Sacramento County Department of Health Services
Health Center Co-Applicant Board (CAB) AGENDA
Monday, July 1, 2024, 9:30 a.m.- 10:30 a.m.
SPECIAL SESSION
4600 Broadway, Community Room 2020, Sacramento, CA
Agenda materials can be found at
https://dhs.saccounty.net/PRI/Pages/Health%20Center/Co-Applicant%20Board/County-Health-Center-Co-Applicant-Board.aspx

The CAB meeting will be held in person at 4600 Broadway, Room 2020. Room 2020 is easily accessible without staff/security needing to let you in. It is at the top of the back stairs (near the Broadway entrance, not the garage entrance).

- If any Board member needs to teleconference for this meeting, a notice will be uploaded to our website at https://dhs.saccounty.gov/PRI/Pages/Health%20Center/Co-Applicant%20Board/County-Health-Center-Co-Applicant-Board.aspx by 8:30 a.m. on the morning of the meeting along with a link available to the public to observe the meeting via Teams video and/or teleconference.

- The meeting facilities and virtual meetings are accessible to people with disabilities. Requests for accessible formats, interpreting services or other accommodations may be made through the Disability Compliance Office by calling (916) 874-7642 (CA Relay 711) or email DCO@saccounty.gov as soon as possible prior to the meeting.

CALL TO ORDER (9:30 AM)

Opening Remarks and Introductions – *Suhmer Fryer, Chair*

a. Roll Call and Welcome
b. Brief Announcements
   i. COI Attestation Needed by 07/02/24

INFORMATION ITEMS (9:35 AM)

1. Review of HRSA Operational Site Visit Corrective Actions Needed

   -Dr. Hutchins

2. ~~Review of Proposed CAB Bylaws Changes~~

   ~~-Dr. Hutchins / Marcie Zakheim~~

~~3.~~2. CAB Diversity and Recruitment Priorities

-Dr. Besse

~~4.~~3. 2024 Quarter 1 No Show Report by Health Center Site

-Dr. Hutchins

INFORMATION/ACTION ITEMS[1] (9:55 AM)

BUSINESS ITEM I.

Presentation of Proposed Revised Sliding Fee Discount Scale for Preventive Dental Service and Preventive Dental Charges

a.) *Recommended Action:* Motion to Approve the preventive dental charges and revised preventive dental sliding fee scale

BUSINESS ITEM II.

Revision of PP-CS-11:03: CAB Conflict of Interest and Attached COI Attestation Form to Reflect Correct Eligibility Requirements

a.) *Recommended Action:* Motion to Approve the proposed revision of Policy and Procedure document *11-03: Co-Applicant Board Conflict of Interest*.

~~BUSINESS ITEM III.~~

~~Review of Proposed Co-Applicant Agreement Changes~~

~~a.) *Recommended Action:* Motion to Approve the revised Co-Applicant Agreement.~~

BUSINESS ITEM III~~IV~~.

Primary Care Center and Loaves and Fishes site hours of operation and planned expanded hours for HRSA Expanded Hours grant.

a.) *Recommended Action:* Motion to Approve expansion of Primary Care Center and Loaves and Fishes site hours in advance of grant decision by HRSA.

PUBLIC COMMENT (10:20 AM)

Anyone may appear at the CAB meeting to provide public comment regarding any item on the agenda or regarding any matter that is within CAB's subject matter jurisdiction. The Board may not take action on any item not on the agenda except as authorized by Government Code section 54954.2.

[1] Time estimate: 5-10 minutes per item, unless otherwise noted

- Should the meeting be made available via teleconference platform, public comment may also be made via Teams teleconference by using the raised hand feature. Those joining the meeting via Teams are requested to display their full name.

CLOSED SESSION
None
MEETING ADJOURNED

Chapter	Demonstrating Compliance Elements	Compliance Demonstrated? (Yes/No/NA)	Notes	Planned Action	Lead	Timing	Take to CAB?
3-NEEDS ASSESSMENT	a. Service Area Identification and Annual Review	N	1) Need to complete 2024 Service Area Analysis; 2) Correct Form 5B - PCC zip codes;	1_ Completed; 2) Submitted, pending HRSA review	1) Sharon; 2) Sharon	Submitted prior to CRO period	No
4- REQUIRED & ADDITIONAL HEALTH SERVICES	a.Providing and Documenting Services within Scope of Project	N	1) Correct Form 5A as agreed upon by Site Reviewers; 2) Referring/linking school-based patients wih other health services & tracking system — evidence	1) Submitted; Pending HRSA approval; 2) Will formulate response once we receive the written report.	1) Sharon; 2) Andrew, Sumi & Michelle	1) Submitted prior to CRO period 2) Michelle/Sumi	No
6-ACCESSIBLE LOCATIONS & HOURS OF OPERATION	c. Accurate Documentation of Sites within Scope of Project	Y	Not a finding, but SCHC has to update the contractor address for 7 school sites on Form 5B.	Sharon will work with Kathy on an admin update. Need letter on our letterhead as well as a letter from SCOE re their correct address.	Sharon	Everything that can be done has been.	No
9-SLIDING FEE DISCOUNT PROGRAM	c. Sliding Fee for Column I Services	N	Dental scale	1) Confer with SNAHC & get their charge; 2) redo Dental Scale - 6/25 mtg 3) Go to CAB with proposed revised scale and/or charges - July 1 (email by 6/27); 4) Submit to HRSA	1) Robyn & Sharon; 2) Sharon & Robert; 3) Michelle; 4) Sharon	Before and during CRO	YES - special meeting? July 1 or 2?
12-CONTRACTS AND SUBAWARDS	e. HRSA Approval for Contracting Substantive Programmatic Work	N	No record of HRSA Approval of UCD Contract	Work with HRSA re submitting UCD contract that was NOT submitted with the SAC application (did not submit the main contract, but the psychiatric contract)	Sharon, Rachel, Adam	CRO - submit contracts into EHBs - 6/28/24	No
16-BILLING & COLLECTIONS	g. Accurate Patient Billing	N		Mark to do workflow. Sharon to submit OCHIN Change Form. Robert will work with Debbie to oversee OCHIN completing the jira. Mark to train folks and implement. Robert to create patient bill files for the new SCDP patients.	Mark, Sharon, Robert & Debbie	During and after CRO	No
19-BOARD AUTHORITY	a. Maintenance of Board Authority Over Health Center Project	N	Co-Applicant agreement does not align with HRSA requirements	1) Amend Co-Applicant agreement; 2) CAB approval; 3) BOS Approval	Michelle & Andrew - Legal Counsel	1-2) CRO; 3) TBD	Yes - 7/1
	c. Exercising Required Authorities and Responsibilities	N	#7 - CAB needs to get data to evaluate utlization data - need to get from all sites by site	1) Admin to evaluate productivity by site; 2) Present to CAB - READY TO PRESENT	Admin & Sharon/ Michelle	1) CRO; 2) CRO	Yes - 7/1 1st reading; 7/19 vote
20-BOARD COMPOSITION	a. Board Member Selection and Removal Process	N	PENDING REVIEW BY HRSA OF LEGAL INFO PROVIDED BY SCHC: Co-Applicant agreement & Bylaws do not align with HRSA requirements; BOS ratification of CAB membership	1) Amend Co-Applicant agreement; 2) BDL written and submitted, 3) CAB approval on 6/4 ; 4) BOS Approval	Michelle & Andrew - Legal Counsel	1-2) CRO - Feldsman & CC; 3) CAB approval; 4) BOS Approval	Yes - 7/1
	b. Required Board Composition	N	Q. 4 - provisions regarding DHS employees - change Bylaws and CAB COI attestation (SES and Age in Bylaws are NOT NEEDED. However, it is not required to remove them.)	1) Ditto above re Bylaws. 2) Change wording of Bylaws and and PP-CS-01-03 and the CAB COI attestation to reflect prohibiton from working at or being related to staff at DHS not Health Center. (Also, recommended to remove SES and Age in Bylaws.); 3) CAB members to sign new COI attestations and approve Bylaw changes	1) Michelle; 2) Michelle, Robyn, & Sharon; 3) Michelle/ Cortney	1) TBD; 2) CRO; 3) CRO/TBD	Yes - 7/1
	c. Current Board Composition	N	Patient board members are not fully representative of patient population - race, ethnicity & gender -- All women; no Asian membership	1) Re-poll CAB members re race, ethnicity & Gender and groups they can represent - e.g. kids if parent member; 2) Revise recruitment plan; 3) Implement plan	Michelle/ Cortney	TBD	Yes - 7/1

No Show Rates by SCHC Service Sites
2024, Quarter 1 (1/1/24 to 03/31/24)

Service Site	No Show	Com-pleted	Grand Total	No Show Rate
4600 Broadway	2,326	12,820	15,146	15%
Loaves & Fishes	41	531	572	7%
Mobile Van	34	293	327	10%
School-Based Mental Health Sites	227	2179	2406	*9%*
Arcohe Elementary School	*12*	*105*	*117*	*10%*
Cordova High School	*7*	*136*	*143*	*5%*
Ethel Baker Elementary School	*19*	*232*	*251*	*8%*
Frederick C Joyce K-8	*5*	*83*	*88*	*6%*
Hiram Johnson High School	*15*	*88*	*103*	*15%*
Howe Ave Elementary School	*0*	*110*	*110*	*0%*
Inderkum High School	*76*	*123*	*199*	*38%*
Isleton Elementary School				
K. Johnson Middle School/Encina HS	*0*	*235*	*235*	*0%*
Las Palmas Elementary School	*15*	*223*	*238*	*6%*
Luther Burbank High School	*38*	*95*	*133*	*29%*
Madison Elementary School	*10*	*180*	*190*	*5%*
Mills Middle School	*0*	*89*	*89*	*0%*
Pacific Elementary School	*16*	*158*	*174*	*9%*
Taylor St. Elementary School	*0*	*25*	*25*	*0%*
Vernon Greer Elementary School	*4*	*205*	*209*	*2%*
Woodridge Elementary School	*10*	*92*	*102*	*10%*
Totals	**2,628**	**15,823**	**18,451**	**14%**

No Show Rates by Program Areas at PCC - 4600 Broadway
2024, Quarter 1 (1/1/24 to 03/31/24)

PCC Site Clinical Program	No Interpreter Needed			Interpreter Needed			Grand Total	Overall No Show Rate
	No Show	Com-pleted	No Show Rate	No Show	Com-pleted	No Show Rate		
ADULT MEDICINE	**789**	**2,783**	**22%**	**491**	**2,758**	**15%**	**6,821**	**19%**
In Person	728	2,358	24%	464	2,540	15%	6,090	20%
Telephone	61	416	13%	27	217	11%	721	12%
Video		9	0%		1	0%	10	0%
PEDIATRIC MEDICINE	**315**	**911**	**26%**	**155**	**600**	**21%**	**1,981**	**24%**
In Person	301	807	27%	142	544	21%	1,794	25%
Telephone	14	104	12%	13	56	19%	187	14%
FAMILY MEDICINE	**95**	**284**	**25%**	**60**	**423**	**12%**	**862**	**18%**
In Person	88	259	25%	57	419	12%	823	18%
Telephone	1	8	11%	1	3	25%	13	15%
Video	6	17	26%	2	1	67%	26	31%
BEHAVIORAL HEALTH SERVICES	**86**	**236**	**27%**	**28**	**81**	**26%**	**431**	**26%**
In Person	69	227	23%	27	78	26%	401	24%
Telephone	17	9	65%	1	3	25%	30	60%
HOMELESS SERVICES	**39**	**504**	**7%**	**2**	**27**	**7%**	**572**	**7%**
In Person	38	479	7%	1	20	5%	538	7%
Telephone	1	25	4%	1	7	13%	34	6%
MOBILE SERVICES	**34**	**287**	**11%**	**0**	**6**	**0%**	**327**	**10%**
In Person	34	287	11%		6	0%	327	10%
REFUGEE SERVICES	**1**	**42**	**2%**	**96**	**3,283**	**3%**	**3,422**	**3%**
In Person		19	0%	67	1,312	5%	1,398	5%
Telephone	1	23	4%	29	1,971	1%	2,024	1%
SPECIALTY SERVICES	**101**	**578**	**15%**	**97**	**792**	**11%**	**1,568**	**13%**
In Person	85	392	18%	96	573	14%	1,146	16%
Telephone	16	186	8%	1	219	0%	422	4%
DENTAL SERVICES	**9**	**22**	**29%**	**3**	**27**	**10%**	**61**	**20%**
In Person	9	22	29%	3	27	10%	61	20%
Grand Total	**1,469**	**5,647**	**21%**	**932**	**7,997**	**10%**	**16,045**	**15%**

	County of Sacramento **Department of Health Services** **Division of Primary Health Services** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**11-01**
		Effective Date	**02-01-12**
		Revision Date	**06-28-24**
Title: **Sliding Fee Discount Program**		Functional Area: **Fiscal Services**	
Approved By: Andrew Mendonsa, PsyD, Division Manager			

Policy:

A. Background and Purpose

The Health Resources and Services Administration (HRSA) has designated the Sacramento County Health Center (SCHC) as a Federally Qualified Health Center (FQHC). As an FQHC, the SCHC is required to abide by regulations regarding service provision to low-income patients. Section 330 of the Public Health Service Act contains these regulations.

The purpose of this policy is to ensure that no patient is denied health care services due to inability to pay for such services and to ensure that any fees or payments charged by the SCHC for such services will be reduced or waived if a patient is eligible for the Sliding Fee Discount Program (SFDP), as outlined by HRSA.

B. Definitions

Sliding Fee Discount Program (SFDP): A set of tiered discounts based on the Federal Poverty Level Guidelines for HRSA-required and additional services:

- Applicable to all individuals and families with annual income at or below 200 percent of the Federal Poverty Level (FPL) Guidelines;
- Providing a full discount for individuals or families with annual incomes at or below 100 percent of the FPL;
- Providing an adjustment of fees based on family size and income for individuals and families with income above 100 and at or below 200 percent of the FPL; and
- Providing no sliding fee discounts for individuals and families with annual income above 200 percent of the FPL.

See *Attachment A*: *SCHC Sliding Fee Tables* for the most current SFDP tiers and nominal charges per service category.

Federal Poverty Level (FPL): The annual income level below which a person (or family) is considered to be living in poverty, depending on family size, that is set in January each year by US Department of Health and Human Services (DHHS) and published in the Federal Register (see https://aspe.hhs.gov/poverty-guidelines). The SCHC sliding fee discount program is based on current FPL levels and is updated annually.

Family: For the purposes of assessing the federal poverty level, a “family” consists of those members supported by the reported income—typically the individuals reported on the federal tax return.

HRSA Required and Additional Services: The set of services that any FQHC is required to provide (directly or indirectly by agreement with another provider) to patients under federal regulations and additional services that an FQHC adds to its official scope of work with approval by HRSA. See *Attachment B: SCHC Scope of Services* for the most current list of

services covered by the SFDP.

Nominal Charge: A small, flat fee that is "nominal" from the patient's perspective and is unrelated to the actual cost of the service provided. The purpose of the charge is to enhance the perceived value of health care services received without creating an economic barrier to receiving care.

C. Applicability of the Sliding Fee Discount Program (SFDP)

Sacramento County Health Center (SCHC) maintains a standard set of procedures for its SFDP. These procedures apply to all patients regardless of health coverage or immigration status. Sliding fee discounts (SFDs) are available to patients with income at or below 200% of the FPL. Patients living below 100% of the FPL are assessed a nominal charge per visit as allowed by HRSA and approved by the Co-Applicant Board (see *Attachment A*: *SCHC Sliding Fee Tables)*.

The SFDP applies to HRSA's required and additional services for SCHC, which constitute all services within SCHC's Scope of Services and all HRSA required services provided by non-SCHC providers through an agreement between SCHC and another party. *Attachment B: SCHC Scope of Services* contains the list of services for which patients may be eligible to receive a sliding fee discount. The SFDP does not cover visits outside of SCHC's Scope of Services (i.e., other than the HRSA required and additional services). For example, if a patient covered by a Managed Medi-Cal plan is approved by that health plan for cosmetic plastic surgery (which is outside of SCHC's Scope of Services) but is subject to a co-pay for that service, the patient may not receive a SFD from SCHC for that co-pay.

Any patient seeking a HRSA-required or additional service from SCHC who meets the SFDP eligibility requirements may receive a SFD. For such patients with health insurance, the SFDP applies to non-covered services, co-payments, deductibles, and coinsurance, as well for services (i.e., sensitive services) for which a patient does not wish to use their insurance coverage. Patients with coverage that cannot be used to pay for services at SCHC (i.e., 3rd party pay or self-pay patients) are also covered by the SFDP.

B. Establishing and Reviewing the Sliding Fee Schedule and Nominal Charge

The SFD Schedule and any nominal charge are set annually after DHHS publishes the federal poverty guidelines in the Federal Register (typically in January). Staff reviews discounts offered by similar entities (e.g. FQHCs, Community Health Centers) in the area and takes costs into account. Staff also reviews the nominal charge for continued appropriateness, comparing fees charged by similar entities in the area. SCHC leadership may engage a consultant to assist with this review. Staff may recommend no change or propose a modification to the discount schedule to the SCHC Co-Applicant Board (CAB). Recommendations are presented to the CAB for review and approval no later than the April meeting each year, except under extraordinary circumstances.

Procedure:

Sacramento County Health Center personnel and contractors follow a standard set of procedures for

- Informing patients and patient guardians or conservators about the SFDP;
- Assessing patients' eligibility for the SFDP;
- Assisting patients to apply for the SFDP and verifying application documentation;
- Providing and billing for services at discounted prices for those in the SFDP;
- Reviewing SFDP patients' continued SFDP eligibility at least annually; and

- Monitoring and evaluating the impact of the SFDP.

A. Communication about the SFDP to Patients

Signage posted at each primary care delivery site and on the SCHC's website informs patients of the SFDP. In addition, the new patient packet contains information on the SFDP, including eligibility requirements and the process to apply. Finally, information about the SFDP is communicated to patients when staff conducts new patient outreach, schedules a new patient appointment, or when revised income or family size information provided by an existing patient alters eligibility.

Assessing Patients' Eligibility for SFDP

1. New Patients
    a. Upon enrollment with SCHC, a Patient Service Representative (PSR) determines whether a patient has healthcare coverage by checking Medi-Cal, Medicare, and healthcare portals. This information is recorded, or updated, if necessary, in the Electronic Medical Record (EMR) system—OCHIN EPIC ("OCHIN").
        i. Patients without health care coverage are encouraged, but not required, to apply for coverage, because it is a valuable asset that can improve a patient's health trajectory and assist them to establish and maintain a medical home.
            1) The PSR informs the patient about possible sources of health coverage, including:
                a) Medi-Cal;
                b) Medicare;
                c) Healthy Partners (Sacramento County's program for undocumented individuals aged 27-49 years); and
                d) Other public and/or private health insurance and/or discount programs available for which the patient may qualify, including prescription drug assistance from pharmaceutical companies.
            2) The PSR asks the patient if they would like a referral to a health care navigator to assist them in understanding what coverage options may be available as well as assistance with insurance enrollment. If the patient agrees, the PSR will refer the patient to either Member Services (for Sacramento County's Healthy Partners) or Sacramento Covered (for the other programs).
            3) Inform patients ≤200% FPL that we have a SFDP and ask if they may be interested in applying. If the patient says yes, explain how to apply, including giving them an application.
        ii. Patients with health care coverage
            1) If the patient's health care coverage is not accepted for payment by SCHC (i.e. is provided by an organization with which SCHC does not have a contract, agreement or other arrangement to provide payment).
                a. The PSR informs the patient of this fact and that they will be responsible for paying for the services on their own. The PSR offers the patient assistance to identify their assigned medical home or to identify a provider that may

accept their coverage or to apply for the Sliding Fee Discount Program. If the patient would still like to receive services from SCHC, the PSR informs the patient that they will be financially responsible for their services. If such a self-pay patient meets eligibility requirements, they can receive a SFD for SCHC health care services.

2) If the patient's coverage is accepted for payment by SCHC but coverage requires patient financial responsibility for a portion of charges incurred (e.g. co-pay, deductible, or coinsurance) or for all HRSA required and additional services, the patient can receive a SFD for SCHC health care services if they meet SFDP eligibility requirements.

b. Prior to enrollment, the PSR asks the patient to provide their family (see *Definitions* section) income and family size (among other demographic information) and records this information in OCHIN. OCHIN calculates the FPL automatically and flags the eligibility of the patient for the SFDP.

c. If the patient is eligible for the SFDP, the PSR explains the program to the patient and asks if the patient would like to apply. Please see *Section C: Application Process for SFDP* below for next steps.

2. Existing Patients

a. Prior to each appointment, a Member Services PSR verifies whether an existing patient has healthcare coverage by checking relevant eligibility portal(s). The PSR records or updates, as appropriate, this information in OCHIN.

b. During check in for each appointment, the registration PSR obtains (or updates) the patient's income, family size and residential address (among other demographics) and records it in OCHIN.

i. If a change to an existing patient's income, family size, and/or residency makes them eligible for the SFDP, the registration PSR explains the program to the patient, provides them with the SCHC Sliding Fee Information Sheet (see *Attachment C*) either in person or via a mutually acceptable electronic method, and asks if the patient would like to apply. Please see *Section C: Application Process for SFDP* below for next steps.

ii. If a change to an existing patient's income, family size, and/or residency changes the SFDP Tier for which the patient is eligible or makes them ineligible for the SFDP, the PSR explains this fact to the patient and lets them know that SCHC will bill (using the new status) for services provided.

B. Assisting Patients to Apply for SFDP

1. When a patient indicates interest in applying for the SFDP, the PSR asks the patient to complete the Sliding Fee Application (see *Attachment D*) and refers the patient to Member Services for assistance in completing the application and identifying appropriate documentation.

   The Member Services PSR meets with the patient (by phone or in person) to explain the type of documentation required to show their income, family size, and residency in Sacramento County (see table below).

Income	
Income includes:	Verification (one of the following):
Wages before deductions (federal gross income)	● Paycheck stub (most recent pay period) ● Current tax return (required if self-employed) ● Letter from employer on letterhead ● Affiliated agency income verification documentation
Other income such as pension, retirement, social security, worker's compensation, unemployment, public assistance, alimony, gambling income, etc.	● Award letter ● Paycheck stub ● Check
If no income	● Self-Attestation of Income form
Family Size	
Family: those members supported by the reported income—typically the individuals reported on the federal tax return	Patient attestations are typically used for verification, although marriage, birth and/or adoption certificates may be requested.
People to include in family size:	● The patient ● Dependents of the patient listed in the patient's most recent federal income tax form ● If the patient is a dependent of a family member, the head of household on the federal income tax form, and any other dependents listed on that form
People <u>not to</u> include:	● Individuals who do not live with the applicant, unless economically dependent on the patient or if the patient is economically dependent on them ● Unrelated individuals (i.e., roommates/housemates) living with the patient
County Residency	
Residency is defined as living in Sacramento County, or intent to live in Sacramento County within 30 days.	Verification by a reoccurring bill with an address within Sacramento County. e.g. a utility bill, tax bill or rental agreement with patient's or family member's name and an address within Sacramento County.

2. Patients who refuse to complete the SFDP application or to provide required documentation are not granted a sliding fee discount and will be assessed full charges for the services (or portion for which they are financially responsible under any health care coverage).
3. If a patient learns about the SFDP just before a scheduled visit, the PSR informs them that SCHC will provide presumptive SFDP eligibility for the visit if they bring in the required documentation within 30 days and before their next visit. Patients who fail to provide required documentation are not granted the SFD and will retroactively be billed full undiscounted charges for the visit with presumptive eligibility.

4. The Member Services PSR scans all documentation provided into the FDS Consent to Bill module in the patient's OCHIN chart. The patient is eligible for a SFD when all documentation is received and FPL criteria for a discount are met.
5. Using the attached sliding fee schedule (see *Attachment A*), the Member Services PSR determines the specific amount of discount for which the patient is eligible.
6. While a patient is awaiting their determination of eligibility from Medi-Cal, Medicare, or Healthy Partners, they will be offered a SFD for services based on their self-reported income, if all other required documentation is provided. If health care coverage is subsequently retroactively granted to the date of service, SCHC will refund any SFD payments accepted.
7. SFDP eligibility remains in effect for 12 months once SFDP eligibility is established.
8. Patients granted SFDP enrollment are notified of their responsibility to inform SCHC of any change in income, family size, or residency within 30 days of the change during this 12-month eligibility period.

C. Billing for SFDP

For the purposes of determining the amount owed by a patient under the SFDP, each visit to SCHC is considered to be separate regardless of the day of service. For example, if a patient has a primary care visit at SCHC on the same day that they receive x-ray services and see the cardiologist at SCHC, each is considered a separate visit and the appropriate SFD (if any) will be applied to each visit separately. Visits to external providers (including Quest Laboratory) contracted by and/or paid by SCHC are also considered separate visits.

SCHC does not collect payment at the time of visit (see *Clinic Services Policy 11-02 Billing and Collections)*. Patients are informed that they are expected to pay and will receive a bill. Discounts for each tier of the SFDP and the nominal charge are published in tables easily accessible by patients (see *Attachment A: SCHC Sliding Fee Tables*). As detailed in *Clinic Services Policy 11-02 Billing and Collections*, SCHC leadership may grant a waiver of charges accrued by a participant in the SFDP due to economic hardship.

D. Reviewing Continued Eligibility for SFDP

Patients are required to be re-qualified for the SFDP annually by providing new/updated documentation of income, family size, and residency. Prior to each visit, a Member Services PSR checks whether existing patients are enrolled in the SFDP. If they are, the PSR checks the annual review date. If that review date is within 6 weeks of the appointment date, the PSR informs the patient and requests the patient provide updated documentation of income, family size and residency.

E. Monitoring Adherence to SFDP policies

1. Each month, the supervisor of Member Services examines data to monitor adherence to this SFDP policy and procedure, including reviewing:
    a. 10% of the charts of patients flagged for eligibility for SFD by OCHIN to determine if the appropriate SFD was offered to the patient; and
    b. 10% of current SFDP patient charts per month to ensure that required documentation was obtained and scanned and that patients' status was reviewed annually.
    c. If they find deviations from this policy and procedure, the Member Services supervisor reviews the error and proper procedure with the staff member who made each error. Repeated errors may result in disciplinary action.

d. If a pattern of errors is found for multiple individuals, all PSRs are retrained on the policy and procedure.

2. The Member Services supervisor reports on the findings of the compliance monitoring monthly at the Compliance Team meeting. Findings of systemic deviations may also result in a quality improvement project being implemented and overseen by the Quality Improvement Committee.

F. Evaluating Effect of the SFDP on Patient Usage of Health Services

At least once every three years, SCHC evaluates its SFDP by:

1. Collecting utilization data that allows assessment of the rate at which patients within each of its discount pay tiers, including those at or below 100% of the FPL, are accessing services;
2. Utilizing this and, if applicable, other data (for example, results of patient satisfaction surveys or focus groups, surveys of patients at various income levels) to evaluate the effectiveness of its SFDP in reducing financial barriers to care; and
3. Identifying and recommending changes as needed to the Co-Applicant Board for possible revision of this document.

References:
HRSA Compliance Manual, Chapter 9: Sliding Fee Discount Program
PP-CS-11-02 Billing and Collections
PP-CS-01-01 Quality Improvement

Attachments:
Attachment A: SCHC Sliding Fee Discount Program Tables, 2024
Attachment B: SCHC Scope of Services
Attachment C: Sliding Fee Information Sheet
Attachment D: SCHC Sliding Fee Discount Program Application
Attachment E: Attestation of No Income Form
Attachment F: Attestation of Sacramento County Residence
Attachment G: Sliding Fee Discount Program Acknowledgement Form
Attachment H: Sliding Fee Discount Program Notice of Enrollment

Contact:
HPM for Quality and Compliance (for Policy questions)
Clerical Supervisor for Member Services (for Procedure questions)

Approval by the Co-Applicant Board:
07/01/2024

Sacramento County Health Center

Attachment A: Sliding Fee Discount Program Tables 2024

Rev. July 2024

SACRAMENTO COUNTY

Sacramento County Health Center

2024 Schedule of Sliding Fee Discounts Based on Income and Family Size for Preventive Dental Care

Persons in Family	Nominal Fee	Tier A	Tier B	Tier C	Full Price
	≤100%[1]	>100% to ≤133%[1]	>133% to ≤167%[1]	>167% to ≤200%[1]	>200%[1]
1	$15,060	$15,061 -$20,030	$20,031 -$25,000	$25,0011 -$30,120	$30,121
2	$20,440	$20,441 - $27,185	$27,186 -$33,390	$33,391 - $40,880	$40,881
3	$25,820	$25,821 - $34,341	$34,342 - $42,861	$42,862 - $51,640	$51,641
4	$31,200	$31,201 - $41,496	$41,487 - $51,792	$51,793 - $62,400	$62,441
5	$36,580	$36,581 - $48,651	$48,652 - $60,723	$60,724 - $73,160	$73,161
6	$41,960	$41,961 -$55,807	$55,808 - $69,654	$69,655 - $83,920	$83,921
7	$47,340	$47,341 - $62,962	$62,963 - $78,584	$78,585- $94,680	$94,681
8	$52,720	$52,721 - $70,118	$70,119 - $87,515	$87,516 - $105,440	$105,441
9	$58,100	$58,101 - $77,273	$77,274 - $96,446	$96,447 - $116,200	$116,201
10	$63,480	$63,481 - $84,428	$84,429- $105,377	$105,378 - $126,960	$126,961
11	$68,860	$68,861 - $91,584	$91,585 - $114,308	$114,309 - $137,720	$137,721
12	$74,240	$74,241 - $98,739	$98,740 - $123,238	$123,239 - $148,480	$148,481
13	$79,620	$79,621 - $105,895	$105,896 - $132,168	$132,169- $159,240	$159,241
14	$85,000	$85,001 - $113,049	$113,050 - $141,100	$141,101 - $170,100	$170,101
Nominal Fee/ Discount*	**$20***	**35%**	**20%**	**10%**	**NO DISCOUNT**

**Per test/service*

[1]Percentage of Federal Poverty Level

Rev. July 2024

SACRAMENTO COUNTY

Sacramento County Health Center

2024 Schedule of Sliding Fee Discounts Based on Income and Family Size for Diagnostic Laboratory Services (through Quest Diagnostics)

Persons in Family	Nominal Fee	Tier A	Tier B	Tier C	Tier D	Full Price
	<100%	>100% and ≤138%	138% and150%	150% and 175%	175% and 200%	>200%
1	≤$15,060	$15,061 -$20,782	$20,783 -$22,590	$22,591 -$26,355	$26,356- $30,120	$30,121
2	≤$20,440	$20,441 - $28,207	$28,208 -$30,660	$30,661 - $35,770	$35,771 - $40,880	$40,881
3	≤$25,820	$25,821 - $35,631	$35,632 - $38,730	$38,731 - $45,185	$45,186 - $51,640	$51,641
4	≤$31,200	$31,201 - $43,056	$43,057 - $46,800	$46,801 - $54,600	$54,601 - $62,400	$62,401
5	≤$36,580	$36,581 - $50,480	$50,481 - $54,870	$54,871 - $64,015	$64,016 - $73,160	$73,161
6	≤$41,960	$41,961 - 57,904	$57,905 - $62,940	$62,941 - $73,430	$73,431 - $83,920	$83,921
7	≤$47,340	$47,341 - $65,329	$65,330 - $71,010	$71,011 - $82,845	$82,846 - $94,680	$94,681
8	≤$52,720	$52,721 - $72,753	$72,753 - $79,080	$79,081 - $92,260	$92,260 - $105,440	$105,441
9	≤$58,100	$58,101 - $80,178	$80,179 - $87,150	$87,151 - $101,675	$101,676- $116,200	$116,201
10	≤$63,480	$68,481 - $87,602	$87,603 - $95,220	$95,221 - $111,090	$111,091 - $126,960	$126,961
11	≤$68,860	$68,861 - $95,026	$95,027 - $103,290	$103,291 - $120,505	$120,506 - $137,720	$137,721
12	≤$74,240	$74,241 - $102,541	$102,542 - $111,360	$111,361 - $129,920	$129,921 - $148,480	$148,481
13	≤$79,620	$79,621 - $109,875	$109,876 - $119,430	$119,431 - $139,335	$139,336 - $159,240	$159,241
14	≤$85,000	$85,001 - $117,300	$117,301 - $127,500	$127,501 - $148,750	$148,751 - $170,000	$170,001
Discount*	**100%**	**75%**	**65%**	**55%**	**25%**	**NO DISCOUNT**

**Per test/service*

[1]Percentage of Federal Poverty Level

Rev. July 2024

SACRAMENTO COUNTY

Sacramento County Health Center

2024 Schedule of Sliding Fee Discounts Based on Income and Family Size for All Other In-Scope SCHC Services (per visit)

Persons in Family	Nominal Fee	Tier A	Tier B	Tier C	Tier D	Full Price
	≤100%[1]	>100% and ≤138%[1]	>138% and ≤150%[1]	>150% and ≤175%[1]	>175% and ≤200%[1]	>200%[1]
1	≤$15,060	$15,061 -$20,782	$20,783 -$22,590	$22,591 -$26,355	$26,356- $30,120	$30,121
2	≤$20,440	$20,441 - $28,207	$28,208 -$30,660	$30,661 - $35,770	$35,771 - $40,880	$40,881
3	≤$25,820	$25,821 - $35,631	$35,632 - $38,730	$38,731 - $45,185	$45,186 - $51,640	$51,641
4	≤$31,200	$31,201 - $43,056	$43,057 - $46,800	$46,801 - $54,600	$54,601 - $62,400	$62,401
5	≤$36,580	$36,581 - $50,480	$50,481 - $54,870	$54,871 - $64,015	$64,016 - $73,160	$73,161
6	≤$41,960	$41,961 - 57,904	$57,905 - $62,940	$62,941 - $73,430	$73,431 - $83,920	$83,921
7	≤$47,340	$47,341 - $65,329	$65,330 - $71,010	$71,011 - $82,845	$82,846 - $94,680	$94,681
8	≤$52,720	$52,721 - $72,753	$72,753 - $79,080	$79,081 - $92,260	$92,260 - $105,440	$105,441
9	≤$58,100	$58,101 - $80,178	$80,179 - $87,150	$87,151 - $101,675	$101,676- $116,200	$116,201
10	≤$63,480	$68,481 - $87,602	$87,603 - $95,220	$95,221 - $111,090	$111,091 - $126,960	$126,961
11	≤$68,860	$68,861 - $95,026	$95,027 - $103,290	$103,291 - $120,505	$120,506 - $137,720	$137,721
12	≤$74,240	$74,241 - $102,541	$102,542 - $111,360	$111,361 - $129,920	$129,921 - $148,480	$148,481
13	≤$79,620	$79,621 - $109,875	$109,876 - $119,430	$119,431 - $139,335	$139,336 - $159,240	$159,241
14	≤$85,000	$85,001 - $117,300	$117,301 - $127,500	$127,501 - $148,750	$148,751 - $170,000	$170,001
Fee*	**$20**	**$25**	**$35**	**$45**	**$55**	**NO DISCOUNT**

**Per visit charge*

[1]Percentage of Federal Poverty Level

Rev. July 2024

Attachment B: SCHC Scope of Services

HRSA Required Services

General primary medical care
Diagnostic laboratory services *(NOTE: SEPARATE SLIDING FEE SCHEDULE)*
Diagnostic radiology
Screenings
Coverage for emergencies during and after-hours
Voluntary family planning
Immunizations
Well child services
Gynecological care
Obstetrical Care
- Prenatal care
- Intrapartum care (labor and delivery)
- Postpartum care

Preventive dental services *(NOTE: SEPARATE SLIDING FEE SCHEDULE)*
Pharmaceutical services
Substance Use Disorder services
Case management.
Eligibility assistance
Health education
Outreach
Transportation
Translation

HRSA Additional Services

Mental health services

SCHC Additional Services

Cardiology
Neurology

Appendix C
Sacramento County Health Center Sliding Fee Discount Program Information Sheet - 2024

The Health Center wants to ensure that all patients get the care they need as quickly as possible. To assist patients who cannot get insurance or other coverage, or who cannot use it at SCHC, there is a sliding fee schedule that you may qualify for to reduce the cost of the care you receive here. The following guidelines apply:

- The sliding fee program is based on income and family size.
- Complete the application and re-apply every year or earlier if your income or family size changes.
- You are required to provide documents in order to enroll in the program. *See below and application for more information.*

SCHC offers a sliding fee discount scale (SFDS) that covers preventive dental services received at SCHC or at the Sacramento Native American Health Center. In partnership with Quest, SCHC offers a SFDS that covers diagnostic laboratory services provided by Quest. Finally, SCHC offers a SFDS that covers primary care office visits with the County Health Center providers, visits with cardiology and neurology providers at SCHC's main site on Broadway, and prescriptions filled at the County Pharmacy located at 4600 Broadway. Prescriptions from retail pharmacies are not covered by the SCHC sliding fee discount program; most pharmacies and pharmaceutical manufacturers have their own discount programs.

Begin the process by applying for Medi-Cal and other available health coverage programs. If you have already done this, please include a copy of your card with other required materials. If you are told you do not qualify, or only qualify for partial services, bring your letter to us with other required materials.

Materials to Bring

1. Sliding Fee Application: completed
2. Identification: California Driver License, State of California Identification Card, or Passport
3. Health insurance card or letter from Medi-Cal or Medi-Care: indicating coverage or eligibility for benefits.
4. Proof of Income: Most recent paycheck stub dated within 60 days of application OR most recent income tax return. Include documentation of any other income such as pension, retirement, social security, public assistance, workers compensation, unemployment, alimony, lottery winnings, etc.
5. Proof of Family Size: "Family" consists of those members related by birth, marriage or adoption who are supported by the reported income—typically the individuals reported on the federal tax return (Birth, Adoption, or Marriage certificates may be requested).
6. Proof of Residence: a utility bill / tax bill / rental agreement with your name and a Sacramento County address

Application Process

- Bring documents to Member Services in Suite 2600 at the Primary Care Center – the main Health Center site at 4600 Broadway. Staff will review your materials and let you know about your eligibility and fees for services. You can call first to make an appointment: 916-874-1805.
- If eligible, your coverage is for a one-year period. You must re-apply immediately if you have a change in income, family size, or residency.

Frequently Asked Questions

Q: Can I obtain the sliding discount if I do not provide the information requested?
A: *No. This is a voluntary program that follows federal rules. You will be responsible for full charges.*

Q: How often do I need to apply?
A: *Every year, OR you must reapply immediately if you have a change in income, residency, or family size.*

Q: Who is considered a member of the family?
A: For the purpose of assessing the federal poverty level, a "family" consists of those members supported by the reported income—typically the individuals reported on the federal tax return.

SACRAMENTO COUNTY HEALTH CENTER

SLIDING FEE DISCOUNT PROGRAM APPLICATION

Patient Information		**Today's Date: / /**		
First Name:	Middle:	Other names:		
Home Address:	City:		State:	Zip:
Mailing Address:	City:		State:	Zip:
Home Phone #:			Mobile Phone #:	
Date of Birth:	Social Security #:		Do you have Health Insurance?	
Marital Status:	Single In a relationship Married Divorced Separated Widowed			

Family Size		
Name	**Date of Birth**	**Social Security Number**

Family Income			
Name	**Amount**	**Frequency (circle one):**	**Employer:**
You	$	Weekly Monthly Yearly	
Partner	$	Weekly Monthly Yearly	
Child	$	Weekly Monthly Yearly	
Child	$	Weekly Monthly Yearly	
Other	$	Weekly Monthly Yearly	
Total	$	Weekly Monthly Yearly	

Other Income						
Other Income	You:	Spouse/Partner	Child	Child	Other	Subtotal
Social Security						
Retirement Pension						
Child Support						
Alimony						
Other						
					Total	$

SLIDING FEE DISCOUNT PROGRAM APPLICATION, CONTINUED
Section to be completed by Applicant:

The date the application is submitted will be the date any eligible discounts will apply to covered services received. In the event that an application is submitted without the required documentation, you will be notified and given 30 days from notification to submit the documentation without moving the submission date forward. If you do not submit the required documentation within the required 30-day time period, the application will be denied, and you will be required to re-submit the application.

Please attach at least one item from each applicable section on the previous page to complete your application. Incomplete applications will result in the patient not being enrolled in the Sliding Fee Discount Program.

I do hereby swear or affirm that the information provided on this application is true and correct to the best of my knowledge and belief. I agree that any misleading or falsified information, and/or omissions may disqualify me from further consideration for the Sliding Fee Discount Program and will subject me to penalties under Federal Laws, which may include fines and imprisonment. I further agree to inform Sacramento County Health Center if there is a significant change in my income, family size, or residence within thirty (30) days. If acceptance to the Sliding Fee Discount Program is obtained under this application, I will comply with all rules and regulations of the Sliding Fee Discount Program, as outlined in the *Sliding Fee Discount Program Acknowledgement Form*. I understand that the information I have provided is subject to verification by Sacramento County Health Center. I hereby acknowledge that I read the foregoing disclosure and understand it.

I will be billed for the sliding fee payment.

_____ _____ _____
PATIENT FIRST NAME MIDDLE INITIAL PATIENT LAST NAME

____/____/_____ _____
PATIENT DATE OF BIRTH PATIENT GENDER

_____
PRINTED NAME OF PARENT/LEGAL GUARDIAN/CONSERVATOR

_____ ____/____/_____
SIGNATURE TODAY'S DATE

_____ _____ ____ _____
BILLING ADDRESS: STREET # AND NAME CITY STATE ZIP CODE

Dear Patient,

Thank you for your interest in our Patient Financial Assistance Program. So that we can determine your eligibility, please complete the attached application form and return it to the correspondence address listed on your invoice, along with one or more of the required documents listed below:

- A copy of last year's W2 form
- A copy of last year's income tax return
- A copy of your most recent pay stub (s)
- A proof source indicating that you are eligible for local, state, or federal assistance programs.

Once we receive your completed application and documentation, we will determine if you meet the established criteria. Please allow approximately two weeks for your application to be processed. Do not make any payments until you receive notification regarding the status of your request.
Applying for acceptance into our Financial Assistance Program does not guarantee reduced charges.

If you have any additional questions or concerns, please do not hesitate to contact us.
Thank you for using Quest Diagnostics. We look forward to serving you in the future.

Sincerely,

Patient Billing Customer Service

Patient Financial Assistance Form

Patient Name:_____ **Telephone Number:** _____
Address:_____ **Patient Date of Birth:** _____
City:_____ **State:**_____ **Zip Code:** _____
Invoice Number(s): _____ **Lab Code:**_____

Please complete all information accurately. The signature of the patient or patient's guardian is required.

Please make sure to attach the required supporting documentation.

1. Does the patient have sufficient resources to pay for the testing and/or the deductible and coinsurance?
   - □ Yes If answer is "Yes", you are financially responsible for payment.
   - □ No If answer is "No", complete form below.
2. Is any source, other than the patient, legally responsible for the patient's medical bills (**e.g**., Medicaid, local welfare agency, guardian or other insurance program)?
   □ Yes □ No If answer is "Yes" list:

   Insurance Company Name: _____
   Address:_____
   Member I.D.: _____
   Other Source: _____
3. Patient/legal guardian's monthly household resources:

Salary	$_____
Social Security	$_____
Cash/Welfare Payment	$_____
Family Contribution	$_____
Income from Savings Accounts, CDs, etc.	$_____
Other	$_____
Total $	_____

4. Number of family members in household: _____

I hereby acknowledge that the above information is true and correct according to the best of my knowledge. I also authorize the release of any and all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified, and Quest Diagnostics will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

_____ _____ _____
Patient Name (PRINT) Parent/Guardian Name (PRINT) Today's Date

_____
Responsible Party Signature

For Official Use Only:

Bill Number	Amount $	Approved	Denied
Date Received:			
PCS Rep:			

Rev. 09/2019

SACRAMENTO COUNTY

SACRAMENTO COUNTY HEALTH CENTER

SLIDING FEE DISCOUNT PROGRAM APPLICATION, CONTINUED
Page to be completed by Primary Health Center Staff

Patient Name: DOB:

Verification Checklist Attach copies of each item checked below	**Yes**	**No**
***Identification/Address (Submit one of the following):** ☐ Driver's license, or ☐ Birth certificate, or ☐ Social Security Card, or ☐ Other: _____	☐	☐
***Income (Submit one of the following):** ☐ Prior year tax return (required if self-employed), or ☐ Single most recent pay stub, or ☐ W-2 or 1099 ☐ Attestation of No Income ☐ Other: _____	☐	☐
***Residence in Sacramento County (Submit one of the following):** ☐ Bill with name and residential address ☐ Signed rental agreement or tax bill for owned home ☐ Attestation of Sacramento County Residence	☐	☐
Health Insurance Information (if applicable): ☐ Insurance card(s) Type: ☐ Commercial ☐ Medi-Cal ☐ Medicare ☐ Share of Cost? Amount: _____ ☐ Evidence of eligibility for public benefits (e.g., letter) ☐ Evidence of rejection for coverage	☐	☐

**For these items, at least one piece of documentation is required.*

CONCLUSION:

☐ Patient is eligible for the Sliding Fee Discount Program in
Dental Tier: ___ Lab Tier: ___ All Other In-Scope SCHC Services Tier: ___ OR

☐ Patient is NOT eligible for Sliding Fee Discount Program based on documents provided.

_____
PRINTED NAME OF STAFF

_____ ____/____/_____
SIGNATURE OF STAFF Today's DATE

SACRAMENTO COUNTY HEALTH CENTER

Attestation of No Income

I hereby attest that I (or the patient) am(is) not employed and do(es) not have other income (*such as alimony, prices and awards, gambling winnings including from the lottery, jury duty pay, capital gains from stock or property sales, nonbusiness credit card debt cancellation*).

_____ _____ _____
PATIENT FIRST NAME MIDDLE INITIAL PATIENT LAST NAME

___/___/_____ _____
PATIENT DATE OF BIRTH PATIENT GENDER

_____
PRINTED NAME OF PARENT/LEGAL GUARDIAN/CONSERVATOR

_____ ___/___/_____
SIGNATURE TODAY'S DATE

SACRAMENTO COUNTY HEALTH CENTER

Attestation of Sacramento County Residence

I hereby attest that I (or the patient) live(s) in Sacramento County but am(is)

☐ Unhoused and do not have proof of my residence in Sacramento County.

☐ The _____ of _____
SPECIFY FAMILY RELATIONSHIP PERSON'S NAME
whose name is on the proof of residence document.

☐ The roommate of _____ whose
PERSON'S NAME
name is on the proof of residence document.

_____ _____ _____
PATIENT FIRST NAME MIDDLE INITIAL PATIENT LAST NAME

___/___/_____ _____
PATIENT DATE OF BIRTH PATIENT GENDER

_____
PRINTED NAME OF PARENT/LEGAL GUARDIAN/CONSERVATOR

_____ ___/___/_____
SIGNATURE TODAY'S DATE

SACRAMENTO COUNTY HEALTH CENTER

Sliding Fee Discount Program Acknowledgement Form

Patient Label Here

ACKNOWLEDGEMENT OF SLIDING SCALE PAYMENT

I understand:

- It is my responsibility to complete the Sliding Fee Discount Program application and provide necessary documents to establish my eligibility for a sliding scale rate.
- Sliding fee services do not include hospital services (emergency stabilization or inpatient) or specialty care provided outside of the Sacramento County Health Center.

ACKNOWLEDGEMENT OF MY RIGHTS

I understand:

- It is my right to be treated with dignity and respect by every staff member whether in person or by telephone.
- There is a formal complaint / grievance process that I may use if I believe my rights are violated. I understand that I can obtain a Clinic Services Comment Form from any Health Center registration desk or download one from https://dhs.saccounty.gov/PRI/Pages/Health%20Center/GI-Sacramento-County-Health-Center.aspx.

ACKNOWLEDGEMENT OF MY RESPONSIBILITIES

I understand it is my responsibility to

- Complete all necessary paperwork within 30 days to enroll in the program and receive a sliding scale rate.
- Notify the Health Center at **916-874-1805** within 30 days of any changes in my health insurance coverage, including Medi- Cal or Medicare, and/or any changes in my name, address, phone number, or family size.
- Work collaboratively with my provider.
- Attend all appointments or cancel appointments at least 48 hours in advance.
- Treat all clinic staff with dignity and respect whether in person or by telephone.

CONTACT INFORMATION

- Sacramento County Health Center staff may use the address and phone numbers provided for appointment reminders, lab results, or other communications regarding my medical care.
- I will update my contact information within 30 days if it changes.

Signature_____ Date_____

Witness_____ Date_____

Rev. July 2024

SACRAMENTO COUNTY HEALTH CENTER

Sliding Fee Discount Program
Notice of Enrollment

We are pleased to inform you that the following patient has been enrolled in the Sacramento County Health Center's Sliding Fee Discount Program.

PATIENT FIRST NAME	MIDDLE INITIAL	PATIENT LAST NAME
_____	_____	_____

PATIENT DATE OF BIRTH	PATIENT GENDER
____/____/_____	_____

This patient is in
Preventive Dental **Tier: ___**
Diagnostic Lab **Tier: ___**
All Other In-Scope SCHC Services **Tier: ___**

Eligibility dates for the Sliding Fee Discount are for one year, from

___/___/_____ to ___/___/_____.

Please remember to

1) Call Member Services if your address, family income, and/or family size changes before the expiration date; and
2) If you want to extend SFDP coverage after the time period shown above, submit a new application and documents at least 30 days prior to the expiration date.
3) Call the Member Services team at 916-874-1805 if you have questions.

	County of Sacramento **Department of Health Services** **Division of Primary Health** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**01-03**
		Effective Date	**01-31-13**
		Revision Date	~~05-24~~07-01-**24**
Title: **Sacramento County Health Center Co-Applicant Board – Conflict of Interest**		Functional Area: **Organization**	
Approved By: Andrew Mendonsa, PsyD, HRSA Project Director			

Policy:

Sacramento County Clinic Services adheres to the Health Services and Resource Administration (HRSA) requirement to maintain written standards of conduct covering conflict of interest. Conflicts of interest involving the Sacramento County Health Center Co-Applicant Board (CAB) must be identified and disclosed when the CAB member is considering entering into a transaction, arrangement, policy, financial, or other work that might benefit the private interest of the Board member. Board members with a conflict(s) of interest including financial interests may not participate in CAB discussions about or decisions regarding that issue. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest that are applicable to governmental, nonprofit, and charitable organizations.

Definitions:

A. Conflict of Interest – An actual or perceived interest by a Board member in an action which results, or has the appearance of resulting, in personal, organizational, or professional gain. A financial interest is a type of conflict of interest.

B. Financial Interest – A CAB member has a financial interest if s/he, directly or indirectly through business, investment, or family has:

   1. An ownership or investment interest in any entity with which the CAB has a transaction or arrangement.
   2. A compensation arrangement with any entity or individual with which the CAB has a transaction or arrangement. Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial, such as consultancy, fee-paid work, and shareholdings.

Procedures:

A. Form 700 - Statement of Economic Interests

   1. CAB members are required to fully disclose their personal assets and income.
   2. CAB members complete and file Form 700 with the Clerk of the Board of Supervisors:
      a. Within 30 days of position appointment;
      b. Annually during appointment by the date specified in the California Fair Political Practices Commission; and
      c. No later than 30 days after leaving the appointed position.

B. Ethics Training

1. CAB members are required to take the provided ethics training course to educate them on ethical standards.
    a. Within 30 days of position appointment; and
    b. Once every two years during appointment.
2. The ethics training course is provided either in person or on-line.

C. Disclosure and Attestation Statement

1. Ethics Training Bylaws require Board members to declare any potential conflicts of interest by completing a Sacramento County Health Center Ethics Training Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest arising from:
    a. Being a Sacramento County Department of Health Services employee; or
    b. Having an immediate familial relationship (defined as being a spouse, child, parent, or sibling (by blood, adoption, or marriage) of a ~~Having an immediate familial relationship (defined as being a spouse, child, parent, or sibling (by blood, adoption, or marriage) of a~~ Sacramento County Department of Health Services employee or a CAB Officer; or~~.~~
    ~~b.~~c. Having an immediate familial relationship with an employee of any Federally Qualified Health Center.
2. Upon ratification by the Board of Supervisors and before becoming voting members, new CAB members complete the Sacramento County Health Center CAB Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest and submit it (hard copy or scanned electronic form) to the HRSA Project Director or designee.
3. Continuing members annually complete the Sacramento County Health Center CAB Conflict of Interest: Disclosure and Attestation Statement and submit it (hard copy or scanned electronic form) in October to the HRSA Project Director or designee.

D. Health Program Manager Responsibilities

1. Reviews and discusses this policy on an annual basis during a CAB meeting.
2. Provides a Disclosure and Attestation Statement to new CAB members for completion.
3. Ensures timely submission and completion of Form 700 - Statement of Economic Interests and Ethics Training.

E. Board Member Responsibilities

1. Disclose any conflict of interest and all material facts to the CAB when there is a proposed transaction or arrangement.
2. Abstain from CAB discussion about an issue with which that member has a conflict of interest (including financial interest).

3. Abstain from voting in a situation where a conflict of interest, including financial interest, exists for that member.

4. Is not an employee or immediate family member of an employee (as defined above) of the Sacramento County Department of Health Services.

References:
HRSA Health Center Program Compliance Manual. Chapter 13: Conflict of Interest
California Fair Political Practices Commission
Sacramento County eDisclosure
Sacramento County Co-Applicant Board Bylaws
California Form 700, Statement of Economic Interests

Attachments:
Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement

Contact:
Health Program Manager

Co-Applicant Board Approval:

Formatted: Indent: Before: 0.08", Space Before: 0 pt

Conflict of Interest: Disclosure and Attestation Statement

Conflict of Interest: Defined as an actual or perceived interest by the member in an action, which results or has the appearance of resulting in personal, organizational, or professional gain.

Duty of Loyalty: CAB members shall be faithful to the organization and can never use information obtained in his/her position as a CAB member for personal gain.

Responsibilities of CAB Members:

A. A CAB member must declare and explain any potential conflicts of interest related to:
    1. Using her/his CAB appointment in any way to obtain financial gain for the member's household or family, or for any business with which the CAB member or a CAB member's household or family is associated; and
    2. Taking any action on behalf of the CAB, the effect of which would be to the member's household or family's private financial gain or loss.

B. No member of the CAB shall vote in a situation where a personal conflict of interest exists for that member.

C. No voting member of the CAB shall be an employee or an immediate family member of an employee of the Health Center or County of Sacramento, Department of Health Services; however, a member may otherwise be an employee of the County.

D. No CAB member shall be an employee or an immediate family member of an employee of a Federally Qualified Health Center.

E. Any member may challenge any other member(s) as having a conflict of interest by the procedures outlined in the CAB's Bylaws, Article ~~IX~~VII.

As a CAB member, my signature below acknowledges that I have received, read, had an opportunity to ask clarifying questions regarding these conflict of interest requirements and the CAB Conflict of Interest Policy and that I understand the contents of this policy as it relates to my membership and responsibilities as a CAB member in capacity of officer, expert volunteer, advocate, consumer, or County staff member. I understand that any violation of these requirements may be grounds for removal from CAB membership. I further understand that I may be subject to all other applicable state and federal conflict of interest requirements in addition to the provisions set forth in these Bylaws. I declare that the above statement is true and accurate to the best of my knowledge.

_____ _____

CAB Member's name (please print) Date

_____

CAB Member's signature

	County of Sacramento **Department of Health Services** **Division of Primary Health** **Policy and Procedure**	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**01-03**
		Effective Date	**01-31-13**
		Revision Date	~~05-24~~07-01-**24**
Title: **Sacramento County Health Center Co-Applicant Board – Conflict of Interest**		Functional Area: **Organization**	
Approved By: Andrew Mendonsa, PsyD, HRSA Project Director			

Policy:

Sacramento County Clinic Services adheres to the Health Services and Resource Administration (HRSA) requirement to maintain written standards of conduct covering conflict of interest. Conflicts of interest involving the Sacramento County Health Center Co-Applicant Board (CAB) must be identified and disclosed when the CAB member is considering entering into a transaction, arrangement, policy, financial, or other work that might benefit the private interest of the Board member. Board members with a conflict(s) of interest including financial interests may not participate in CAB discussions about or decisions regarding that issue. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest that are applicable to governmental, nonprofit, and charitable organizations.

Definitions:

A. Conflict of Interest – An actual or perceived interest by a Board member in an action which results, or has the appearance of resulting, in personal, organizational, or professional gain. A financial interest is a type of conflict of interest.

B. Financial Interest – A CAB member has a financial interest if s/he, directly or indirectly through business, investment, or family has:

   1. An ownership or investment interest in any entity with which the CAB has a transaction or arrangement.
   2. A compensation arrangement with any entity or individual with which the CAB has a transaction or arrangement. Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial, such as consultancy, fee-paid work, and shareholdings.

Procedures:

A. Form 700 - Statement of Economic Interests

   1. CAB members are required to fully disclose their personal assets and income.
   2. CAB members complete and file Form 700 with the Clerk of the Board of Supervisors:
      a. Within 30 days of position appointment;
      b. Annually during appointment by the date specified in the California Fair Political Practices Commission; and
      c. No later than 30 days after leaving the appointed position.

B. Ethics Training

1. CAB members are required to take the provided ethics training course to educate them on ethical standards.
    a. Within 30 days of position appointment; and
    b. Once every two years during appointment.
2. The ethics training course is provided either in person or on-line.

C. Disclosure and Attestation Statement

1. Ethics Training Bylaws require Board members to declare any potential conflicts of interest by completing a Sacramento County Health Center Ethics Training Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest arising from:
    a. Being a Sacramento County Department of Health Services employee; or
    b. Having an immediate familial relationship (defined as being a spouse, child, parent, or sibling (by blood, adoption, or marriage) of a ~~Having an immediate familial relationship (defined as being a spouse, child, parent, or sibling (by blood, adoption, or marriage) of a~~ Sacramento County Department of Health Services employee or a CAB Officer; or~~.~~
    ~~b.~~c. Having an immediate familial relationship with an employee of any Federally Qualified Health Center.
2. Upon ratification by the Board of Supervisors and before becoming voting members, new CAB members complete the Sacramento County Health Center CAB Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest and submit it (hard copy or scanned electronic form) to the HRSA Project Director or designee.
3. Continuing members annually complete the Sacramento County Health Center CAB Conflict of Interest: Disclosure and Attestation Statement and submit it (hard copy or scanned electronic form) in October to the HRSA Project Director or designee.

D. Health Program Manager Responsibilities

1. Reviews and discusses this policy on an annual basis during a CAB meeting.
2. Provides a Disclosure and Attestation Statement to new CAB members for completion.
3. Ensures timely submission and completion of Form 700 - Statement of Economic Interests and Ethics Training.

E. Board Member Responsibilities

1. Disclose any conflict of interest and all material facts to the CAB when there is a proposed transaction or arrangement.
2. Abstain from CAB discussion about an issue with which that member has a conflict of interest (including financial interest).

3. Abstain from voting in a situation where a conflict of interest, including financial interest, exists for that member.

4. Is not an employee or immediate family member of an employee (as defined above) of the Sacramento County Department of Health Services.

References:
HRSA Health Center Program Compliance Manual. Chapter 13: Conflict of Interest
California Fair Political Practices Commission
Sacramento County eDisclosure
Sacramento County Co-Applicant Board Bylaws
California Form 700, Statement of Economic Interests

Attachments:
Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement

Contact:
Health Program Manager

Co-Applicant Board Approval:

Formatted: Indent: Before: 0.08", Space Before: 0 pt

Conflict of Interest: Disclosure and Attestation Statement

Conflict of Interest: Defined as an actual or perceived interest by the member in an action, which results or has the appearance of resulting in personal, organizational, or professional gain.

Duty of Loyalty: CAB members shall be faithful to the organization and can never use information obtained in his/her position as a CAB member for personal gain.

Responsibilities of CAB Members:

A. A CAB member must declare and explain any potential conflicts of interest related to:
    1. Using her/his CAB appointment in any way to obtain financial gain for the member's household or family, or for any business with which the CAB member or a CAB member's household or family is associated; and
    2. Taking any action on behalf of the CAB, the effect of which would be to the member's household or family's private financial gain or loss.

B. No member of the CAB shall vote in a situation where a personal conflict of interest exists for that member.

C. No voting member of the CAB shall be an employee or an immediate family member of an employee of the Health Center or County of Sacramento, Department of Health Services; however, a member may otherwise be an employee of the County.

D. No CAB member shall be an employee or an immediate family member of an employee of a Federally Qualified Health Center.

E. Any member may challenge any other member(s) as having a conflict of interest by the procedures outlined in the CAB's Bylaws, Article ~~IX~~VII.

As a CAB member, my signature below acknowledges that I have received, read, had an opportunity to ask clarifying questions regarding these conflict of interest requirements and the CAB Conflict of Interest Policy and that I understand the contents of this policy as it relates to my membership and responsibilities as a CAB member in capacity of officer, expert volunteer, advocate, consumer, or County staff member. I understand that any violation of these requirements may be grounds for removal from CAB membership. I further understand that I may be subject to all other applicable state and federal conflict of interest requirements in addition to the provisions set forth in these Bylaws. I declare that the above statement is true and accurate to the best of my knowledge.

_____ _____

CAB Member's name (please print) Date

_____

CAB Member's signature

	County of Sacramento Department of Health Services Division of Primary Health Policy and Procedure	Policy Issuer (Unit/Program)	**Clinic Services**
		Policy Number	**01-03**
		Effective Date	**01-31-13**
		Revision Date	**07-01-24**
Title: **Sacramento County Health Center Co-Applicant Board – Conflict of Interest**		Functional Area: **Organization**	
Approved By: ~~A~~ndrew Mendonsa, PsyD, HRSA Project Director			

Policy:

Sacramento County Clinic Services adheres to the Health Services and Resource Administration (HRSA) requirement to maintain written standards of conduct covering conflict of interest. Conflicts of interest involving the Sacramento County Health Center Co-Applicant Board (CAB) must be identified and disclosed when the CAB member is considering entering into a transaction, arrangement, policy, financial, or other work that might benefit the private interest of the Board member. Board members with a conflict(s) of interest including financial interests may not participate in CAB discussions about or decisions regarding that issue. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest that are applicable to governmental, nonprofit, and charitable organizations.

Definitions:

A. Conflict of Interest – An actual or perceived interest by a Board member in an action which results, or has the appearance of resulting, in personal, organizational, or professional gain. A financial interest is a type of conflict of interest.

B. Financial Interest – A CAB member has a financial interest if s/he, directly or indirectly through business, investment, or family has:

   1. An ownership or investment interest in any entity with which the CAB has a transaction or arrangement.

   2. A compensation arrangement with any entity or individual with which the CAB has a transaction or arrangement. Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial, such as consultancy, fee-paid work, and shareholdings.

Procedures:

A. Form 700 - Statement of Economic Interests

   1. CAB members are required to fully disclose their personal assets and income.

   2. CAB members complete and file Form 700 with the Clerk of the Board of Supervisors:

      a. Within 30 days of position appointment;

      b. Annually during appointment by the date specified in the California Fair Political Practices Commission; and

      c. No later than 30 days after leaving the appointed position.

B. Ethics Training

1. CAB members are required to take the provided ethics training course to educate them on ethical standards.
    a. Within 30 days of position appointment; and
    b. Once every two years during appointment.
2. The ethics training course is provided either in person or on-line.

C. Disclosure and Attestation Statement

1. Ethics Training Bylaws require Board members to declare any potential conflicts of interest by completing a Sacramento County Health Center Ethics Training Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest arising from:
    a. Being a Sacramento County Department of Health Services employee; or
    b. Having an immediate familial relationship (defined as being a spouse, child, parent, or sibling (by blood, adoption, or marriage) of a Sacramento County Department of Health Services employee or a CAB Officer; or
    c. Having an immediate familial relationship with an employee of any Federally Qualified Health Center.
2. Upon ratification by the Board of Supervisors and before becoming voting members, new CAB members complete the Sacramento County Health Center CAB Conflict of Interest: Disclosure and Attestation Statement, indicating that they meet membership requirements from HRSA that reduce the likelihood of a conflict of interest and submit it (hard copy or scanned electronic form) to the HRSA Project Director or designee.
3. Continuing members annually complete the Sacramento County Health Center CAB Conflict of Interest: Disclosure and Attestation Statement and submit it (hard copy or scanned electronic form) in October to the HRSA Project Director or designee.

D. Health Program Manager Responsibilities

1. Reviews and discusses this policy on an annual basis during a CAB meeting.
2. Provides a Disclosure and Attestation Statement to new CAB members for completion.
3. Ensures timely submission and completion of Form 700 - Statement of Economic Interests and Ethics Training.

E. Board Member Responsibilities

1. Disclose any conflict of interest and all material facts to the CAB when there is a proposed transaction or arrangement.
2. Abstain from CAB discussion about an issue with which that member has a conflict of interest (including financial interest).
3. Abstain from voting in a situation where a conflict of interest, including financial interest, exists for that member.

4. Is not an employee or immediate family member of an employee (as defined above) of the Sacramento County Department of Health Services.

References:
HRSA Health Center Program Compliance Manual. Chapter 13: Conflict of Interest
California Fair Political Practices Commission
Sacramento County eDisclosure
Sacramento County Co-Applicant Board Bylaws
California Form 700, Statement of Economic Interests

Attachments:
Co-Applicant Board Conflict of Interest: Disclosure and Attestation Statement

Contact:
Health Program Manager

Co-Applicant Board Approval:
07/01/24

Conflict of Interest: Disclosure and Attestation Statement

Conflict of Interest: Defined as an actual or perceived interest by the member in an action, which results or has the appearance of resulting in personal, organizational, or professional gain.

Duty of Loyalty: CAB members shall be faithful to the organization and can never use information obtained in his/her position as a CAB member for personal gain.

Responsibilities of CAB Members:

A. A CAB member must declare and explain any potential conflicts of interest related to:
    1. Using her/his CAB appointment in any way to obtain financial gain for the member's household or family, or for any business with which the CAB member or a CAB member's household or family is associated; and
    2. Taking any action on behalf of the CAB, the effect of which would be to the member's household or family's private financial gain or loss.

B. No member of the CAB shall vote in a situation where a personal conflict of interest exists for that member.

C. No voting member of the CAB shall be an employee or an immediate family member of an employee of the Health Center or County of Sacramento, Department of Health Services; however, a member may otherwise be an employee of the County.

D. No CAB member shall be an employee or an immediate family member of an employee of a Federally Qualified Health Center.

E. Any member may challenge any other member(s) as having a conflict of interest by the procedures outlined in the CAB's Bylaws, Article VII.

As a CAB member, my signature below acknowledges that I have received, read, had an opportunity to ask clarifying questions regarding these conflict of interest requirements and the CAB Conflict of Interest Policy and that I understand the contents of this policy as it relates to my membership and responsibilities as a CAB member in capacity of officer, expert volunteer, advocate, consumer, or County staff member. I understand that any violation of these requirements may be grounds for removal from CAB membership. I further understand that I may be subject to all other applicable state and federal conflict of interest requirements in addition to the provisions set forth in these Bylaws. I declare that the above statement is true and accurate to the best of my knowledge.

_____ _____

CAB Member's name (please print) Date

_____

CAB Member's signature

Co-Applicant Board: Patient Member Survey

1. Which Sacramento County Health Center site do you normally use? Select the single bet answer.

   a. Primary Care Center at 4600 Broadway → *Go to question 1a)*
   b. Loaves & Fishes site at 401 N. 12th Street → *Go to question 1b)*
   c. Mobile van → *You are done with the survey!*
   d. School-based mental health site → *You are done with the survey!*

   1a) If clinic hours were expanded, would it help you to see a provider? Select all that apply:

   a. Appointments between 7 – 8 am
   b. Appointments between 5 – 7 pm
   c. Appointments on Saturdays 8 am – 5 pm

   1b) If the L&F clinic was open until 2 pm one day each week, would it increase your ability to see a provider? Select the day(s) of the week that would help you most.

   a. Monday
   b. Tuesday
   c. Wednesday
   d. Thursday
   e. Friday