Charges are to reflect the amount for which the payer is responsible. Deductibles, copayments, and uncovered services for which the patient is personally responsible should be reclassified and reported as self-pay. Similarly, any charges not payable by a third party payer that are due from the patient or another third party should be deducted

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from the payer's charges and added to the account of the secondary payer. The reclassification of charges to secondary and subsequent payers may be estimated based upon a sample.

Sites may elect to include or exclude all or some portion of paid referred care services rendered to the site's patients at off-site locations. This election may be based upon the ability or ease of reporting this information on a site-specific basis. The same scope of offsite referred care should be used to complete the visit, patient, charge, and cost tables.

(Column b) Amount Collected: the actual cash received during the period for services rendered, regardless of the date of service. This includes RHC and FQHC settlement receipts, case management fee receipts, incentive receipts from managed care plans, and other similar receipts.

Amounts collected are the amounts collected from the payer. If there is more than one payer involved in a given visit, the charges due from the primary payer and the amount collected from the primary payer are reported on the primary payer line. The charges due from the secondary payer are reported on the secondary payer line along with any amounts collected from the secondary payer. The reclassification of charges and collections to secondary and subsequent payers may be estimated based upon a sample of accounts.

(Column c) Adjustments: the difference between the full charges and the amount actually received or expected. The only adjustments to be reported here are self-pay adjustments.

(Line 1) Medicare (Title XVIII): charges and receipts related to services provided to Medicare beneficiaries that are payable by insurance plans operated under Title 18 of the Social Security Act, including FQHC, RHC, or any other reimbursement arrangement including capitated managed care administered by Medicare or its fiscal intermediaries.

(Line 2) Medicaid (Title XIX): charges and receipts related to services provided to Medicaid beneficiaries and payable by insurance plans operated under Title 19 of the Social Security Act, including FQHC, RHC, case management, fee-for-service managed care, EPSDT Program, CHIP and any other reimbursement arrangement, including capitated managed care, administered either directly by the state agency or by its fiscal intermediaries.

(Line 3) Other Public/Private Funds: charges and receipts related to services provided to patients and payable by categorical or other grant funds. This also includes state or local indigent care or charity care programs that are earmarked to subsidize services rendered to uninsured patients, such as the Massachusetts Free Care Pool, New Jersey Uncompensated Care Program, New York Public Goods Pool Funding, New Mexico Tobacco Program, or Colorado Indigent Care Program.

(Line 4) Private Insurance: charges and receipts related to services provided to patients and payable by insurance plans other than those reported above, such as a private insurance plan, managed care plan, or a contractual arrangement. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers, schools, health departments, and others. Health benefit plans offered to government employees, retirees and dependents, such as TRICARE, the Federal Employees Insurance Program, state employee health insurance benefit programs, teacher health insurance, as well as workers' compensation, and similar plans are to be classified as private insurance.

(Line 5) Sliding Fee Schedule (SFS) and SFS Adjustments: charges and receipts related to services provided to patients participating in the site's sliding fee discount program who do not have other coverage. NHSC sites are expected to make services available through the use of a sliding fee discount schedule or other documented means of eliminating financial barriers for those at or below 200 percent of the federal poverty income Guidelines.

SFS Adjustments: the value of charge discounts granted to patients prior to service and based upon financial hardship. It does not include professional courtesy, staff, service incentive, or similar discounts. Also, it does not

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include bad debt adjustments related to patients who were initially charged full fee but unable to pay because of financial hardship or other reasons. If a hardship fund is used to pay for the referred lab, x-ray, pharmacy or other care for sliding fee patients, report the charge value of those services in column (a) and an offsetting sliding fee adjustment in column (c). Sliding fee discounts reflect the site's compliance with its assurance to the NHSC that there are no financial barriers to care for those at or below 200 percent of the current federal poverty income guideline.

(Line 6) Self-Pay and Self-Pay Adjustments: charges and receipts related to services provided to patients without any principal health insurance or to patients with insurance but only that portion for which the patient is personally liable such as deductible, copayments, and uncovered charges. Charges not paid by a third party payer and due from the patient should be deducted from the full charges of the third party payer and added to the full charges for the self-pay patients. This also includes charges not payable by categorical or other grant funds.

Self-Pay Adjustments: the value of all self-pay adjustments only. This includes bad debt to self-pay patients who were initially charged a full, discounted, or partial fee but who subsequently were either unwilling or unable to pay the amounts charged. It does not include bad debt related to other pay sources, which may be caused by a failure to file timely claims, payer bankruptcy or similar reasons.

(Line 7) Total: the sum of lines 1–6.

Table 3: Patient Applications for the Sliding Fee Schedule

This table provides information on the number of unique sliding fee schedule applications submitted by patients/clients during the reporting period.

(Line 1) SFS Applications Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were approved for discounted Service.

(Line 2) SFS Applications Not Approved: the number of patient applications for the sliding fee schedule received during the reporting period that were not approved for discounted services for any reason (e.g., incomplete application, patient did not meet poverty guideline requirements, application not processed).

(Line 3) Total SFS Applications Received: the total number of patient applications for the sliding fee schedule received during the reporting period. This should be equal to the sum of lines 1-2.

Table 4: Service Site Staffing

This table profiles the personnel by major service category. The number of staff is reported in full time equivalents (FTEs).

Staff: salaried full-time or part-time employees of the applicant site who work on behalf of the site and non- salaried individuals paid by the applicant site who work for the site on a regular schedule that is controlled by the site under any of the following compensation arrangements: contract, retainer, capitation, block time, fee-for-service, and donated time. Regularly scheduled means a pre-assigned number of work hours devoted to the site's activities.

FTEs are reported for staff and are not reported for non-staff individuals. Some examples of staff and non-staff personnel are noted below:

• Providers working at MHAC clinics under contract on a scheduled basis are considered staff. • Referral providers who are paid by the MHAC clinics are considered non-staff when working independently such as the referral provider's office.

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• Contracted support staff working under a contract which replaces personnel the MHAC would otherwise have hired, who work directly for our clinics, who may work either on or off-site or telehealth, and who work on a regularly scheduled basis are considered “staff” whose time or FTE value is to be reported. If individuals under these arrangements work on an irregular, unscheduled or indirect basis, they are considered non-staff and their FTEs are not counted.
• Professionals working for the site under legal, audit, actuarial, management consulting, and similar contracts for services provided on a one-time, sporadic, or unscheduled basis are considered non-staff. • Consulting pathologists, radiologists, and other consulting providers who provide services on an unscheduled or sporadic basis are considered non-staff.

FTEs: full time equivalents for all staff. Full time equivalents are computed on an individual basis by dividing the total number of hours in the reporting period for which a person was compensated by the total number of hours in the year considered by the site to be full-time. The total number of hours for which an individual was compensated includes the number of hours a person was present for work and paid for their time, as well as paid leave time including vacation, sick leave, continuing education trips, etc. For example, An annual hours pay base of 2,080 (40 hours/week x 52 weeks/year) is typical but the base may vary by organization and by class of employee. Employees who work less than the annual hour base are normally considered part time. An individual staff member is not to be reported as more than 1.00 full time equivalents regardless of any overtime hours worked or compensation paid. Round FTEs to the second decimal place.

Salaried provider staff FTEs are to be calculated based upon the number of paid hours, not the number of scheduled hours. A provider who schedules 32 hours per week to see patients but who is paid for a 40-hour week is considered full time or 1.00 FTE.

Contract provider and support staff FTEs are to be calculated by dividing the hours the staff worked by the hours a full time employee of that type would be expected to work. The time worked in the numerator is to be taken from contracts, invoices, schedules or similar sources. The denominator or base of hours considered full-time for these arrangements should not include leave time unless leave is directly charged or the time salaried clinicians of that type are ordinarily not scheduled to see patients. For example, if full time salaried providers are expected to schedule 32 hours of patient care per week, a contract provider who was paid for 16 hours of scheduled patient care per week would be considered half time or 0.50 FTE. The annual scheduled hour’s base considered full-time for contract providers is likely to vary by clinical specialty.

Time for personnel performing more than one function should be allocated as appropriate among the major personnel service categories. For example, the time of a physician who is also a medical director should be allocated between medical care services and administration. Time for nurses who also provide case management services should be allocated between medical care and case management.

Personnel by Major Service Category: FTEs are classified into four service categories.

The categories are: medical care services; ancillary services, dental services; and mental health and behavioral health services.

(Lines 1 through 2) Physicians: (M.D. or D.O.): separate FTE totals for family practitioners, general practitioners, psychiatrists, including those physicians who obtained a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver, and all other specialists. Use board certification to classify physicians by specialty. Classify physicians with more than one board certification in the specialty representing the service the physician provides most, or allocate based upon time Spent.

(Line 3) Total Physicians: FTE total for medical services, lines 1-2.

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(Line 4) Nurse Practitioners and Physician Assistants: FTE total for nurse practitioner and physician assistant staff performing medical services. Nurse practitioners include psychiatric nurse practitioners. Nurse practitioners and physician assistants also include those who obtained a DATA 2000 waiver.

(Line 5) Certified Nurse Midwives: FTE total for nurse midwives performing medical Service.

(Line 6) Nurses: FTE total for nurses that are involved in provision of medical services, including registered nurses, licensed practical nurses, home health and visiting nurses, clinical nurse specialists, and public health nurses. If an individual's time is divided between medical and nonmedical services, allocate the FTEs to reflect this division of time. For example, nurses who provide case management or education/counseling services in addition to medical care should be allocated between medical services and other services.

(Line 7) Other Medical Support Personnel: FTE total for medical assistants, nurse aides, and all other personnel providing services together with or in direct support of services provided by a physician, nurse practitioner, physician assistant, certified nurse midwife, or nurse. FTEs for registration, reception, appointments, transcription, patient records, and other support personnel are not reported.

(Line B) Total Medical Services: FTE total for medical services, lines 4-7.

(Line 8) Mental Health and Behavioral Health Specialists: FTE total for licensed individuals providing counseling or treatment services related to mental health or behavioral health, including clinical psychologists, clinical social workers, psychiatric social workers, psychiatric nurses, mental health nurses, and family therapists. Report psychiatrists, including those who obtained a DATA 2000 waiver, on line 6 under physicians. Report psychiatric nurse practitioners, including those who obtained a DATA 2000 waiver, on line 9 under nurse practitioners.

● Mental Health and Behavioral Health Support Personnel: FTE total for assistants, aides, and all other personnel providing services in conjunction with or in direct support of services provided by mental health and behavioral health specialists. (Line 9) Total MH & BH Services (lines 7-8)

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Public Notice Signage

Required to inform patients of the Sliding Fee Discount Program. The following example illustrates language to be posted prominently online and at the physical site. NHSC encourages sites to establish multiple methods of informing patients.

NOTICE TO PATIENTS:
This practice serves all patients regardless of ability to pay. Discounts for essential services are offered based on family size and income. For more information, ask at the front desk or visit our website.
Thank you.

AVISO PARA PACIENTES:
Esta práctica sirve a todos los pacientes, independientemente de la capacidad de pago. Descuentos para los servicios esenciales son ofrecidos dependiendo de tamaño de la familia y de los ingresos. Usted puede solicitar un descuento en la recepción o visita nuestro sitio web.
Gracias.