VIRGINIA DEPARTMENT OF HEALTH

GUIDANCE DOCUMENT

For

Virginia Administrative Code Chapter 200

"REGULATIONS GOVERNING ELIGIBILITY STANDARDS AND CHARGES FOR MEDICAL CARE SERVICES TO INDIVIDUALS"

August 1, 2007

Approved:

____

Commissioner of Health

____

Date

General Comments and Overview

The regulations in the Virginia Administrative Code governing eligibility standards and charges for medical care services to individuals, as approved by the Board of Health, are necessarily somewhat general in nature and cannot be written to cover every circumstance. For this reason, the Commissioner of Health is granted the authority to interpret the regulations so that they are applied consistently to myriad specific circumstances, and to incorporate experience gained in applying the regulations to meet the challenges of delivering health care in an ever changing environment. This Guidance Document provides those interpretations.

Each section of the regulations, e.g., 12VAC5-200-10, is listed in the order in which it appears in the regulations. All the sections are listed; however the amount of material after each section varies considerably. If there is no information, the section is felt to be essentially self-explanatory. Except for the section titles, the Guidance Document generally does not repeat textual material from the regulations.

The Guidance Document is reviewed whenever the regulations are reviewed or when needed. Changes are approved by the Commissioner of Health and are effective upon approval.

This document was originally approved on March 28, 2004 and was last modified on August 24, 2004.

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10 College Student
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12 College students are normally considered full pay patients whose charges are
13 not discounted. A district director may choose to discount the charges to all
14 college students. If a district discounts charges to college students, and a
15 college student wishes to receive discounted charges, he or she must undergo
16 the same eligibility determination as any other patient and be identified as part of
17 an appropriate family or economic unit. College students who are receiving any
18 support from their family are considered part of the family, and the family's
19 income must be included in determining the student's charges. Such support
20 may take the form of money payments to the student, student expenses paid
21 directly by the parent(s), or in-kind support. If the student resides with his or her
22 parent(s) during breaks from class or during vacations, the student is considered
23 to be receiving in-kind family support, and the family's income should be included
24 in determining the student's charges.
25
26 If a student is married, he or she and his or her spouse are generally considered
27 the family unit, and the spouse's income must be included in determining the
28 student's charges.
29
30 If an unmarried student can demonstrate that he or she receives no support of
31 any type from his or her family, either financial or in-kind, the student may be
32 considered a family or economic unit of one.
33
34 Health districts may bill any health insurance plan that provides coverage for the
35 student. College students shall receive non-chargeable services (as defined in
36 the regulations) at no cost. College students who are minors will be treated in
37 accordance with the procedures applicable to minors.
38
39 Do Not Contact (DNC)
40
41 A DNC patient is any person receiving Family Planning, maternity, sexually
42 transmitted infection (STI), or HIV services and who requests that no bills or
43 notices for these services be sent to his or her home. Prior to services being
44 rendered, health department staff shall provide the DNC patient with an
45 explanation of the charges, applicable discounts, and expected payment.

Maternity patients who request DNC status are generally DNC patients only for a limited time, i.e. until it becomes obvious that they are pregnant. A health district must determine when to end a maternity patient's DNC status on a case-by-case basis, taking into account relevant factors.

Health districts should make an arrangement for an alternative method of communication whereby a DNC patient can be contacted without violating the patient's confidentiality. This will allow health districts to inform patients of needed follow-up services, e.g. for an abnormal Pap smear, and for notifying patients of their unpaid bills. DNC patients' unpaid charges for these services shall not be referred to a collection agency or for debt set-off, and they shall not be denied service due to unpaid charges.

Family, Family Unit, or Economic Unit

Family Unit The family unit or economic unit (used interchangeably for eligibility purposes) may consist of:

A. A husband and wife and their minor dependents.

B. A single individual and his/her minor dependents.

C. An individual with no minor dependents.

D. Individuals who pool or commingle their income.

1. All related or non-related persons who share income as an economic unit shall be counted as part of a family unit. "Shared income" is income that is pooled or commingled to support the economic unit. For eligibility purposes, the total income from all members of the economic unit should be used to determine the applicant's income level. "Shared expenses" is not the same as "shared income," and does not define an economic unit. For example,

   - Students or other individuals who share the rent for an apartment but who do not share or commingle their incomes would not be considered a family or economic unit.

   - An adult patient lives with her parents. The patient is employed and pays her own expenses. She pays rent to her parents. The patient would be considered a family unit of one and only her income would be used for eligibility because payment of rent to parents does not constitute pooling of income.

   - An unmarried patient lives with a companion. Both are employed. They are both signators on their apartment lease and pay living expenses for food, utilities, etc. out of both incomes. The patient and the companion

would be considered an economic unit of two and both incomes would be used for eligibility determination.

2. A woman who is pregnant should be counted as a multiple beneficiary, i.e., the mother and the baby (or babies) are counted together when the pregnancy has been verified by a physician or a nurse practitioner working under the supervision of a physician. Alternatively, the pregnancy may be verified by a nurse based on a compatible clinical history and a positive urine or blood pregnancy test. Verification by a nurse becomes effective on the date the nurse makes the determination, but the pregnancy must also be verified by a physician or a nurse practitioner working under the supervision of a physician at the next prenatal visit.

3. A husband and wife who are separated and are not living together shall be considered separate units. If a husband and wife are legally separated, but are living together and sharing their income, the two of them become a single economic unit despite their separated status. *This determination should be made by questioning the client and documenting the client's answer in the client's record.*

4. Proof of dependency from the Internal Revenue Service is not considered a basis for the determination of a family or economic unit. Examples of minors who are considered separate family or economic units:

   A. A minor placed in a foster care home and who is the legal responsibility of a welfare agency.

   B. A minor living with a legal guardian who does not have financial responsibility for the minor.

5. A Medicaid recipient who is a minor receiving Special Supplemental Income (SSI) payments shall be a separate family unit. The child who is considered a separate family unit is not part of the larger family unit when calculating the larger family unit's income.

6. A Medicaid recipient without SSI shall be part of a basic family unit as described above.

7. Individuals requesting DNC shall be treated as a separate family unit and shall require an eligibility determination.

8. In cases of joint custody of a minor, both parents must designate a head of family. The family unit will be that of the designated head and his/her family unit plus the child in joint custody. If the head of the family unit is not designated, the parent presenting for services will be considered the head of the family.

9. The family unit for a parent paying child support excludes the minors for whom the child support payments are intended. The family unit which receives child support payments shall include the minors for whom the child support payments are intended.

Gross Income

Proof of Income. In the majority of cases, income can be verified by determining the family's money wages and salaries before any deductions or withholdings (i.e., gross income). Wage and salary verification must be determined for all adults in the family. (Earned incomes of minor children are excluded.) If there is any question about the authenticity of the pay stub (e.g. no name or social security number), staff may require a statement from the employer on company letterhead. Staff should be sure to determine whether multiple family members are working.

The following documentation can be used as proof of income.

1. Pay stub with year-to-date total. If the calendar year-to-date total is on the stub; and, the applicant was employed by the same employer since January 1st; and, the year-to-date income covers three or more months of continuous employment, then only one pay stub is needed.

2. If year-to-date totals are not available, then check stubs for the past three consecutive pay periods are recommended.

3. For people who have worked on their current job for less than three months, use current check stubs to determine a regular amount of pay (hourly, weekly, monthly, etc.) and calculate income as if the person were working the entire year.

4. Persons on strike shall be treated as persons who have changed jobs.

5. Persons who are employed but off the payroll for sickness or some other reason should have their family income figured based on the income at the time of application. When they return to work, a new eligibility must be completed.

6. In some cases it may be inappropriate to use check stubs as verification (seasonal workers, for example). In those cases, an income tax form W-2 from the previous year should be requested.

7. When making the initial eligibility application, if the interviewer notes a large amount of overtime as part of the gross income, the applicant should be asked if the overtime is a regular occurrence. If it is regular, the overtime is

counted as part of gross earnings. If it is not regular, the overtime is counted as part of gross earnings on an interim basis and the applicant shall be asked to bring back three future consecutive pay stubs. The eligibility would be recalculated based on the gross pay of those stubs. All pay stubs must note the pay period for which the stated income was earned.

8. If no wage or salary statements are available, then the following verifications are acceptable:

   A. The most recent annual tax return should be requested. The total income is shown on line 22 of the income tax form 1040. (Line 14 on the 1040A form and line 4 on the 1040 EZ form). If the applicant is self-employed, income is figured as above plus any depreciation shown on line 13 of schedule C. If income includes or is totally from farm income, income must include any depreciation taken on Schedule F (line 16).

   B. If no tax return is available, one of the following will be considered as adequate proof of income:

      (1) Statement from employer (See Appendix 3). Required to be on company letterhead, dated, signed by a company official, and have sufficient information to allow calculation of current gross pay. (In exceptional cases, oral verification from the employer may be used as proof of income.) Although a letterhead statement is preferred in all cases, the district may accept a statement written on plain paper. If neither of these is available, the district director may accept a self-declaration of income.

      (2) Some people who are self-employed may only have ledgers that they keep with their business' revenues and expenses. When these ledgers are brought in as proof-of-income one of two approaches may be used:

         (a) If possible, determine what they paid themselves and their family members.

         (b) If (a) is not possible then determine their revenues and subtract out all expenses except depreciation. This remaining total will be their gross income.

      (3) In certain cases a self-declaration of income is acceptable. Examples are those who are homeless and day workers. Individuals who earn tips can report them in this manner. The applicant should be asked to write out a statement such as "My

estimated yearly income is _____." The statement must be signed and dated by the applicant.

(a) Migrant and seasonal workers may also self-declare their income.

(4) A signed letter from the Department of Social Services stating the income used by Social Services to determine eligibility.

9. Social Security and railroad retirement. Any one of the sources listed below may be used as verification:

   A. Documents stating the amount of entitlement.

   B. Official award letter or notice.

   C. Benefit payment check or proof of direct deposit account. Deductions for Medicare Part B are to be added to this amount to compute total monthly income.

   D. If none of the above sources are available, other sources, such as an adult child, may be contacted, but only with the written consent of the applicant.

10. Persons Receiving Unemployment Benefits. The only allowable verification is a statement from the Virginia Employment Commission stating the amount of benefits and the weeks remaining. The person receiving unemployment benefits should be treated as a person who has changed jobs. (Refer to #3, above.)

11. Worker's Compensation/Veteran's Benefits. (Note: A person receiving these benefits could also be currently employed.) Any one of the sources listed below may be used as verification:

   A. Documents stating the amount of the payment.

   B. Benefit payment check or proof of direct deposit amount.

12. Applicant states he/she has no income All applicants claiming no income should be closely questioned about how they are supporting themselves. The interviewer should also make certain that they are identifying the correct family unit.

   A. If the applicant states that he/she has no income, the following documentation may be used:

(1) Statement from Virginia Employment Commission denying unemployment compensation.

(2) Termination notice from previous employer.

(3) Layoff notice from previous employer.

B. Applicants (other than Family Planning patients and DNC applicants seeking confidential Family Planning, STI, HIV, or maternity services) who have no income, and none of the documents in 12-A, may "self declare" that they have no income by signing a simple statement to that effect. (See sample statement, Appendix 2.) The statement should list possible sources of income and the declaratory statement should indicate that the applicant has no income from any of those sources.

A self-declaration of income initially establishes the applicant as a full pay patient. The applicant has 30 calendar days to obtain a “proof of no income” letter that identifies the source of the applicant's food and shelter. The letter must be from an appropriate institution (e.g. a church or shelter) and must be on the institution's letterhead stationery. (See sample statement, Appendix 3.) Upon presentation of a “proof of no income” letter, the applicant will be reclassified as “income A.”

If the applicant is dependent on a relative, friend, or some other non-institutional source of support, the individual providing the source of support must provide the "proof of no income" letter. (See sample statement, Appendix 4.) The individual must include in the letter a statement of his relationship to the applicant and a certification as to the truthfulness of the letter. The applicant may bring in the relative or friend, along with the letter, and have the relative or friend certify its authenticity. (Each district may determine for itself the authentication it will consider acceptable.) Alternatively, the relative or friend may send a notarized letter. As a third alternative, the district director may accept a "proof of no income" letter from the applicant.

If the applicant does not provide a “proof of no income" letter or other income statement within 30 days, the applicant remains classified as “full pay” and the district shall attempt to collect full payment from the applicant. A “proof of no income" letter must be renewed annually.

13. Alimony/Child Support. This can be verified by the applicant providing any legal document (divorce papers, letter of support, judgment, custody papers, copies of checks) that state the amount and frequency of payment. A written declaration of child support is also acceptable. A copy of the ex-spouse's tax return showing alimony payments would also be acceptable.

14. Military Pay. The most recent copy of the military member's Leave and Earnings Statement (LES) form must be used to determine income. Income includes monthly base pay, hazardous duty pay, "bonus pay(s)" and any other special pay(s). Income does not include allowances for subsistence, quarters, or quarters in high cost housing areas.

15. Training Stipends. These are funds paid to a person while in training. This includes Job Corps, or payment of part or all of a salary while in school. Verification can be made by check stub or by a letter of award that the student receives.

16. Child in Foster Care. Children in foster care are considered separate families. Any payment from the Department of Social Services for their care should be considered part of the child's income and not part of the foster parents' income.

17. Family with Income Only from Checking/Savings Accounts. Sometimes an applicant may claim no income, but have a sizable amount of money (e.g., a combined amount of more than $10,000) in a checking or savings account. The district can verify this income by requiring the applicant to bring a current account statement, passbook, or other document displaying the amount of money in the account. In such cases, the interviewer needs to determine if the amount is earned income. ("Earned income" is that income that the family was able to save when a family member was employed.)

    A. If the amount is from earned income, only the interest from those accounts should be counted as income.

    B. If the amount is not earned income (examples: money brought into the country by legal aliens, past judgment awards), then the entire amount in the accounts is to be considered as income. It would also be permissible to use the amount that was withdrawn from the accounts in one year's time, but the applicant must have bank records to the prove the difference.

18. Other types of benefits.

    A. Private pensions/Military retirement pay. The same types of verifications are acceptable as for the recipient of Social Security. As for most categories, tax records are acceptable.

    B. Regular Insurance or Annuity Payment. See 9A above.

    C. Dividends and Interest. Acceptable types of verification are bank statements (quarterly or semi-annual statements give a better picture

of what the annualized amount would be), the past year's 1099 or a copy of the applicant's past year income tax form 1040. Dividends are on line 9; interest is on lines 8a and 8b. For the self-employed and in other cases where the total income is used (line 22 of the form 1040) it is not necessary to add in dividends and interest and other sources of income.

D. Net Rental Income. Review the relevant tax information. The details are included in schedule E and will be included on line 17 of income tax form 1040.

E. Net Royalties. Review the relevant tax information. The details are included in Schedule E and will be included on line 17 of income tax form 1040.

F. Periodic Receipts from Estates or Trusts. Several possible sources of verification are acceptable. These include copies of legal documents, tax records, income tax form 1099 and bank records.

G. Lump Sum Settlements. These include inheritances, one time insurance payments, and injury compensation awards. Verification can be made by checking the award letter or copying the check. In some cases it may be necessary to check with the court.

H. Net Gambling Winnings. These are included on line 21 of income tax form 1040, "Other income" and are, therefore, part of the line 22 total.

I. Lottery Winnings. Although the recipient should be asked about any income derived from lottery winnings, verification is not required unless the applicant is known to have won a large prize, defined as $1,000 or more. Lottery winnings are included on line 21 of income tax form 1040, "Other Income,"

J. Unrestricted Grant Assistance. Assistance that produces income that the recipient may use without restriction is considered income.

19. Gross income does not include:

A. Food stamps.

B. WIC checks.

C. Fuel assistance payments.

D. Housing assistance.

E. Money borrowed.

F. Tax refunds.

G. Gifts.

H. Withdrawal of earned income from bank accounts. Interest is to be included as income.

I. Earnings of minor children.

J. Money received from the sale of property.

K. General relief from the Department of Social Services.

L. College or university scholarships, grants, fellowships, assistantships, or any other types of aid that are specified as applicable to tuition; fees; books, supplies, and equipment required or recommended for course work; or housing and food service payments or provided in-kind.

Medically Indigent

Synonymous with Income A.

Minor

A minor is an unmarried person less than 18 years of age whose parents are responsible for his or her care. A minor will be considered a separate family unit when married or not living with any relative or deemed an adult.

A minor may be deemed an adult for the purposes of consenting to Family Planning, maternity services, testing or treatment for sexually transmitted infection (STI), HIV services or any reportable infectious or contagious disease.

A minor will be treated as an economic unit of one when he or she seeks confidential services for a sexually transmitted infection, HIV infection, Family Planning, or maternity services (including the diagnosis of a possible pregnancy). (These four services may be provided confidentially to a minor without consulting or informing his or her parents.) Minors seeking these confidential services should automatically be treated as income A patients unless the district has reason to believe that the minor, as an economic unit of one, has income that exceeds the income A level.

Minors seeking Family Planning services pose special issues of confidentiality even when they do not ask for confidentiality or DNC status because minors may

be reluctant to admit they are there without their parents' knowledge. For example:

- A minor seeking Family Planning services arrives without a parent or guardian.

    - If the minor brings her parents' pay stubs or other proof of family income, she and the family are treated as an economic unit and her parent's pay stubs or other documentation are used to make the eligibility determination.

    - If the patient does not bring proof of family income, the interviewer checks to determine if the parent or guardian is already on file in connection with other services received from the health department. If so, the same eligibility determination will be used for the minor. If the eligibility is at level B through G, the minor will be informed that there will be a charge for service and that the guarantor will be billed.

    - If no prior eligibility determination is found for the parent or guardian, the minor is asked to complete a self-declaration of family income as described below in section 12VAC5-200-80. Application process, Special Eligibility Procedures, Family Planning.

Non-chargeable Services

Non-chargeable services are defined in section 12VAC5-200-150 of these guidelines.

Part II
General Information

12VAC5-200-20. Authority for regulations

12VAC5-200-30. Purpose of chapter

12VAC5-200-40. Administration of chapter

12VAC5-200-50. Recipients of services

12VAC5-200-60. Application of the Administrative Process Act.

12VAC5-200-70. [Repealed]

Part III
Application and Charges

12VAC5-200-80. Application process

The application process begins when the Community Health Services (CHS) CHS-1 form, Consent for Health Care, is completed, an eligibility interview is conducted, proof-of-income is requested from the patient and the patient is appropriately classified according to income level and family size so that eligibility for discounts for medical care services can be determined.

Citizenship Status

Citizenship and immigration status shall not be included as factors in VDH eligibility requirements.

- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 as amended (PRWORA), was passed as a reform of the federal welfare system. Title IV of the Act deals with public assistance to aliens and specifies that only “qualified aliens” (as defined in the Act) are eligible, with certain exceptions, for “Federal public benefits” or “State or local Public Benefits.”

- VDH programs are not “federal or state public benefits” as defined in the basic statute and in implementation regulations published by the Department of Justice, the Department of Health and Human Services and the Department of Agriculture. In accordance with the U.S. Attorney General’s guidance, and to avoid the risk of national origin discrimination, inquiry as to citizenship or immigration status shall not be made of applicants for VDH services.

Social Security Number

The Privacy Act of 1974, § 7(a), prohibits states from requiring individuals to disclose their social security number (SSN) unless it is required by federal statute or the state has a system of records in place that was operating before January 1, 1975 and disclosure of the SSN was required under a statute or regulation adopted prior to this date. In accordance with this statute, VDH does not have authority to require SSNs from clients. Nor may VDH deny or restrict clinical services or apply special payment requirements because of a refusal by a client to supply an SSN.

Members of a patient’s family are also not *required* to supply their SSNs as part of the eligibility process. One or more family members could refuse to supply the SSN, while others in the family might voluntarily supply their SSNs. If the patient

is a child, only the child's SSN is in question and the parent may or may not supply it. The parent is not *required* to supply his or her own SSN.

All applicants should be informed (1) that providing an SSN is voluntary that if they choose not to supply an SSN, they will not be denied service or treated differently in any way; and (2) that VDH will use an SSN only to verify identification, to maintain patient records, to verify income by cross matching with the Virginia Employment Commission, to assist with collection efforts should that become necessary and to process refunds of payments, if any, for the patient.

Residency Requirements

Residency restrictions may be established by the District Health Director to the extent permitted in 12VAC5-200-190, Limitations, below.

General Eligibility Procedures

This section describes the general eligibility determination process applicable to most medical services. The next section describes special procedures for Family Planning, WIC, Child Care Connection (CCC), and Child Development Clinic (CDC) services.

- If a valid proof-of-income is not presented at the time the CHS-1, *Consent for Health Care*, is completed, the applicant will receive no discount for services received unless the applicant provides proof of income within 30 days or at the next visit, whichever is sooner. If a valid proof-of-income is provided within 30 days, charges will be discounted back to the date of completion of the original form CHS-1. If the applicant does not provide proof-of-income with 30 days, no discounts will be given for prior services. If an applicant provides the information after 30 days and is determined to be medically indigent, the previous charges may be discounted at the district director's discretion.

- In certain limited circumstances, an applicant who does not request DNC status may be part of an economic unit with another family member or companion who refuses to supply the proof of income needed by the applicant. VDH staff should be sensitive to such situations and should question the applicant thoroughly to ascertain the facts. If the explanation seems reasonable in the judgment of the interviewer, the matter should be discussed with the interviewer's supervisor. If the supervisor concurs, the case shall be referred to the District Director who may approve use of a self-declaration of household income (see Appendix 5), which shall be used as the basis for the eligibility determination, without further requirement for proof of income from the other family members. District Directors shall not delegate this responsibility to other staff.

If an applicant receives a Medicaid card after the eligibility date, Medicaid shall be billed for all possible charges. Any credits to the account shall be refunded to the applicant. (Note: The Department of Accounts requires a social security number or alien registration number to process a refund request.) If the applicant is a minor whose parent, or other adult who is fiscally responsible for the minor's charges, paid the minor's charges, any refund should be issued to the parent or other adult, using the parent's social security or alien registration number.

A new eligibility must be completed every 12 months, or other frequency as required by a specific program. Eligibility determinations should also be completed when 1) Income scales are revised, 2) The health district has reason to believe the patient's eligibility status or family composition has changed, 3) The patient has an overdue account and denial of service is contemplated, or 4) A patient requests a waiver.

To the extent possible, the health district shall attempt to verify income information by accessing the data bases of the Virginia Employment Commission (VEC) to determine if there is a record of income earned by the patient and any of the named household members. If such income information is identified, the data will be discussed with the applicant to determine if it should be used as the basis for the eligibility determination or if changes in the applicant's financial situation have occurred that make the VEC data obsolete or incorrect. If no reasonable explanation is provided for an exception, the VEC data shall be used.

If a VDH clinic seeks to maintain efficient patient flow by temporarily postponing the eligibility step in order to get the patient to an available clinician, it is an acceptable practice to do so. However, before moving to the clinician, the patient must be informed of the fee, that the eligibility step which is being temporarily skipped will be completed that day, and that it will determine whether they must pay no fee, part of the fee or all of the fee under the sliding scale. If staff is not always available to explain this, the district must have a plain language document that the clinic can provide to waiting patients that explains the process (in 2 or more languages). The patient must be given the option of waiting until an eligibility determination can be made before moving to the clinician. If the patient elects to wait for the eligibility determination, the next patient in line can be offered the explanation and the option, etc. If the patient is not advised of the option, the eligibility step must not be skipped. In no circumstance will a patient be provided service without completion of a required eligibility determination.

Special Eligibility Procedures

Family Planning

(Note: The procedures described in this section are applicable only to patients who are Family Planning clinic patients and are not applicable to patients at WIC or other clinics who also seek Family Planning services during their visit.)

VDH Family Planning services are partially funded by federal Title X grants. Title X regulations require that every Family Planning patient must receive an eligibility determination, except in the case of patients who have qualified for Medicaid. Title X also specifies that no Family Planning patient may be denied service because of inability to pay. Through its eligibility determination process and application of the sliding scale, VDH is in full compliance with this requirement. The eligibility process identifies those patients who are unable to pay and assigns them to income level A. The fees for all other Family Planning patients, i.e., those who have an ability to pay, are computed on the sliding scale, based on their income and family characteristics.

The normal proof-of-income documents should be requested from Family Planning patients. The definitions and guidance in Part II relating to proof of income apply to Family Planning patients. For Family Planning patients, however, the following special procedures also apply.

Self-Declaration and Proof of Income for Family Planning Patients

According to guidance received from the federal Office of Family Planning,

> "Title X projects may **request** proof of income, but they may not require it. Thus, if a client has no proof of income, but provides a self-declaration of income, the Title X project should accept the self-declaration and charge the client based upon what he or she has declared. Title X projects may not assess the client at 100% of the charge because they do not have proof of income, as this may present a barrier to the receipt of services."

In accordance with this guidance, if patients who present at a Family Planning clinic do not have proof-of-income documents (pay stubs, etc.) with them, they may self-declare their family income (See sample in Appendix 5) and the eligibility determination as to income level shall be based on the income listed in that self-declaration. They will not be classified as full fee patients pending receipt of proof of income documents.

If the Family Planning patient seeks medical services other than those in the Family Planning clinic, another eligibility determination must be made and proof of income will be **required** as usual for those clinical services.

- If the patient provides the proof of income documents required for the other medical services, the resulting eligibility determination will supersede the original Family Planning determination based on the self-declaration.

- If the patient does not provide proof of income for this eligibility determination, the general rules apply and the patient will be

classified as full-pay for those medical services until the necessary documentation is supplied or if a waiver is approved as described in the general rules.

- If the patient later returns for follow-up Family Planning services or supplies while the full-pay status is in effect for the other medical services, the original Family Planning eligibility determination based on the Family Planning self-declaration continues in force for the Family Planning services or supplies and the full-pay status continues for the other medical services.

The Family Planning self-declaration will remain in effect until the next annual verification period or if the patient informs VDH of any changes prior to that time.

Minors seeking Family Planning services pose additional issues of confidentiality, even when they do not request DNC status. See the discussion of such cases above in section 12VAC5-200-10. Definitions, Minor.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

The WIC program requires receipt of proof-of-income before certification and delivery of services.

Care Connection for Children (CCC)

The CCC program requires receipt of proof-of-income before certification and delivery of services. As applicable, CCC also requires proof of the applicant having applied to Medicaid, Supplemental Security Income (SSI), or any other state-sponsored medical insurance program.

Child Development Services (CDS)

If applicable, CDS applicants must also supply proof that they have applied to Medicaid, SSI, or any other state-sponsored medical insurance program.

12VAC5-200-90. Charges for services

Overview

Unless otherwise specified, the provisions of the this and the following sections pertaining to charges for services, billing, collection and denial of service are applicable equally to all patients served at all VDH medical clinics, *including Family Planning clinics funded in whole or in part by federal Title X grants.*

Services provided by health districts can be grouped into two broad categories, "clinical care" provided by health district personnel, and "goods" such as biologicals, pharmaceuticals, and diagnostic tests ordered by district personnel.

- Clinical care services are charged on a “sliding scale,” on the basis of a patient’s income and represent a discount from the “standard” charge, which is usually the Medicaid charge. Charges for income A patients are discounted 100%, i.e. they pay nothing. Income B-F patients pay a discounted charge, as detailed elsewhere in 12VAC5-200-10, 12VAC5-200-20, and 12VAC5-200-110, and this Guidance Document. Income G, or “full pay” patients pay the standard charge.

- “Goods” are charged on a “flat rate charge” basis, representing the cost to the local health district of the goods provided to or ordered for the patient, plus, in some cases, an appropriate handling or administration charge. In general, there is no discounting of flat rate charges based on income, and even income A patients pay 100% of the flat rate charge.

(Services that must be provided at no charge to all patients are excluded from sliding scale and flat rate charges.)

<u>Establishment and promulgation of charges</u>

The Commissioner may designate an individual to maintain and update the tables listing the medical care services charges and codes, and to disseminate updated information to the districts, and other relevant individuals or positions. The Commissioner or designee has the authority to determine new charges when there are no appropriate Medicaid or Medicare charges, and establish convenience charges (e.g. charges rounded to the nearest dollar).

Districts may submit requests for new charges (and codes), or for changes in existing charges (and codes), to the Commissioner or his designee. Districts may not implement new charges (and codes) or change existing charges (and codes), without the prior permission of the Commissioner or his designee.

Whenever possible, charges for services will use the most appropriate current Medicaid charges (and matching Medicaid codes). If there is no Medicaid charge (or code) for a particular service, the most appropriate current Medicare charge (and code) will be used. If both Medicaid and Medicare charges (and codes) exist for the same service, the Medicaid charge (and code) will be used.

If neither a Medicaid nor a Medicare charge or code exists for a particular service, the Commissioner or his designee will determine an appropriate charge and code. Estimated or actual costs associated with providing the service, including an administration or handling charge when appropriate, will be determined by one or more districts and submitted to the Commissioner or his

designee. The submission will include sufficient documentation to support the reported costs. The Commissioner or his designee will review this information and determine a standard charge and code that will apply throughout the state, except that the charge for services in Northern Virginia (as defined in 12VAC5-200-10) may be 10% higher than the charge in the rest of the state.

Charges may include additional charges to cover mileage or other ancillary costs associated with providing a service. For example: If the service is provided away from a health district facility there might be no additional charge for services provided within five miles of the facility; a $5.00 additional charge for services provided more than five miles but less than 15 miles from a facility; and so forth. (This example is for illustrative purposes only.) The Commissioner or his designee must approve any such additional charges.

Any Medicaid or Medicare charges that are higher in Northern Virginia will remain in effect. The Commissioner or his designee may add additional medical care services to the list of those for which a higher charge is allowed in Northern Virginia.

The costs of any products (goods) or services which are obtained through a central purchasing contract will be charged to patients at the same rate throughout the state, i.e. higher charges are not permitted in Northern Virginia for these items unless the purchasing contract specifically indicates health districts in Northern Virginia will pay a higher price. Any administration, handling, or other service charges added to these items will be the same throughout the state.

An underlying assumption of this section is that the majority of services and charges provided by health districts are available through state contracts or other standard arrangements, and therefore the costs are the same to all health districts. Where services and products are available only from local vendors, or for practical reasons they must be obtained from local vendors, health districts may request that a charge be established that is appropriate to the district's circumstances. In these cases, the district will submit appropriate justification for using a local vendor with their request to the Commissioner or his designee.

12VAC5-200-100. Flat rate charges

1. Unless otherwise approved by the Commissioner or designee, all charges shall be on a sliding scale basis and there shall be no charge for income A patients.

2. In general, all clinical services and procedures provided by health district personnel (physicians, dentists, nurses, nurse's aides, pharmacists, and other health care professionals) shall be charged on a sliding scale basis. Conceptually, these services may be thought of as "hands on" services by a health care provider such as taking a medical history, performing an

examination or procedure, or assessing a patient. Included in the basic sliding scale charge for any given service are the cost of any consumable supplies associated with the service such as gloves, examination gowns, necessary examination equipment, and surgical instruments. Patients may not be charged extra for these items.

a. Family Planning services that are supported in whole or part by federal Title X or Title V funds *must* be charged on a sliding scale basis. The sliding scale must also must be applied to Pap smears and other tests obtained as part of the patient's evaluation, and to all contraceptive methods. Family Planning patients at income Level A cannot be charged for any services, Pap smears or other tests, or contraceptive products.

b. Family Planning patients who receive Pap smears in clinical settings other than Family Planning, e.g. a sexually transmitted infection clinic, may be charged for their Pap smears in accordance with procedures in effect at the other clinic.

3. In general, flat rate charges apply to goods purchased by health districts and provided to patients. They also apply to certain services arranged by the health district (i.e. ordered by its health care providers) and provided by others, or in some cases provided by the health district. Flat rate charges generally apply to pharmaceutical and biological products (except those services described in 12VAC5-200-150, "Services provided at no charge to the patient"), laboratory tests, and other tests and diagnostic procedures.

4. The Commissioner or his designee must approve flat rate charges prior to implementation. This includes both approval to charge a flat rate charge and the specific charge itself. The Commissioner or his designee shall maintain and promulgate to the districts lists of sliding scale and approved flat rate charge services along with their appropriate charges.

5. If the cost of a flat rate charge item, plus any handling or administration charge, is less than the charge approved by Medicaid, Medicare, or the Commissioner or designee, the district may not increase the charge to match that allowed by Medicaid, Medicare, or the Commissioner or his designee. The district may request the Commissioner or his designee to be allowed to increase the charge.

6. District directors have the authority to apply sliding scale discounts to goods or services for which flat rate charges have been approved.

a. If a given good or service is discounted, all patients must receive the sliding scale discount for the given good or service.

b. If a district director elects to charge according to the sliding scale, an eligibility determination must be done before providing these goods or services and must be offered to all patients.

c. District directors may discount all or only certain flat rate charges. In the latter instance, discounts shall apply to specific goods or services, or categories of goods or services (e.g. a specific class of pharmaceuticals), but not to individual patients.

d. If a district director elects to discount flat rate charges, this practice is not an acceptable basis for the district to operate at a deficit.

e. The Commissioner or his designee reserves the right to require a district not to discount charges.

Pre-approved flat rate charges

The Commissioner has approved the use of flat-rate charges for the following categories of goods and services. The complete list of goods and services for which flat-rate charges have been approved may be found in the data base maintained by the Commissioner or his designee.

1. Travel medicine services Health districts may charge flat rate charges for goods and services, including vaccines and their administration (except those described in 12VAC5-200-150, “Services provided at no charge to the patient”), which they provide to a patient who requests medical advice for travel outside the United States. Patients may be charged for the evaluation and recommendations, immunizations, and other goods or services provided to them.

2. Mass Clinics Health districts may charge a flat rate charge for services at special mass clinics (except those described in 12VAC5-200-150, “Services provided at no charge to the patient”). The intent is to allow health districts to provide immunizations, especially influenza and pneumococcal vaccines, and other services such as cholesterol screening, in a simple, expeditious fashion without the need to do eligibility determinations. Typically, these are circumstances where the health district is providing a streamlined, high volume, low cost service, and the goal is to serve as many people as possible, in as simple and convenient a fashion as possible.

    a. Health districts that provide services at special mass clinics by charging a flat rate must also offer an alternative method or venue whereby patients can obtain these services by paying a sliding scale charge (and income A patients can receive these services at no charge).

b. The alternative sliding scale method must be provided with sufficient frequency and convenience that patients have a realistic alternative to obtaining them on a flat fee basis.

12VAC5-200-105. Charges for services provided by contract

Establishment of charges when health districts partner with other agencies

Charges for clinical services and flat rate charges shall be governed by the Board of Health Regulations (12VAC5-200-10, 12VAC5-200-20, and 12VAC5-200-110), and this Guidance Document. In general, if a health district has primary operational control of a clinic or medical care delivery arrangement, the Board of Health Regulations and this Guidance Document shall determine the charges.

If a health district contracts to provide medical care on behalf of an outside agency and the charges or method of determining the charges are specified in the contract, the contract shall govern. If the contract does not specify the charges or how they are determined, the Board of Health Regulations and this Guidance Document shall determine the charges.

For other arrangements in which the health district contributes only partial support to an operation, other methods of determining patient charges are acceptable. However, health districts cannot charge, or allow patients to be charged, for services that they would normally provide free or at a reduced charge. These include services such as those provided under Section 12VAC5-200-150 ("Services provided at no charge to the patient"). This prohibition applies only if the health district is actually providing these services in partnership with some other agency. It would not apply if the health district does not provide these services in a partnership arrangement. For example, a city operates an indigent medical center with some services provided by the health district. If the health district was not involved in the services provided in the center, the center could determine the charges for the services. If the health district were providing the services, the charges would be determined in accordance with applicable state law, Board of Health regulations and this document.

This section does not restrict a district's ability to bill third party insurance carriers for covered services, unless otherwise prohibited.

12VAC5-200-110. Income levels for charges

Clients of the Virginia Department of Health shall not be denied service or subjected to any variation in quality of service due to *inability* to pay. The agency's eligibility determination process has been designed to take the patient's ability to pay into account. Depending on income and applying annual federal poverty income guidelines, the agency determines whether the client should not

be charged a fee (income level A) or whether the client is able to pay some percentage of the cost on a sliding scale, up to 100% (income levels B-G).

12VAC5-200-120. Automatic eligibility

Once it is established that a person is in one of the categories listed below, he or she is eligible for services as a medically indigent person. Once the documentation of one of the categories listed below is provided, no other financial information is necessary for a patient to receive services. However, it is important to obtain any insurance information so that the insurance companies may be billed for services provided. Documents required for automatic eligibility:

1. General relief: Check stub or letter.

2. Medicaid: Current card or notice of eligibility, the person is listed on the Medicaid printout, or by a documented call to the Audio Response System (ARS) or other automated Medicaid verification systems. A copy of the card shall be made at the time of the eligibility determination or the information on the card may be documented in the applicant's record. Similarly, information obtained from the Medicaid printout or verification system may be documented in the applicant's record. Babies born to mothers on Medicaid do not receive automatic eligibility. Although the applicant may be covered by Medicaid, the remaining family members do not receive automatic eligibility status.

3. School lunch (for school dental services only): The school must verify that the child is eligible for the free lunch program. This eligibility applies only to students eligible for a free lunch and not to students eligible for a reduced lunch.

12VAC5-200-130. Explanation of charges

To the extent possible, patients who are able to pay (i.e., in one of income levels B through G) should be advised of the estimated charges they will encounter and their payment responsibility at the time an appointment is made for their visit. Prior to services being rendered on the date of the appointment, an explanation of the estimated charges, applicable discounts, and expected payment shall be provided to the applicant.

Insurance Deductibles and Co-payments

Deductibles: At the start of the benefit year, the insured patient may have charges from all providers applied to a deductible threshold before benefits can begin to be paid. At the time of service, VDH will not know whether a charge will be applied to a deductible because deductible amounts vary from plan to plan and the VDH charges may or may not be dated after charges from other

providers have met the deductible. If the VDH charge is not paid by the insurer because it is applied to the deductible, then the patient is responsible for paying the full amount due for the service as determined by the sliding scale.

Co-payments: If the patient's insurance requires a co-payment, the patient is responsible for the payment as determined by the sliding scale. There is never a co-payment for family planning services or supplies under Medicaid.

Statement of Charges:

When the services, tests and supplies have been rendered, the patient will be provided a detailed statement of charges and will be expected to pay the balance owed on the date of service, within thirty days of that date, or in accordance with the terms of a payment plan. A patient in one of income levels B through G who does not pay for the services, tests or supplies at the time of the visit will be offered financial counseling, including the following information:

1. Clients who are able to pay are expected to pay for the services, tests and supplies during the visit or, if they elect not to pay during the visit, within 30 days of the date of the visit;

2. The client has an opportunity to agree to a payment plan, permitting payments to be made in installments over a period of months instead of within 30 days;

3. If necessary, the district will work with patients to make arrangements to accept partial payments until the patient has paid all charges. If the client makes a partial payment of an amount due, the health department will recognize it as a good faith effort to pay and will suspend the initiation of debt set-off or collection actions until the next billing cycle.

4. State regulations require that delinquent accounts be referred to the Department of Taxation for debt set-off and to private agencies for collection;

5. If the client experiences a serious personal or family financial emergency, the client may request a waiver of payments for ***new*** services, tests and supplies. The health department may waive all or a portion of such payments for up to 180 days (a "financial waiver").

6. If the client has unusually serious health problems, the health department may waive all or a portion of payments for ***new*** services, tests and supplies for up to 180 days (a "medical waiver").

7. Before taking any action to deny further services, tests or supplies because of unpaid debts, the district will conduct a new eligibility review to

determine whether the patient's income level should be changed. If a determination is made that the patient is unable to pay, the patient will be assigned to income level A and will continue to receive services and supplies without charge. If the eligibility review finds that the patient is still able to pay, the failure to pay will be deemed a refusal to pay.

8. Refusal to pay will be cause for denial of future services, tests and supplies, unless a waiver of payment for the new services is approved as described in Part VI below:

9. If the patient is receiving on-going medical care and a waiver has not been granted, the department will continue providing medical care and will make a good faith effort to find alternative care.

The patient will be asked to sign a form CHS-1C, Application And Agreement For Payment Plan, documenting this counseling. A patient shall not be denied future services, tests and supplies unless this financial counseling has been provided.

Billing, Refusal to Pay and Collection

This section is applicable only to patients ***who are able to pay*** as determined through the eligibility process (i.e., patients in income levels B through G).

Accounts receivable policies and procedures of VDH are in compliance with the Code of Virginia § 2.2-4800 et seq., "Policy of the Commonwealth; collection of accounts receivable," which provides as follows:

> "… Each state agency and institution shall take all appropriate and cost-effective actions to aggressively collect its accounts receivable. Each agency and institution shall utilize, but not be limited to, the following collection techniques, according to the policies and procedures adopted by the Department of Accounts and the Attorney General: (i) credit reporting bureaus, (ii) collection agencies, (iii) garnishments, liens and judgments, and (iv) administrative offset…
>
> … Each state agency and institution shall develop internal policies and procedures, in accordance with accounts receivable policies of the Department of Accounts and the Attorney General, for delaying or withholding certain state services to those persons who refuse to pay their debts. .."

Throughout the billing and collection process, patient contact and confidentiality requirements will be appropriately considered and addressed.

Bills to patients will include a disclosure to the effect that non-payment of the balance or any portion thereof may be cause for denial of future services and that

delinquent accounts will be referred to the Department of Taxation for debt set-off and to private collection agencies.

Districts are encouraged to work with patients to make arrangements to accept partial payments until the patient has paid all charges. Alternative payment arrangements are acceptable. If the client makes a partial payment of an amount due, the health department will recognize it as a good faith effort to pay and will suspend the initiation of debt set-off or collection actions until the next billing cycle.

If the patient fails to make the payment(s) as scheduled, the patient will be sent a “delinquent” bill with a notice that a refusal to pay the amount due, plus a late charge, may be cause for denial of future services, tests and supplies or that payment for future services may be required in advance. The notice will urge the patient to contact the health department where service was provided to discuss the matter with someone in the business office.

This business office discussion could form the basis for a new eligibility determination in accordance with 12VAC5-200-140, below, applying the most recent federal poverty income guidelines, and/or a waiver by the District Health Director of all or a portion of new charges for up to 180 days as provided in Part VI below. This discussion will be documented in the patient's record.

VDH staff should be alert to situations in which a waiver for medical reasons may be appropriate (e.g., a pregnant patient in a high risk category), ***whether or not the patient requests such a waiver***. The health director shall be informed of such situations before services are denied.

If these alternate measures are not applicable and the overdue payment is not made within the next 30 days, the account will be referred to the Department of Taxation for debt set-off and to private collection agencies and it will be written off in accordance with standard procedures.

Denial of Service

12VAC5-200-80 provides that:

> “Individuals who have failed to make any payment within the past 90 days for medical care services or other goods or services they have received may have their medical care services terminated. The district director may terminate services only following notice to the individual that such services will be terminated and only after determining that terminating services would not be detrimental to the individual's health. Medical care services cannot be terminated for individuals receiving ongoing care without making a good faith effort to secure alternative care.”

If a patient in one of income levels B through G (including a patient in a Family Planning clinic funded in whole or in part by federal Title X grants), has refused to pay and the account has gone through the counseling, billing and collection sequence described above, further services, tests and supplies shall be provided only under the following circumstances:

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1. Clients with overdue bills are eligible for non-chargeable services and may not be denied such services.

2. For all other services, a new eligibility determination will be made, applying the latest federal poverty income guidelines. If the patient refuses or does not provide the necessary documentation, the new services, tests or supplies will be denied.

3. If the eligibility determination establishes the patient is at level A, (i.e., is unable to pay), the services, test and supplies will be rendered.

4. If the eligibility review determines that the patient is still at level B through G, (i.e. is able to pay, but refuses to do so) the services, tests, and supplies will be denied. Alternatively, at the option of the health director, or his/her designee, the patient shall be required to pay for new services, tests and supplies in advance of receiving them.

As required by 12 VAC 5-200-80, the district will make a good faith effort to find alternative care before denying continued service to patients. Health District Directors may terminate services only when doing so would not be detrimental to the individual's health. For example, in a Family Planning clinic, although further contraceptive services may be terminated, follow-up services for an abnormal pap smear or other event with ongoing medical implications and consequences may not be denied unless an alternative provider for these treatments has been identified. Health District Directors shall make this determination and this responsibility shall not be delegated.

12VAC5-200-140. Redetermination of eligibility

A new eligibility must be completed every 12 months, or other frequency as required by a specific program. Eligibility determinations should also be completed when 1) The health district has reason to believe the patient's eligibility status or family composition has changed, 2) The patient has an overdue account and denial of service is contemplated, or 3) A patient requests a waiver.

Part IV
Non-chargeable Services

12VAC5-200-150. Services provided at no charge to the patient

General

In accordance with the Code of Virginia (12VAC5-200-150), certain services are to be provided by health districts at no charge to Virginia residents. Because there is no charge, no eligibility determination is required. However, health districts may charge patients' private health insurance providers. If the private health insurance provider requires a co-payment, the co-payment will be collected based on the sliding scale.

Non-chargeable services are discussed in detail in the following sections. For reference purposes, the relevant sections of the code are cited here: Immunization of children, § 32.1-46; Examination for suspected tuberculosis, § 32.1-50; Sexually transmitted diseases, § 32.1-57; HIV testing, § 32.1-55.1. However the following sections include diseases and services beyond those that are required in the code and delivery of them or assurance of their availability is required of local health departments.

Immunizations

All immunizations required for children or adolescents by the Code of Virginia at § 32.1-46 must be provided at no charge to the patient for vaccine, vaccine administration, or vaccine handling. Currently, these immunizations include those against tetanus, diphtheria, pertussis, polio, measles, mumps, rubella, Haemophilus influenza type B infection, hepatitis B, and varicella. From time to time additional immunizations will be added to this list and must also be provided at no charge. Consult the Virginia Department of Health, Office of Epidemiology, Division of Immunization for the most current list of required vaccines.

Patients may be charged a flat rate charge for immunizations provided in a Travel Medicine clinic. However, if any of the immunizations required by the Code of Virginia are administered in a Travel Medicine clinic there must be no charge to the traveler as long as the traveler is within the appropriate age group.

Tetanus, diphtheria, measles, mumps, rubella, and polio (inactivated polio vaccine, IPV) immunizations are to be provided to adults at no cost for the vaccine, even if these individuals obtain these immunizations in a Travel Medicine clinic. The patient may be charged an administration charge but service cannot be denied because of the patient’s inability to pay the charge.

All other immunizations provided by the department may be charged to the patient. This includes charging for immunizations administered to children if the immunization is not required by Code of Virginia. Vaccines purchased on federal procurement contracts and provided to the health districts by the Division of Immunization must not be used for a chargeable service. Health districts must use local or coop budget funds to purchase chargeable vaccines.

Tuberculosis

State code at § 32.1-50 requires health departments to assess, examine, and test individuals suspected of having, or known to have tuberculosis disease at no charge. This service extends to contacts of individuals with known active tuberculosis as determined by the district director or other appropriate authority, and to individuals with a newly positive tuberculin skin test. (Positivity is defined in accordance with the current Centers for Disease Control and Prevention. American Thoracic Society, American Lung Association, and Agency guidelines.) Individuals assessed, examined, or tested for other purposes, e.g. as an employment-screening requirement, may be charged for this service.

Assessment, examination, and testing may include initial and follow-up: assessment, physical examination, chest x-rays, tuberculosis skin testing, and sputum collection and testing (collection containers, sputum induction, making and examining a sputum smear, mycobacterial culture and sensitivity, mycobacterial diagnosis by DNA probe, PCR, or other molecular biology techniques). The district director or other appropriate authority shall determine which tests and procedures are appropriate for any given patient.

Treatment of active disease, or treatment of latent tuberculosis infection (LTBI), may be charged to the patient or the patient's health insurer. The health district should charge a flat rate charge for drugs, laboratory tests (e.g. liver function tests), chest x-rays, and other tests or procedures needed to monitor treatment unless the district director elects to charge for such drugs, tests, x-rays, and other tests or procedures on a sliding scale. Clinic visits shall be charged on a sliding scale. Patients cannot be charged for any services, laboratory tests, or x-rays paid for, directly or indirectly, by the Division of Disease Prevention. Health districts may not charge venipuncture, admininistrative, handling or other fees for services, laboratory tests, or x-rays paid for, directly or indirectly, by the Division of Disease Prevention. Health districts may not charge for providing the services of Directly Observed Therapy (DOT) or Directly Observed Preventive Therapy (DOPT).

Patients with suspected or confirmed tuberculosis (active disease or infection) shall not be denied treatment for non-payment.

Sexually Transmitted Infections

Sexually transmitted infections for which there is no charge when seen in a sexually transmitted infections clinic (State code at § 32.1-57) include: presumptive diagnosis and treatment of gonococcal urethritis, cervicitis, pharyngitis, and proctitis; presumptive diagnosis and treatment of chlamydial urethritis, cervicitis, pharyngitis, and proctitis; presumptive diagnosis and treatment of non-gonococcal urethritis and mucopurulent cervicitis; presumptive

diagnosis and treatment of pelvic inflammatory disease; diagnosis and treatment of neonatal ophthalmia due to gonococcal or chlamydial infection; diagnosis and treatment of syphilis; clinical diagnosis of genital herpes simplex infection; clinical diagnosis and treatment of chancroid; clinical diagnosis and treatment of lymphogranuloma venereum; clinical diagnosis and treatment of granuloma inguinale; clinical diagnosis of genital human papilloma virus infection; serological diagnosis of hepatitis B virus infection. There is no charge for venipuncture and there are no administrative or handling charges associated with the diagnosis or treatment of the infections identified in this paragraph as being non-chargeable. If any of these diseases (except syphilis, gonorrhea, chancroid, granuloma inguinale, lymphogranuloma venereum) are seen in a setting where the service is billable, the patient should be billed.

Human Immunodeficiency Virus

There is no charge for the clinical diagnosis of, or the serological testing for, HIV infection as determined by the presence of anti-HIV antibodies. There is no charge for testing for HIV infection as determined by rapid diagnostic tests for HIV infection that are intended for use and interpretation within a single clinic visit. There is no charge for venipuncture and there are no administrative or handling charges associated with such HIV testing.

12VAC5-200-160. Immunization services

If a district director elects to provide free immunizations because of an actual or potential outbreak of a communicable disease, the director should document in writing the rationale for such action. No specific format is prescribed; however the document should include: the actual or presumed etiologic agent of the outbreak, the evidence that an outbreak had occurred or might occur, an estimate of the magnitude of the actual or potential outbreak, the number of doses of vaccine provided and their cost, the method of mass immunization, evidence that the immunization program was effective (if available), and a discussion of alternative means (if any) to control the epidemic that did not involve providing free immunizations and a rationale for providing free immunizations. Similar documentation should be created if the Commissioner directs a district to provide free immunizations. (Documentation is not required for immunizations that are routinely provided at no cost to specific populations.)

12VAC5-200-170. Other health care services

If a district director elects or is directed to provide free medical care services to a substantial number of citizens as a group, the director should document in writing the rationale or justification for this action. The documentation should include a description of the circumstances or medical problem, the rationale for this action or the direction by the Commissioner to do so, the nature and extent of the services provided, the number of individuals served (with a demographic

breakdown if available and appropriate), the cost of providing these services, and the outcomes of this action (if these can be determined).

Part V
Exceptions

12VAC5-200-180. Exceptions

12VAC5-200-190. Limitations

Residency Requirements

As a general rule, there is an expectation that VDH services will be provided to all clients who present for services, regardless of their residence. Health Directors shall request approval from the Deputy Commissioner for Community Health Services before restricting health services by legal residency, e.g., to residents of Virginia or to residents of the health district. Such restrictions may not impose a duration of residency, which is generally held to be a violation of the constitutional right to travel. Special rates or flat fees for non-residents shall not be established.

Residency requirements shall be governed by the following guidance:

1. If a service is fully funded by a grant or contract, residency restrictions may be imposed, with approval by the Deputy Commissioner, to the extent authorized by the funding organization.

2. If a service is funded by state general funds and local match and is a mandated service, residency restrictions limiting service to Virginia residents may be imposed, with approval of the Deputy Commissioner. Restriction to residence in a particular district or local jurisdiction is not permitted.

3. If a service is funded by state general funds and local match and is not mandated, residency restrictions limiting service to Virginia residents or residents of the health district may be imposed, with approval of the Deputy Commissioner.

4. If a service is funded by 100% local funds, narrower residency restrictions (i.e., providing services only to locality residents) may be imposed, with approval of the Deputy Commissioner, in accordance with the wishes of the funding locality.

5. Except in the case of 100% locality-funded services, services shall not be restricted by residency to a lower geographic level than district-wide.

Proof of residence may be a Virginia driver's license, rent or mortgage payments, utility payments, voter registration, federal or state income tax forms, or any other document that establishes Virginia residency. Proof of residence may also be established by meeting the requirements in this Guidance Document under Section 12VAC5-200-10, Gross Income, Proof of Income, 12-B, "no income."

12VAC5-200-200. Reserved

Part VI
Waiver of Charges

12VAC5-200-220. General

In instances where applicants or their immediate families have unusually serious health problems, or an extraordinary financial hardship is demonstrated to exist, and there are no other avenues of care, the patient, guardian, or other authorized person may request a waiver of all or a portion of charges for up to 180 calendar days. A waiver must be requested in writing.

By regulation, the Commissioner is designated to grant or deny waivers. The Commissioner delegates this authority to district directors. This authority shall not be delegated further down in the organizational structure.

12VAC5-200-230. Waivers

The waiver provides a 100% discount for all or a specified portion of medical care services for up to 180 days. The start of the initial waiver period will be the day the waiver request is received by the district. Balances owed prior to the waiver period may not be waived. When a waiver is requested, the health district may complete a new eligibility determination. If the applicant does not provide documentation to support the waiver request or eligibility determination, the applicant must provide it within 10 working days. If the needed documentation is not provided within 10 working days, the beginning date of the waiver will be moved to the date the documentation is provided and the applicant will be responsible for any charges incurred prior to the date of the waiver.

The waiver may be extended for periods of up to 180 days at the discretion of the district director. The applicant must apply for any waiver extension, and provide the same documentation required for the initial waiver before any extension can be granted. The applicant will be liable for any charges incurred between the expiration of a waiver and the approval of its extension.

No waivers will be issued to persons believed to be eligible for Medicaid, Medicare, or any state sponsored medical insurance program for indigent persons until the applicant provides evidence that he or she has applied for them. Health district staff should review the eligibility information already provided or do

a new eligibility determination to determine if the applicant may be eligible for one of these programs.

- An applicant or the applicant's immediate family will be determined to have unusually serious health problems when the family's total medical bills are $\geq$ 7.5% of the applicant's family's gross income. Medical bills may include office visits to medical facilities; medications; medical supplies and equipment; dental services; laboratory, radiographic, and other diagnostic tests and procedures; surgery; hospitalization; home health care services; and outpatient treatment. In addition, the applicant may include travel expenses for transporting family members to medical appointments. If family members are transported in a family-owned car, the applicant may claim mileage as an expense at the current state rate for mileage reimbursement. The CCC form 402 may be used to list medical expenses including those that are reimbursed.

  Medical expenses used to determine a waiver in one period may be used in the waiver calculations for subsequent periods. Each time an applicant applies for a waiver, he must present the billings that show his current outstanding indebtedness.

- Extraordinary financial hardship includes such causes as natural disasters, damage to or loss of uninsured real or personal property, unpaid legal liabilities, and obligatory and unavoidable expenditures for close relatives outside the family unit.

- Extraordinary financial hardship also includes unique circumstances in which careful, sensitive interviewing determines that a patient relies on others for payment of charges and those with the income refuse to pay for services. Examples of these circumstances are 1) adult patients whose spouse or companion refuses to pay for prior services being billed; and 2) minors in family planning clinics whose parents are aware of the clinic visits, but refuse to pay for prior services being billed. In these situations, if the District Director approves, the patient may be permitted to request a waiver of new charges. As noted above, spouses, companions or parents will still be liable for payment of bills for prior services for which they are the guarantors.

If a district director waives all or a portion of the charges for medical care services, this decision should be documented in writing by the director and placed in the patient's medical record. The documentation should include a statement that all or a specific portion of the charges are waived for a specific period (which should be specified in the documentation) and a description of the circumstances that necessitate a waiver of the charges. If the waiver is renewed, there should be ongoing documentation of the need for charges to be waived, including a statement that the patient's circumstances have not changed.

Part VII
Appeal Process

12VAC5-200-270. Rights

A patient who wishes to appeal a decision regarding the delivery of medical care services should generally first appeal to the district director. If the services are provided through a specific program that has its own requirements, e.g. WIC or Breast and Cervical Cancer Screening, the appeal should generally be made to director of the specific program. However in the latter case, district directors should assist patients by providing them with the necessary information to make an appeal, e.g. name and contact information for the program director.

Part VIII
Fraud

12VAC5-200-280. Fraud

In those cases where fraud is suspected, a new eligibility determination should be made and the patient charged accordingly. Previous charges should not be readjusted.

Where there is proof of willful misrepresentation and other agencies may also be misled, those agencies should be notified that the person may be defrauding them. Medical care services may be discontinued to the affected person 30 days after notifying the person in writing, by certified mail, that services will be discontinued.

APPENDIX 1

Acronyms and Abbreviations

ARS	Audio Response System
CDS	Child Development Services
CHS	Community Health Services
CCC	Care Connection for Children
DNC	Do Not Contact
HIV	Human Immunodeficiency Virus
LES	Leave and Earnings Statement
SSI	Social Security Insurance
SSN	Social Security Number
STI	Sexually Transmitted Infections (replaces the term STD)
STD	Sexually Transmitted Diseases
VEC	Virginia Employment Commission
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX 2

Sample Individual Statement

SELF DECLARATION OF "NO INCOME"

I, ___name of applicant___, certify that I have no income.

I understand that "income" includes:

- pay, wages, or salaries
- Tips
- unemployment benefits
- social security benefits
- welfare benefits
- disability, worker's compensation or other payments for an injury or illness
- retirement or pension benefits
- alimony or child support payments
- insurance or annuity payments to me
- interest or dividends from savings accounts or investments
- rental income or other income from a business
- income from royalties, patents, gambling, or lottery winnings

I understand that if I have any of these types of income, I must tell the eligibility worker about them.

I have 30 days to give the health department a letter from a church, shelter, relative, or some other person who is providing my housing and meals. If I do not do this, I will be charged the full amount for any care the health department provides to me.

____
(Signature of applicant or guardian)

____
(Printed name of applicant or guardian)

____
(Date)

APPENDIX 3

Sample Agency Support Statement

STATEMENT MUST BE ON AGENCY LETTERHEAD STATIONERY*

We understand that ___name of applicant___ is receiving medical care from the Virginia Department of Health. Because the applicant has no income, our agency is providing food and shelter for the applicant.

____
(Signature of agency representative)

____
(Printed name of agency representative)

____
(Position at the agency)

____
(Telephone number if not given above)

____
(Date)

*See page 7, section 8-B-1, of this document for exceptions.

1 **APPENDIX 4**
2
3 **Sample Relative or Friend Support Statement**[*]
4
5
6
7 I understand that ___name of applicant___ is receiving medical care from the Virginia
8 Department of Health. Because the applicant has no income, I am either providing the
9 applicant with food and shelter or providing the applicant with financial support.
10
11
12
13
14 ____________________________________
15 (Relationship to applicant - for example, friend, cousin)
16
17
18 I am providing _____ food and shelter, _____ financial support.
19
20
21 ____________________________________
22 (Approximate amount of financial support per month)
23
24
25 ____________________________________
26 (Signature of person providing support)
27
28
29 ____________________________________
30 (Printed name of person providing support)
31
32
33 ____________________________________
34 (Address)
35
36
37 ____________________________________
38 (Telephone number)
39
40
41 ____________________________________
42 (Date)
43
44
45 [*]See pages 9-10, section 12-B, paragraph four for details on acceptable authentication
46 of this letter.

APPENDIX 5

Sample Individual Statement

SELF DECLARATION OF HOUSEHOLD INCOME

I, ___________________ ______, understand that the amount I am charged for health department services depends on my household income. I understand that household income includes my income and the income of all family members living with me. If I do not live with a spouse or parents, I understand that household income includes the income of any companions, friends or relatives living with me who pool their income with mine or who pay all my living expenses.

I understand that "income" includes:

- pay, wages, or salaries
- Tips
- unemployment benefits
- social security benefits
- welfare benefits
- disability, worker's compensation or other payments for an injury or illness
- retirement or pension benefits
- alimony or child support payments
- insurance or annuity payments to me
- interest or dividends from savings accounts or investments
- rental income or other income from a business
- income from royalties, patents, gambling, or lottery winnings

I understand that if the members of my household have any of these types of income, I must tell the eligibility worker about them and include the income in the estimate. The health department requests that I bring copies of pay stubs or other documents as proof of income, to verify how much I will have to pay for services.

I declare that my estimated yearly household income is $______________.

____
(Signature of applicant or guardian)

____
(Printed name of applicant or guardian)

____
(Date)