FSCC Sliding Fee Discount Program Policy

Practice Management Solutions | Family Solutions Counseling Center (FSCC) | Louisiana Sites

Document control	Value
Policy owner / Compliance Officer	Millie Huffman, FSCC COO / Compliance Officer
Revenue owner	LaTori Young, Director of Revenue
SFDP operational date	October 1, 2026
Consolidated revision	November 12, 2026
Approved by / approval date	LaTori Young, Director of Revenue / November 12, 2026
Next scheduled review	November 2027, and within 30 days after the 2027 FPG are published

1. Purpose

FSCC will make covered outpatient behavioral health services accessible regardless of ability to pay through a written, uniform Sliding Fee Discount Program (SFDP). SFDP eligibility and discount classification are based solely on family/household size and gross annual family/household income under the current HHS Federal Poverty Guidelines (FPG).

2. General Policy and Scope

No one will be denied access to medically or clinically appropriate services due to inability to pay. Offer the SFDP to every patient, including uninsured, underinsured, and insured patients. Insurance status, citizenship, assets, credit score, payment history, diagnosis, or proof of an application for or denial of insurance are not SFDP eligibility criteria. The SFDP applies to all eligible services within each site's NHSC service scope; Billing must identify additional services with different standard rates before charging a patient.

Insurance and government-program limitations may affect how a lawful patient charge is calculated or reduced, but never the patient's eligibility classification. A required scheduling deposit or minimum payment must not prevent medically appropriate care due to inability to pay. Any deposit or no-show policy must be separately reviewed for compliance with payer requirements and SFDP access protections.

2A. Retired Hardship / Copay Assistance Program

The predecessor Hardship / Copay Assistance Program retired September 30, 2026. Existing approvals in effect on that date continue according to their documented original terms until expiration, subject to applicable law and payer terms. No new Hardship approvals are issued. All new assistance requests use the SFDP application, without retroactive conversion of older approvals.

3. Definitions

Term	Definition
Family/household size	The patient plus family members/dependents whose finances and support are considered together under FSCC's documented, consistently applied household methodology, regardless of marital status. No individual may be counted twice. For shared custody, divided households, or unusual support arrangements, the Compliance Officer/designee documents the selected household size and supporting financial circumstances. Count corresponding income consistently with the same household definition.
Income	Gross annual cash income before taxes, including wages, net self-employment income calculated consistently with supporting records, Social Security/retirement, unemployment, pension, alimony, and other recurring cash income. Do not count assets or noncash benefits as income. Document any nonstandard income source determination consistently; consult current NHSC guidance for borderline categories.
Provider standard charge	The individual rendering clinician's undiscounted rate for the covered visit type/service in the separately maintained FSCC Cash-Pay Fee Schedule. No universal clinician rate is assumed.
Adjudicated patient responsibility	The remaining legally billable amount designated as patient responsibility on the EOB/ERA after all applicable payers, adjustments, and coordination of benefits have been processed.

Term	Definition
Underinsured	An insured person whose cost sharing or noncovered services create a financial barrier. This term does not create an additional eligibility test.

4. Eligibility, Verification, Temporary Approval, Reassessment

Front Desk offers the current SFDP Application (Sections A–I) and assistance completing it. Billing calculates the FPG tier using family/household size and gross annual income. Tara Fuller approves self-attestations and exceptions, reviews the recommendation, and LaTori Young makes the final eligibility approval as shown on the controlled application. The patient receives a written determination; the discount class does not depend on insurance or clinician charges.

Acceptable verification includes a recent tax return, W-2/1099, recent pay stubs, benefit or pension award, unemployment statement, employer verification, or other reliable proof. Do not request asset reports, credit checks, or Medicaid denial letters for eligibility.

If documentation is unavailable, a signed self-attestation of family/household size and income may be accepted with Tara's approval and a documented reason. Temporary eligibility may be granted for up to 30 calendar days while information is collected. Before expiration, Billing reviews available documents or an accepted self-attestation and records the final or continued determination. If information is still insufficient, treat the application as pending verification unless a final denial is justified by documented policy criteria; do not label missing conventional documents alone as a final denial. Notify the patient of any change and reconsideration rights. Lack of documents alone must not prevent clinically appropriate care.

Reassess eligibility at least annually and sooner upon a reported material change. Record approval start, end/review dates, supporting calculations, and notification.

5. Discount Calculation and Provider Standard Charges

For uninsured patients and services confirmed noncovered for which the patient can lawfully be billed, apply the Section 12 discount to the applicable clinician/service standard charge in the current Cash-Pay Fee Schedule. Billing must verify the actual rendering provider and visit/service category before calculation. A denied claim is not automatically a patient-billable noncovered service; first investigate the denial reason, authorization, coordination of benefits, contractual restrictions, and applicable notice/consent rules.

For covered insured services, submit and adjudicate claims under the relevant payer agreement. After all payers process the claim, apply the approved SFDP tier to legally billable adjudicated patient responsibility when permitted by law and contract. The tier remains unchanged by insurance status. If a rate is missing, place the calculation on hold and obtain a documented rate confirmation from the Director of Revenue or authorized designee; do not invent a standard rate.

6. Full Discount, Financial Barriers, and Collection

Patients with income at or below 100% FPG receive a full 100% discount on eligible patient charges, for a $0 SFDP charge, subject to the government-program and contractual billing rules in Section 8. FSCC elects no nominal fee. No minimum payment, upfront deposit, or copayment will be required as a condition of medically appropriate services solely due to inability to pay. A restriction on waiving insured cost sharing does not eliminate a patient's SFDP eligibility; Billing documents the specific limitation and lawful balance.

Patients above 100% through 200% FPG receive the graduated discounts in Section 12. FSCC will make reasonable, respectful efforts to collect only lawful discounted balances; statements, discussion of balances, and reasonable payment arrangements may be used. Do not harass or discontinue medically appropriate care solely for inability to pay. Distinguish inability to pay from refusal; a patient reporting hardship or missing a payment arrangement is not automatically refusing. Further collection action requires documented review and approval by Revenue leadership consistent with written collection procedures, applicable law, and patient access protections. Maintain collection communications and adjustments in restricted financial records and audit practices periodically.

7. Advertising and Access to Applications

Post clearly visible signs in patient-accessible reception/intake areas and publish required notice on FSCC's official website, including: “No one will be denied access to services due to inability to pay.” and “A sliding fee schedule is available based on family size and income.” Offer notices in prevalent patient languages as appropriate, include information in new-patient materials, and train intake staff to explain how to apply. Maintain two clear photographs of signs for each applying site and a dated website screenshot with URL.

8. Insurance, Medicaid, Medicare, and Payer Restrictions

FSCC will accept Medicare assignment and maintain applicable Medicare, Louisiana Medicaid fee-for-service (FFS), Medicaid managed care organization (MCO), and CHIP participation or agreements as required for each applying NHSC site.

The Director of Revenue and Credentialing Department will verify each rendering clinician's payer enrollment status, effective dates, and applicable service coverage using the current Credentialing Matrix and payer enrollment records. Before determining a patient's legally collectible responsibility, Billing will confirm that applicable payer enrollment, coverage, claim adjudication, and coordination-of-benefits requirements have been satisfied.

Payer Restriction List

The Director of Revenue maintains a Payer Restriction List for each payer/product, identifying verified cost-sharing waiver restrictions and exceptions, with source, effective date, reviewer, billing instruction, and review date. A payer restriction must be supported by applicable law, a verified contract provision, or documented written payer guidance; a payer marked “Under Review” is not treated as prohibiting SFDP discounts. The Compliance Officer reviews the list at annual review and upon relevant contract/rule changes. Billing checks it before insured-patient adjustments. Only documented restrictions justify withholding a discount on otherwise lawful cost sharing; notify patients in writing and document any exception and alternative arrangements.

Medicare Qualified Medicare Beneficiary (QMB) billing protections

QMB is a Medicare Savings Program eligibility classification, not an insurance plan that disqualifies a patient from SFDP. Patients with QMB status must be offered the SFDP and evaluated using the same family/household size and income criteria as other patients; QMB status does not change the patient's SFDP eligibility tier.

Federal law prohibits billing or collecting from QMB patients Medicare Part A or Part B deductibles, coinsurance, and copayments for Medicare-covered services, whether the patient has Original Medicare or Medicare Advantage, even when Medicaid pays none or only part of the cost sharing. These amounts are not legally collectible patient balances and must not be treated as patient charges or recorded as SFDP write-offs merely to eliminate them. Billing verifies QMB status for the date of service, completes required Medicare/Medicaid coordination, suppresses patient statements and collections for prohibited cost sharing, and records any nonbillable balance using the approved QMB/Medicaid adjustment process. If a prohibited QMB amount has been billed or collected, Billing promptly corrects the account and refunds the patient when appropriate.

Services not covered by Medicare must be reviewed separately for Medicaid coverage, applicable beneficiary protections, required notices or consent, and whether patient billing is legally permitted; any lawful patient charge remains eligible for the approved SFDP discount subject to applicable rules.

Louisiana Medicaid

After Medicaid and applicable other payers adjudicate, do not balance bill for prohibited amounts. Treat nonbillable balances as contractual/Medicaid adjustments rather than SFDP discounts. Any patient-billable noncovered service requires advance verification of payer rules and required disclosures/consent. Do not automatically classify a claim denial as noncovered or patient collectible. The exact treatment of FFS and each MCO must be consistent with current rules and payer contracts.

Insured billing workflow

- Confirm the SFDP tier.
- Bill payer(s) and complete coordination of benefits.
- Verify whether a collectible patient balance exists.
- Check the Payer Restriction List, QMB status, and Medicaid protections.
- Apply any permitted SFDP percentage to the lawful collectible balance.
- Record the “Sliding Fee” write-off separately from QMB, Medicaid, or contractual write-offs.
- Bill only the lawful final balance, and provide written notification when a documented restriction prevents an otherwise expected discount.

9. Grievances and Reconsideration

A patient may request written reconsideration of an SFDP determination, income calculation, or tier within 30 calendar days of notice. Front Desk forwards requests to Jessica Marchand the same business day; Billing does the same for requests emailed to billing@fs-pms.com. The Compliance Officer or an impartial designee who was not the original decision-maker reviews and issues a written response within 10 business days. Retain review grounds, outcome, and patient notice in restricted records; track grievances for quarterly audit. An existing approved tier remains in effect during review when applicable, subject to its validity period. Grievances do not delay clinically appropriate care.

10. Annual Schedule and Policy Review

Within 30 days after HHS publishes new annual FPG amounts, the Compliance Officer coordinates updated thresholds, signage and website consistency, staff training, and approval. Review the Cash-Pay Fee Schedule, payer restrictions, collections, and affordability of resulting discounted balances at least annually and after meaningful changes. Retain dated evidence of actual operation, approvals, and training.

11. 2026 Federal Poverty Guidelines (48 Contiguous States and DC)

These are the HHS guidelines that apply to Louisiana. Use a new approved table when the 2027 guidelines are published. Figures are annual income thresholds in U.S. dollars.

Household	100%	125%	150%	175%	200%
1	$15,960	$19,950	$23,940	$27,930	$31,920
2	$21,640	$27,050	$32,460	$37,870	$43,280
3	$27,320	$34,150	$40,980	$47,810	$54,640
4	$33,000	$41,250	$49,500	$57,750	$66,000
5	$38,680	$48,350	$58,020	$67,690	$77,360
6	$44,360	$55,450	$66,540	$77,630	$88,720
7	$50,040	$62,550	$75,060	$87,570	$100,080
8	$55,720	$69,650	$83,580	$97,510	$111,440

For households larger than 8, add $5,680 per additional person to the 100% guideline before calculating higher thresholds. At exactly 100% FPG, the patient remains in the full-discount category.

12. SFDP Discount Tiers

Annual household income	Discount	Patient pays
At or below 100% FPG	100%	0% of eligible charge ($0; no nominal fee)
Over 100% through 125% FPG	80%	20% of eligible charge
Over 125% through 150% FPG	60%	40% of eligible charge
Over 150% through 175% FPG	40%	60% of eligible charge
Over 175% through 200% FPG	20%	80% of eligible charge
Above 200% FPG	No SFDP discount	Lawful applicable charge; no denial of care due to inability to pay

“Eligible charge” means the clinician-specific standard charge for uninsured or legitimately noncovered patient-billable services, or lawful adjudicated patient responsibility for insured covered services, after applying Section 8 protections and restrictions. These percentage discounts must be reviewed to ensure patient charges do not become a barrier to care.

13. Administrative Workflow and Responsibility

Step	Owner	Procedure
1	Front Desk	Offer SFDP to every patient, explain eligibility, and make the application available.
2	Front Desk	Explain household-size/income information; assist without demanding an insurance denial.
3	Biller	Review income and calculate the current FPG percentage and proposed tier.
4	Tara Fuller	Review and approve self-attestations, temporary eligibility, and exceptions; document rationale.
5	Tara Fuller / LaTori Young	Recommendation followed by final eligibility approval per controlled Application Sections F–H.
6	Biller	Record tier and approval/review dates in TherapyNotes and the SFDP tracker; hold pending cases separately.

Step	Owner	Procedure
7	Biller (uninsured / noncovered) · Payment poster — Dakota (insured)	Determine the lawful charge per Sections 5 and 8; apply the approved discount with the correct adjustment reason. For insured patients, the payment poster applies the discount after the claim pays.
8	Biller	Send the current approval/denial letter and put a copy in TherapyNotes Documents; pending requests use a separate notice.
9	Biller	Save all applications and support in the restricted-access NHSC patient financial records folder on the secured company shared drive, not the general NHSC binder.
10	Front Desk	Flag annual reassessment or patient-reported material changes.
11	Compliance Officer	Prepare de-identified monthly reports and reconcile Sliding Fee, QMB, Medicaid, and other adjustments as separate categories.
12	Compliance Officer	Quarterly audit; resolve discrepancies; document reconsideration outcomes and corrective action.

14. Evidence, Records, and Data Protection

Store patient-identifiable applications, income records, approval/denial notices, self-attestations, rate calculations, and insurer determinations in the designated restricted-access NHSC patient financial records folder on the secured company shared drive and/or authorized patient financial record system. TherapyNotes documentation is limited to authorized staff; do not store patient-identifiable evidence in the general NHSC readiness binder. Maintain de-identified or aggregate NHSC evidence separately and follow FSCC retention/security policies.

- Current signed policy and version-control record
- Approved FPG sliding fee schedule and verified standard charges
- Current patient SFDP Application (Sections A–I) and controlled letters
- Income determination worksheet, self-attestation, and temporary eligibility records
- Two posted-sign photos per applying location and website screenshot/URL
- Staff training, dates, and intake workflow records
- Six months of actual de-identified SFDP operational/site data as applicable
- Monthly SFDP reports, write-off reconciliations, and quarterly audit reports
- Payer Restriction List and payer/source verification documentation
- Annual FPG updates and affordability/collection reviews
- Grievance/reconsideration log and written determinations

15. Related Controlled Documents

- PMS_FSCC_SFDP_Form.docx — SFDP Application (Sections A–I)
- PMS_FSCC_SFDP_Approval_Letter.docx
- PMS_FSCC_SFDP_Denial_Letter.docx
- PMS_FSCC_CashPay_Fee_Schedule.docx — clinician/service-specific standard charges
- Payer Restriction List and Credentialing Matrix
- PMS_ALL_WriteOff_SOP.docx
- PMS_FSCC_SFDP_Lobby_Poster.pdf and website public notice
- FSCC collections, record-retention, security, and deposit/no-show procedures

16. Approvals and Revision Control

By signing, authorized leaders confirm review and approval of this consolidated policy. This revision takes effect on the approval date below.

Approver	Signature	Approval date
Millie Huffman, FSCC COO / Compliance Officer		November 12, 2026
LaTori Young, Director of Revenue		November 12, 2026

Date	Changes
October 2026	SFDP operational October 1, 2026, replacing the Hardship / Copay Assistance Program (retired September 30, 2026).
November 2026	Consolidated revision approved November 12, 2026: added QMB billing protections; named Tara as approver for self-attestations and exceptions; payment poster applies discounts for insured patients after the claim pays; rebranded to the PMS format.

Regulatory and Program References

- National Health Service Corps (NHSC) Site Reference Guide, April 2025, or the most current version published by HRSA
- NHSC Site Application and Recertification Checklist
- NHSC Site Agreement
- Current U.S. Department of Health and Human Services Federal Poverty Guidelines
- Centers for Medicare & Medicaid Services (CMS) Qualified Medicare Beneficiary (QMB) billing requirements
- Applicable Louisiana Medicaid fee-for-service and managed care billing requirements
- Applicable federal and state laws and payer agreements

Document Owner: Millie Huffman, FSCC COO / Compliance Officer | Revenue Owner: LaTori Young, Director of Revenue | Practice Management Solutions

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