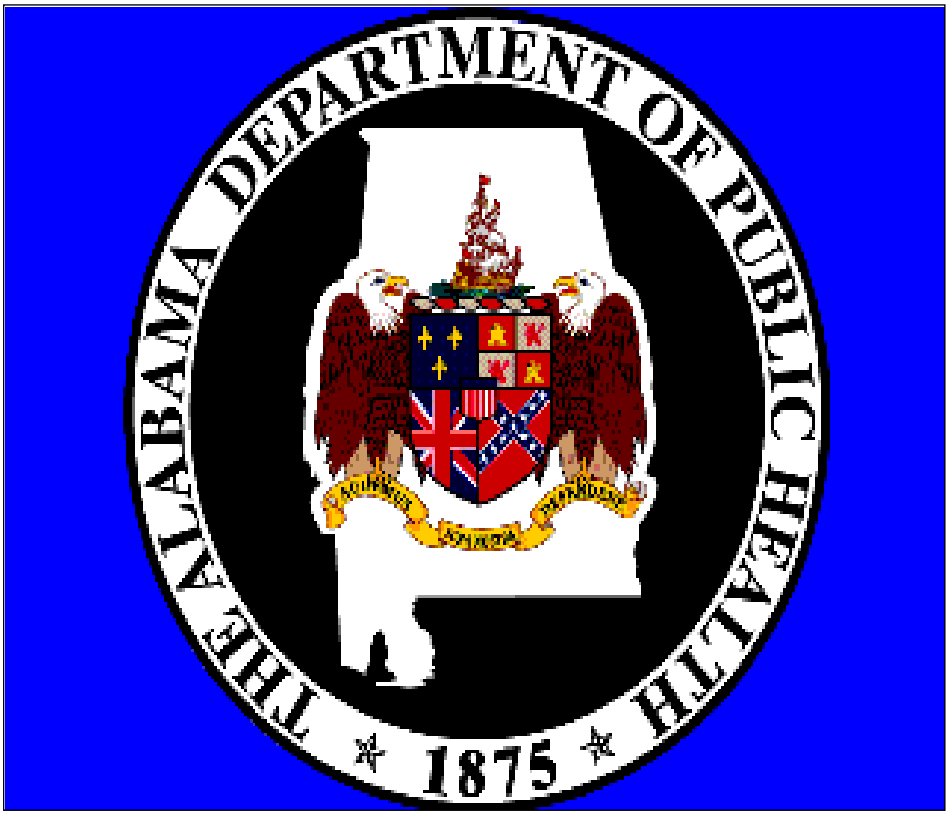
Alabama Department of Public Health

Fee System Manual

Bureau of Financial Services
201 Monroe Street
Montgomery, AL 36104



DPH-HF-130 Rev. 08/13(JW)

Revised August 2013

MANUAL REVISION LOG

Manual Name: _____

Revision Number	Revision Date	Page Number(s)	Date Posted	Initials

MANUAL REVISION LOG INSTRUCTIONS

1. Insert Manual Revision Log in front of the appropriate manual.
2. **MANUAL NAME:** Enter the Manual name.
3. **REVISION NUMBER:** Enter number of revision from Policy Letter.
4. **REVISION DATE:** Enter date of revision from Policy Letter.
5. **PAGE NUMBERS:** Enter the page number from pages that were changed.
6. **DATE POSTED:** Enter the date page changes were inserted in Manual.
7. **INITIALS:** Initials of individuals posting the changes.
8. ADPH Policy Letter may be discarded or filed in manual.

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CHAPTER 1

GENERAL INFORMATION

INTRODUCTION

The fee system for the Alabama Department of Public Health is a critical operation. The policies and procedures for collection and accountability of fees by county health departments are established in the Fee System Manual. It is imperative that county health departments adhere to the policies and procedures outlined in this manual.

GENERAL INFORMATION

This manual provides uniform procedures for collection and accountability of fees charged in the county health departments. Fees collected include Family Planning fees, Environmental fees, Health Statistics fees, Other Clinic fees, and Miscellaneous receipts.

Instructions are designed for employees who are directly responsible for the collection of fees. All clinic staff should be knowledgeable about the Fee System.

Questions and situations not fully covered in this manual should be referred to the:

- Local administrator, health officer, or office manager,
- Area administrator or clerical director,
- Office of Program Integrity,
- Bureau of Financial Services.

Why do we have a Fee System? All counties charge fees for services. All counties charge for family planning services and for certified copies of Health Statistics records. Fees are assessed based on federal or state law.

Some counties charge for additional services where fee legislation or a fee bill has been passed. Each Fee bill identifies the specific authority that designates the services that fees may be charged and designates who sets the fee.

Disclaimer: This is not an all exclusive manual for certain detailed instructions may need to see your supervisor.

Why do counties charge fees? In some instances (family planning and health statistics) charging fees is required by law. Fee legislation was sought to obtain revenue for the county health departments to help offset the cost of providing services.

Who benefits from charging fees? Fees collected in the county health departments are deposited into a local "Depository Account" or "Fee Account". Fee accounts are interest-bearing accounts, which provide another source of revenue for the county. Fees are transferred on an as-needed basis by ADPH Financial Services - Budget and Receipts Office to the State Treasury to meet county payroll or other county expenses.

Required procedures: The FeeSystemManual provides a standardized method for collection and accountability of fees. Some information may not apply to ALLhealth departments; the procedures were written to address any issue, which may arise. Although the FeeSystemManual addresses issues that may not apply to all county health departments, it is necessary to understand the procedures to obtain fee certification.

Other issues: The Fee System Manual also addresses the Imprest Account and other bank accounts maintained and operated by the county health department. These accounts are also covered on the fee certification test.

Fee Certification: All employees who perform duties associated with the Fee account, the Imprest account, or any other health department bank account must be certified to handle cash. This process includes:

- defining tasks and assigning employees to tasks,
- training and testing of employees, and
- reporting tasks and employees on the Cash Accountability Plan.

Personnel assigned to WIC who perform income assessments for WIC eligibility do not have to be fee certified. These individuals must be knowledgeable of the information contained in Chapter 2, Income Assessments. Since these assessments can be used as the basis for collecting fees in other clinic services, documented training is required. The income assessment portion of the fee certification test will be administered. The income assessment portion requires a passing score of 85 or above. The Imprest section requires a passing score of 85 or above. A passing score of 102 or above on the Fee Depository test is required and the rated test results are put in the employee's file at each health department for review by Program Integrity. The maximum possible score on the test is 128.

FEE COLLECTION

All clients must understand fees will be charged for services. Clients must also understand their responsibility in the fee collection process. Clinic staff should make every effort to inform clients of the following facts. ***Clients should know:***

- Before they arrive at the clinic, that there will be a fee charged for services. If possible, the client should know the fee amount and come prepared to pay.
- They may be asked to show proof of income.
- What is covered by the fees, e.g., supplies, tests, exams, and other services,
- The client will not be harassed and will be treated fairly and courteously regardless of ability to pay.
- The approximate cost of services, such as the cost per patient or cost per visit.
- The client will not be pressured but will be expected to pay the full amount due as soon as possible (preferably at the first visit).
- Clinic visits will remain confidential and if requested the patient will not receive phone calls or bills in an effort to obtain payment.
- Contributions help keep the clinic operational.

The following methods may be used to inform clients and the public that fees are a routine part of clinic services:

- Posters in the clinic
- Pamphlets
- News releases
- Word-of-mouth
- Distribution of fee information/material to other agencies, i.e., Department of Human Resources and Mental Health
- Work through the local Advisory Council

NOTE: Clients must be provided services without regard to religion, race, color, national origin, handicapping condition, age, gender and number of pregnancies or marital status. Clients must not be denied services or be subjected to any variation in quality of services because of the inability to pay.

EMPLOYEE RESPONSIBILITY

Knowledge of the Fee System is every clinic employee's responsibility. Clients may ask anyone a question regarding fees. All county health department employees should answer questions or refer the client to an employee who can answer questions.

The clerk or other designated employee who has initial contact with clients, either in person or by phone, will receive the majority of questions. The initial contact employee holds the key to the success of the Fee System. The clerk's initial impact with the client does not minimize the importance of other employees. For example, clients may wait until they are talking with the nurse or nurse practitioner before asking a question, or perhaps the client will trust an aide and expect the aide to answer questions.

It is important that the way information is given, the amount of information that is given, and the tone of voice in which it is given, will affect a client's response. Nonverbal cues such as facial expression or the amount of eye contact may seem unimportant but will affect client/staff relationships. Employees should realize that a client might not be comfortable with paying a fee. When an employee responds to a client's questions and answers each fully, the issue of fees should not arise again.

If you have questions regarding fees, contact the appropriate departmental contact person listed on the following page.

DEPARTMENT CONTACTS

Questions regarding the Fee System Manual should be directed to the employee or office listed below:

CERTIFICATION
CLINIC FEES
GENERAL INFORMATION MISCELLANEOUS
RECEIPTS
E-DAY SHEET SYSTEM /ONE-WRITE SYSTEM (BACKUP SYSTEM)

County Office Manager	See directory
Area Clerical Director	See directory
Program Integrity	PHONE: 334-206-5312 FAX: 334-206-5844

CLINIC SERVICES

Family Health Services	PHONE: 334-206-5675 FAX: 334-206-2950

ENVIRONMENTAL SERVICES

Environmental Services	PHONE: 334-206-5373 FAX: 334-206-5788

FEE SYSTEM MANUAL CHANGE, COMMENTS OR REVISIONS

Bureau of Professional and Support Services	PHONE: 334-206-5226 FAX: 334-206-5663

HEALTH STATISTICS SERVICES

Center for Health Statistics	PHONE: 334-206-5426 FAX: 334-206-2659

LOCAL FEE POLICY

Local Administrator	See directory
County Office Manager	See directory

MONTHLY RECAPS

Financial Services Budget and Receipt Office	PHONE: 334-206-5250 FAX: 334-206-5485

REVENUE RECOVERY

Office	PHONE: 334-206-5668 FAX: 334-206-0333

SAFE PROGRAM

As you are aware, the county health departments maintain funds on deposit outside the state treasury that must be insured. You will also remember that the SAFE Program (Security for Alabama Funds Enhancement program) was implemented in 2001 and was designed to provide security for public funds on deposit in local banks. You have done well to ensure that your local accounts are with financial institutions participating in the SAFE Program, and Program Integrity has been able to verify this by obtaining copies of the banks' SAFE Certificates. The Examiners of Public Accounts informed us that we need to ensure the security of the department's funds on deposit. It is not enough to verify the bank holds a SAFE Certificate; we must verify that **all** public accounts are included in the SAFE pool for collateral purposes.

What is included?

The SAFE law, Section 41-14A-3, Code of Alabama, 1975, requires public deposits to be secured.

INCLUDE in SAFE	DO NOT INCLUDE in SAFE
Fee Account	Employee Coffee Fund
Imprest Account	Employee Flower Fund
Miscellaneous Account – Money goes to fee account at end of account life	Miscellaneous Account – Reverts to donor at end of account life
Car Seat Account – Funded with federal money	
Building Fund	
(Ask Program Integrity for guidance)	(Ask Program Integrity for guidance)

SAFE PROGRAM

What is required?

The State Treasurer issued instructions in the administrative code, 892-X-1-.08(2), requiring the qualified public depositories to do the following:

> Annually, prior to November 1st, provide a report as of the last business day of September to each public depositor that summarizes their deposit account relationship. This report shall be in addition to regular statements and shall include an indication to public depositors the purpose of the report and that the following accounts are designated as public deposits subject to the SAFE Program. The report shall be deemed correct unless the public depositor notifies the depository to the contrary within 60 calendar days of receipt of the statement.

Please notify your financial institution of your expectation to receive such report. A sample letter of request is enclosed for your use as you begin discussions with your bank. When you receive the report, please review carefully to ensure that **all** of your public accounts are included and the September 30 account balances are stated correctly. Forward a copy of the report to the Office of Program Integrity, RSA Tower – Suite 1500. Keep the original at the county health department.

If you have questions, please contact Program Integrity at (334) 206-5312.

SAMPLE LETTER FOR SAFE PROGRAM

Date

Bank Contact Person
Bank Organization Name
Street Address
City, State Zip

RE: SAFE Program Requirements 892-X-1-.08
Annual Statement of Account Relationship

Dear [insert bank contact person]:

The Alabama Department of Public Health, [insert county health department name] is a government entity and is therefore subject to the requirements of the SAFE Program identified in Section 41-14A, Code of Alabama, 1975. As such, all public funds on deposit outside of the State Treasury must be deposited in qualified public depositories and included in the SAFE Program.

Accordingly, we are requesting that you provide us with the annual report as specified in the administrative code, 892-X-1.08(2), requiring qualified public depositories to do the following:

> Annually, prior to November 1st, provide a report as of the last business day of September to each public depositor that summarizes their deposit account relationship. This report shall be in addition to regular statements and shall include an indication to public depositors the purpose of the report and that the following accounts are designated as public deposits subject to the SAFE Program. The report shall be deemed correct unless the public depositor notifies the depository to the contrary within 60 calendar days of receipt of the statement.

If you have any questions regarding this request, please contact me at [insert telephone number of county health department's contact person].

Sincerely,

[CHD contact person]
[CHD]

Common Questions and Answers

Question: Does Service Code 168, Copy of Medical or Dental Record, refer to the entire CHR or to a specific page within the CHR? Also, do we charge our patients for copies of their own records? Do we charge other state agencies?

Answer: A flat fee based on the latest approved fee schedule will be charged regardless of the number of pages copied from the CHR. In other words, whether copying one page, or all pages in the record the charge is the flat fee based on the latest approved fee schedule. This fee will be assessed for non-medical information requests only. No fee will be charged for copies of medical records sent to other providers to ensure continued quality of patient care. In other words, the patient or other state agencies will only be charged if the copies are for non-medical information purposes.

Question: Some insurance companies send more than the flat fee based on the latest approved fee schedule for a medical record copy. Can the county keep the extra?

Answer: Yes, the county may keep the extra and put the excess as a donation.

CHAPTER 2

INCOME ASSESSMENT

PATIENT REGISTRATION/INCOME ASSESSMENT

PURPOSE:
The purpose of this form is to provide basic identification and demographic data for patient care; direct and third party billing; computerized data entry; and documentation for standardized assessment of income and family size to determine eligibility for and percentage of charge, if applicable, for all Health Department services. Documentation may be based upon a declaration, except for WIC eligibility. For WIC eligibility, proof of identity, residence, and income is required and is documented by entering the type of proof document in PHALCON during the income assessment and prior to Food Instrument issuance. See the WIC Procedure manual for explanation of proof requirements.

PATIENTS SHOULD NOT BE DENIED SERVICE FOR FAILURE TO PRESENT DOCUMENTATION EXCEPT FOR WIC.

The Income Assessment is an essential tool for implementation of the Fee System. County health departments charge fees on a sliding scale based on family size and income which is captured on the income assessment.

The Income Assessment:

- provides documentation of income assessment;
- records income and family size;
- determines eligibility for all applicable health department services;
- determines percentage of charge for services; and
- is completed at each client's first visit to the clinic, when a client volunteers an update and annually thereafter except WIC. Income assessments are completed at each WIC certification or recertification and when there is knowledge of a change in income.

All sections of the CHR-2 must be completed.
Fees are charged based upon the last annual income assessment. A new income assessment must be completed if the last assessment is more than 12 months from the date of the signed declaration or the client declares a change in status.

Family size and income must be documented to validate the percentage of charge. ***Income assessments without this information are audit exceptions.*** The client/parent/legal guardian/legal custodian/proxy signature signifies client understands his/her rights and responsibilities.

- **Determining Percentage of Charge**
  Family size and income from the income guidelines determine if the percentage of charge will be either 100%, 75%, 50%, 25% or 0%. The percentage of charge identifies the client's payment category and the fee amount. Medicaid eligible clients are exempt from fee charges for covered services.

PATIENT REGISTRATION/INCOME ASSESSMENT

Status of Medicaid eligibility must be checked at every Child Health, Family Planning, Maternity, Immunization and Care Coordination visit using the Medicaid swipe card, or the web-eligibility verification (AVRS), with the fee based upon the last income assessment.

Automated CHR-2 Form Sample

PATIENT REGISTRATION/INCOME ASSESSMENT

CHR: T00126919 DATE: 07/16/2012
NAME:
DOB: 05/20/2010 Race: A,W Sex: F
SSN: ###-##-9458 MEDICAID
ADDRESS: 101 MAIN ST
PRATTVILLE, AL 36067
PHONE:

Country of Birth: UNITED STATES
Limited English Proficiency(LEP): N Spoken Language: ENGLISH
Contact Person: JOE BIDDO Contact Phone:
Employer Name: MONSANTO Employer Phone:
Employer Address: 101 CATO DR City: PRATTVILLE State: AL Zip: 36066
Health Care Provider: DR. CURLY
Directions to Home: TWO MILES PAST THE OLD BRIDGE.

PATIENT DECLARATION:
I certify that the information I will provide on this form in order to determine my eligibility for services of this agency, as well as to determine the amount which I will pay for the services I receive, is true and correct to the best of my knowledge. I understand that Social Security information is used for identification purposes only and is not required for me to obtain services. I understand this assessment is being made in connection with the receipt of Federal and State subsidized services and/or assistance. Officials of this agency have my permission to verify this information, and I will cooperate fully by providing documentation of my income if requested by this agency. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State Agency, in cash, the value of the food benefits improperly issued to me and subject me to civil or criminal prosecution under State and Federal law.

Signature of Patient (or Parent/Guardian) **Signature & Title of Assessor/Witness** **Date**
☐ Parent not here today, proxy signature

Family Size: 2

MEDICAID: N **Self:** ____ **Family Member:** ____
Verified: ______________ **(Date/Initials)**
Applied for: Y **Date applied for: 07/16/2012**
Family Assistance: N **SNAP:** N **All Kids:** N
American Indian/Alaskan Native: N **Private Insurance:** Y

Vaccines for Children Eligibility requirements:
Medicaid"Yes", (Private Insurance "No" and AllKids "No") or
American Indian/Alaskan Native "Yes" or
FP-unaccompanied minor without insurance "Yes"

FP-unaccompanied minor without insurance: ☐
Verified ______________ (Date/Initials)

Explanation of Services: ☐ **Required Education:** ☐
Notice of Ineligibility **Verbal:** ☐ **Written:** ☐

INCOME	**(Source)**	**(Annual Amount)**
Amount1:	joes stationary	$23,489
Amount2:	papers R us	$6,000
Amount3:		$0
	Total:	$29,489

Payment Bracket: 50 % Income Self-declared: N
Student ☑ **School:** CATHOLIC HIGH
Special Circumstances:

Interim Visits

Medicaid: ____ No ____ Yes **If VFC "Yes" circle eligibility qualifier** VFC Eligibility: ____ No ____ Yes
Medicaid "Yes" (Private insurance "No" and All Kids "No") : American Indian/Alaskan Native "Yes" : FP-unaccompanied minor without insurance "Yes"
Verified ______________ (Date/Initials)

Medicaid: ____ No ____ Yes **If VFC "Yes" circle eligibility qualifier** VFC Eligibility: ____ No ____ Yes
Medicaid "Yes" (Private insurance "No" and All Kids "No") : American Indian/Alaskan Native "Yes" : FP-unaccompanied minor without insurance "Yes"
Verified ______________ (Date/Initials)

Medicaid: ____ No ____ Yes **If VFC "Yes" circle eligibility qualifier** VFC Eligibility: ____ No ____ Yes
Medicaid "Yes" (Private insurance "No" and All Kids "No") : American Indian/Alaskan Native "Yes" : FP-unaccompanied minor without insurance "Yes"
Verified ______________ (Date/Initials)

Medicaid: ____ No ____ Yes **If VFC "Yes" circle eligibility qualifier** VFC Eligibility: ____ No ____ Yes
Medicaid "Yes" (Private insurance "No" and All Kids "No") : American Indian/Alaskan Native "Yes" : FP-unaccompanied minor without insurance "Yes"
Verified ______________ (Date/Initials)

CHR 2 **AUTOMATED FORM** ADPH-CHR-2/Rev. 9-01 -MC

PATIENT REGISTRATION/INCOME ASSESSMENT

Automated CHR-2 Instructions: PROCEDURE

1. **PHALCON label:** Patient information will populate in the space provided.

2. **Country of Birth:** Indicate the country of birth in the space provided.

3. **Limited English Proficiency (LEP):** Indicate if patient's native or dominant language is not English and if an interpreter is required. **Spoken Language** - Specify language spoken.

4. **Contact Person/Phone:** Enter name and phone number of a parent, guardian, relative or friend to be notified in case of emergency. Indicate if patient refuses information.

5. **Employer Name/Phone/Address:** Enter information, if applicable.

6. **Health Care Provider:** Enter name of physician, if applicable.

7. **Directions to Home:** Enter directions to home and/or place of employment, if applicable.

8. **Patient Declaration:** Patient/parent/legal custodian/legal guardian, or proxy must read to ensure he or she understands the rights and responsibilities. When necessary read the declaration to the patient/parent/legal custodian/legal guardian. The signature of one of these individuals is required. **In the case of an infant of a WIC mother (Nutrition Risk Code 701)**; the proxy may sign in the signature space. The assessor will indicate in the box provided, "parent not here today, proxy signature".

9. **Signature and Title of Assessor/Witness:** The assessor/witness (Health Department staff completing this form) signs and dates his/her section after the patient or parent/guardian has signed. The assessor and witness may be the same person.

   The patient's fee ledger card is to be used as a back-up if the E-Day Sheet is ever down. The patient's fee ledger card should be securely placed in an envelope in back on the left side of the patient's CHR folder OR filed alphabetically in a secure location based on local discretion. All transactions are to be entered into the E-Day Sheet once it is back up and running.

10. **Family Size:** The following guidelines are to be used to verify family size and income in order to: 1) assign a fee for Family Planning and Other Clinical Programs; and 2) to determine WIC eligibility. The WIC Program does not charge fees to clients for services.

    A. <u>Family Planning and Other Clinical Programs, excluding WIC</u>:
    Family refers to a person or persons related or non-related by blood, marriage (including common law), or adoption living under one roof. Dependents away at school are also included. The income of all these persons should be counted to calculate the total income of the family.

Family Planning and Other Clinical Programs, excluding WIC: continued

- Examples of one member families:
  - A single person living alone
  - A person living with her/his parents who is not legally responsible for her/him

  - Exceptions to the one member family unit:
    - A foster child is considered a family size of one
    - A single teenager living with parents and in need of confidential services is considered a family size of one

- Examples of two or more member families:
  - A couple with or without children
  - A single parent with one or more children
  - A couple with or without children living with and being supported by a family unit of relatives all living in the same house
  - A pregnant women expecting to deliver one child is considered a family of two
  - A pregnant woman expecting twins, a family of three; and, expecting triplets, she is considered to be a family of four

- Other examples:
  - A child is counted in the household size of the parent or guardian with whom she/he lives.
  - In joint custody cases, consider the income of the household of the parent who initiates the service for the child. Fees are to be based on the income of the parent who initiated the service.
  - A child/student residing in a school or an institution and being supported by the parent, guardian, or caretaker is counted in the household size of the parent, guardian, or caretaker.
  - An adopted child, or a child for whom a family has accepted the legal responsibility, is counted in the household size with whom he/she resides.
  - If an adolescent has parental consent for contraceptive services, the fee should be based on family income.

B. WIC – Family Size:

A family is defined as a group of related or non-related individuals who are living together as one economic unit which may consist of an adult and his/her spouse, (including common law), and children/dependents under 18 (or under 21 if in school) related by blood, marriage, or adoption who are residing in the same household. A member of this economic unit temporarily out of the home, e.g., attending school but returning for holidays and vacations or hospitalized, continues to be considered a part of the family.

WIC – Family Size: continued

Note: There may be several economic units sharing a household, but only count and document the income for the economic unit requesting or applying for services. Often there may be situations in which the assessor must make a judgment because living arrangements vary considerable from household to household. The following should be used when determining family size for WIC:

- **Single Client**
  - with or without children living alone
  - with or without children supporting relatives, i.e., father, mother, brother, sister
  - Non-wage earner applying for herself or for a child, living with and being supported by the economic unit of relatives all living in the same house. Count all income of the economic unit when assessing income eligibility.

- **Single Wage Earner**
  - living with parents and not supported by parents, should be classified as a family of one and only his/her income should be counted

- **Married or Cohabitating Couple**
  - With or without children
  - With or without children supporting relatives, i.e. father, mother, brother, sister
  - With or without children living with and being supported by a family unit of relatives all living in the same house. Count all the income of this family unit when assessing for income eligibility.

- **Pregnant Woman**
  - Expecting to deliver one child is considered to be a family of two.
  - Expecting twins, she is considered to be a family of three.
  - Expecting triplets, she is considered to be a family of four.
  - When determining the family size for the child of a pregnant woman, the unborn child/children are also counted as family members.

- **WIC Applicants** living in institutions including incarcerated pregnant women and homeless women/individuals
  - The family size of an institutionalized person or unit of related persons, e.g., a mother and her children in a temporary shelter for battered women, does not include other residents of the shelter. Income of the institutionalized person is also separate from the income of other residents and general revenues of the institution.

- **WIC Applicants with Military Spouse**
  - Military personnel serving overseas or assigned to a military base and temporarily absent from the home should be considered members of the household and counted when determining family size.

WIC Applicants with Military Spouse: continued

- **Exceptions to the Basic Family Unit Include**
  - Foster child is considered a family unit of one.

11. Medicaid Assessment:

Indicate "no" if the client does not have Medicaid benefits and complete the income assessment. Indicate "yes" if the patient is eligible for Medicaid benefits. The assessor should ask for proof of Medicaid eligibility (i.e., plastic Medicaid card and/or eligibility letter). To verify current Medicaid eligibility, the clinic MUST swipe the Medicaid card, check Web Eligibility verification or call the 1-800-number on the card. Indicate "No" or "Yes" to document verification, date and initial. An application should be taken if indicated and check the box indicating "applied for". If Medicaid is being applied for Family Planning, do not charge client for services. See below for additional instructions.

For WIC only:

- MSIQ can be used to verify current Medicaid eligibility. Medicaid eligible clients are exempt from fee charge for covered services. Clients who are Medicaid eligible automatically quality for all family health service programs.
- Indicate "self" or "family member" to denote who is receiving Medicaid benefits.
- **NOTE:** For WIC, Medicaid adjunctive income eligibility applies to the client who receives Medicaid (indicate self in PHALCON) or to the client who is a member of a family in which a prenatal or infant receives Medicaid (indicate family member in PHALCON).
- The self-declared income of all adjunctively income eligible (Medicaid, SNAP and Family Assistance) WIC participants must be entered in PHALCON at certification/ recertification.

If after a Medicaid Status check is completed and the patient is no longer eligible for Medicaid, complete a new income assessment. If the patient is on WIC and the new income assessment shows that the patient is no longer eligible for WIC, an income assessment must be done for each family member and the patient and each participating family member must be terminated from WIC and given a Notification Form (WIC-119). Patients applying for the Plan First Program will be provided services eligible under the Family Planning Waiver without charge. During the application process, patients should be informed that if it is determined they are not eligible for the Family Planning Waiver; they will be responsible for any bills since the time of the application.

NOTE: On subsequent visits if the client does not yet have a Medicaid card, status of Medicaid eligibility must be checked. If the application is still pending, continue to treat the client without charge and enter the services in PHALCON. If it has been more than 45 days since the initial visit, check with the Medicaid eligibility worker to determine the status of the application. As long as the application is pending, continue to treat the client without charge. If the client is shown as "Medicaid Application Denied", treat them on a fee for services basis and charge for services rendered since the time of the application.

Medicaid Assessment – continued

SPECIAL PROCEDURES FOR FOSTER CHILDREN: For Medicaid-eligible foster children, the foster parent should present the child's Medicaid card during intake. For non-Medicaid-eligible foster children, an income assessment must be completed. To comply with Department of Human Resources (DHR) guidelines, the DHR social worker must complete and sign the income assessment and other documents for both Medicaid-eligible and non-Medicaid eligible foster children at the Health Department except for WIC certification. Foster parents may sign the income assessment for WIC certification only.

12. Family Assistance:

Indicate "No" if the client does not receive assistance.
Indicate "Yes" if the client receives family assistance.

The assessor must see the copy of the Family Assistance Notice of Eligibility. Certification dates are listed on the notice. The documents are on the WIC Proofs screen in PHALCON.

13. SNAP (Supplemental Nutrition Assistance Program):

Indicate "No" if the client does not receive SNAP benefits.
Indicate "Yes" if the client receives SNAP benefits.
The assessor must see the Notice of Action sent to the family/household by the Alabama Supplemental Nutrition Assistance Program to determine current participation. The documents are on the WIC Proofs screen in PHALCON.

14. ALL Kids

Indicate "No" if the client is not covered by the ALL Kids insurance coverage.
Indicate "Yes" if the client is covered by ALL Kids.

15. American Indian/Alaskan Native:

Indicate "no" if the client is not American Indian/Alaskan Native.
Indicate "yes" if the client (parent or guardian) states that they are American Indian or Alaskan Native.

16. Private Insurance:

Indicate "No" if the client has no private health insurance coverage.
Indicate "Yes" if the client has any type of private health insurance.

17. Vaccines for Children (VFC) Eligibility Requirements: Nothing in this section is to be marked. It is to be used to provide an at-a-glance indication of children eligible for vaccine provided by VFC using the information obtained in the Medicaid, Private Insurance, and American Indian/Alaskan Native questions. Note that children 0 through 18 years of age are eligible for vaccines furnished by VFC if they are on Medicaid, have no health insurance, or are American Indian or Alaskan Native. Children who are on Medicaid **and** have private insurance may be given VFC vaccine.

18. Mark box to indicate if the patient is an unaccompanied minor for FP without insurance information. Include date and initials of person who verified information.

19. Explanation of Services: All applicable health services must be explained and offered to all clients, regardless of the program. WIC participants eligible for other programs such as SNAP (formerly Food Stamps), Family Assistance (formerly TANF), or Medicaid must be referred to the appropriate agency. Indicate after health services are explained.

20. Required Education: Three of the required education topics 1) WIC as Supplemental Food, 2) WIC Foods for Participant, and 3) Using WIC Identification Folder may be explained to WIC participants by clinic staff according to clinic procedure and documented here. Indicate after the Required Educations Topics are explained. See WIC Procedure Manual, Chapter 4.6.B.1.e. (1).

21. Notice of Ineligibility: When a client is ineligible to receive certain program benefits, indicate in the appropriate space whether VERBAL or WRITTEN notification was given. This shows that the client was informed of ineligibility and how to appeal as specified in the specific program protocols and procedure manuals. **The WIC Program requires that written notification be given.**

22. Income: Assess income status based on program protocol requirements.

This section **MUST BE COMPLETED**. If not, this will be considered an audit exception.

A. Family Planning and Other Clinical Programs:

- Income refers to the gross annual income for all members of a household. Income eligibility must be determined annually. Income includes:
    1. Wages, salaries and tips received before deductions
    2. Net earnings from self-employment. Net income is determined by subtracting the self-employed individual's operating expenses from his/her gross receipts
    3. Survivor's Social Security benefits such as widow's benefits or children's allowance.
    4. Private pensions or annuities
    5. Regular contributions from persons not living in the household
    6. Lump sum payments such as "new money" include gifts, inheritances, lottery winnings, worker's compensation for lost income, and severance pay
    7. Union strike benefits
    8. Long-term disability benefits received prior to minimum retirement age;

- Income does NOT include:
    1. Food, rent or other non-cash items received in lieu of wages
    2. SNAP benefits received
    3. Withdrawal from savings
    4. Money received from sale of personal possessions
    5. Loans received
    6. Student loans or grants received for school expenses
    7. Earnings of children under 14 received
    8. Settlements for legal damage

Family Planning and Other Clinical Programs: continued

- Income does NOT include:
    9. Maturity payments on insurance policies received
    10. Pay received for work while an inmate in a penal institution
    11. Interest and dividends
    12. Retirement Income
    13. Social security
    14. Unemployment benefits
    15. Alimony
    16. Child support

Reference: Internal Revenue Service (IRS):
"What is earnedIncome":http://www.irs.gov/individuals/article/0,,id=176508,00.html

- Determination of Income:
    1. Income is by self-declaration and is documented as an annualized income.
    2. Consider the income of the household during the past 12 months (annual income) and the family's current rate of income to determine which income more accurately reflects the family's current status.
    3. Count income of all members of the household who are employed, or have other sources of income (e.g., pension, etc).
    4. If an individual declares zero income, ask for information as to how they obtain food, shelter, clothing, medical care, etc. The information must be recorded in the client's file.

- Reassessment of Income - Income must be reassessed annually and when a client has a change in income status.

B. WIC

Current income is defined as gross cash income from all sources before deductions for income taxes, employees social security taxes, insurance premiums, bonds, etc. which the client, spouse and all other members of the family unit (included in Medicaid Eligibility) are earning or receiving at the time of the assessment.

- WIC Eligibility:
    - Income eligibility must be determined at certification/recertification prior to issuance of benefits (food instruments, formula). Infants born to mothers who participated in WIC as a prenatal patient must be income eligible. Income eligibility must be determined at certification/recertification and when a client has a change in income status. This includes certifications conducted at a clinic, a hospital or during home visit. Proof of income is required for WIC and the type of proof document must be entered in PHALCON at each certification/recertification.

- WIC Eligibility: continued

  - The WIC Program will use the same Income Guideline Chart used by other programs in the Health Department. All programs will implement changes in the income schedule at the same time. WIC participants cannot exceed 185% of poverty, unless there is proof of current participation in Medicaid, Food Stamps, or Family Assistance. Self-declared income, annual amount, and source must be documented.

- WIC Sources of Income:
  Documentation must include the name of the place of employment, company, or business. Sources of income include:
  - Alimony
  - Annuities
  - Business Profits
  - Child Support (Note: this is not included as income for FP patients)
  - Help from relatives and non-relatives not living in the household
  - Lump sum payments
    - Gifts
    - Inheritances
    - Lottery winnings
    - Severance pay
  - Military pay should include all forms of pay except on or off-base military housing allowance payments and Family Substance Supplemental Allowance (FSSA). Basic Allowance for Subsistence (BAS), hazardous duty/hostile fire, jump, separation/family separation pay, etc. must be counted with Base Pay.
  - Net earnings from self-employment
  - Net investment income (rent, interest, dividends)
  - Net royalties and any other cash income including received or withdrawn from savings, investments, trusts, or other resources
  - Sick pay
  - Workman's compensation
  - Pension or retirement payment
  - Regular contributions from persons not living in the household
  - Salaries (must document the name of the place of employment, company, or business)
  - Social security cash benefits such as widow's benefits or children's allowance
  - Tips
  - Unemployment compensation
  - Veteran's benefits
  - Wages

- WIC Sources not counted as Income:
  The following non-inclusive listing of reimbursements, payments, assistance, or allowances is NOT counted as income:
  - Bank loans
  - Student loans
  - Earned Income Tax Credit
  - Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970
  - Home Energy Assistance Act
  - Title I (VISTA and others) and Title II (RSVP, foster grandparents and others) of the Domestic Volunteer Services Act of 1973
  - Small Business Act (SCORE and ACE)
  - Job Training Partnership Act
  - National School Lunch Act
  - Child Nutrition Act of 1966
  - Food Stamp Act of 1980 (SNAP benefits)
  - Statutes related to certain claims settled with various Indian tribes
  - Student financial assistance received from any program funded under Title VI which includes:
    - The Pell Grant
    - Supplemental Education Opportunity Grant
    - BYRD Honor Scholarship Programs
    - Any other Title VI programs
  - Child care payments made under Section 402(g)(1)(E) of the Social Security Act
  - Any at-risk block grant child care payments made under Section 5081, gPub.101-508
  - Any child care provided or paid for under the Child Care and Development Block Grant Act.
  - Military pay does not include: On or off base Military Housing Allowance; Combat pay, Family Subsistence Supplemental Allowance (FSSA); Overseas Continental US (OCONUS) cost of living allowance.

  For additional federal assistance programs that can be excluded from being counted as income, see USDA WIC Regulations, Section 246.7(d) (2) (iv).

- Migrants
  A migrant farm worker or logger is defined as an individual:
  - Whose principal employment is in agriculture on a seasonal basis;
  - Who has been employed in agriculture within the last 24 months, and;
  - Who establishes, for the purposes of employment, a temporary abode or home.

- Migrants - continued

  Principal employment means over 5 percent of the migrant farm workers job in agriculture. Agriculture means all activities which include:
  - Cultivation and tillage of the soil;
  - Cultivation, growing, and harvesting of any commodity grown in or on the land;
  - Or as an adjunct or part of a commodity grown in or on the land including logging or harvesting of trees.

  When determining income for migrants at certifications, annual income is often more reliable and more easily obtained than current income.
  The migrant farm worker family who presents expired VOC cards/letters indicating that income eligibility was accomplished within the previous 12 months does not need income reassessed. They are considered income eligible.

21. Payment Bracket: After calculation of annual income and family size, the income percentage is written in this section to indicate the payment class for fees (100%, 75%, 50%, 25%, or 0%). Income schedules, also known as Poverty Guidelines, are generally released annually by the Department of Health and Human Services (DHHS).

PHALCON is updated to accommodate the income changes and counties must use the most recent schedule when assessing clients for charges.

NOTE: When the income schedule/poverty guidelines are released and PHALCON is updated, the payment bracket may change for the client and may vary from the information printed on the CHR-2 located in the chart. Clerks need to be cognizant of this possibility and will need to reprint the CHR-2 with updated information and charge clients appropriately if applicable. No fee is charged to clients receiving services under WIC, STD, and TB programs, or service covered by Medicaid.

22. Income Self-Declared – Self-declared income (annual amount) and sources of income must be entered. (For WIC, verification of self-declared income is not required if patient qualifies due to adjunctive eligibility).

Indicate "No" if the income is not self-declared.
Indicate "Yes" if the income is self-declared.

Note: Self-declared income must also be entered on the WIC Proof screen in PHALCON.

23. Student/School: Mark the box to indicate if the client is a student. List the name of the school if applicable.

24. Special Circumstances: At times there will be special circumstances which impact a client's ability to pay. The Income Assessment should include questioning about special circumstances. Examples include extreme medical expenses, temporary layoffs, unemployment or layoff for an extended period followed by recent unemployment.

Special Circumstances: continued

Family Planning

- Fees must be waived for individuals with family incomes above the amounts shown in the schedule who, as determined by the assessor/supervisor, are unable for good cause, to pay for family planning services.
- The county health department Administrator or Area/Clinic supervisory staff is required to approve waived fees for services as recommended by intake assessor. The approver is to initial in the Special Circumstances box.
- This is self declared information. Proof of cause is not required (example: hospital bill).
- Fees may be waived for services and/or supplies when the client meets any one or more, but not limited to other reasons deemed reasonable, of the following definitions of "Good Cause".
  - *Recent layoff from employment
  - *Recent Funeral Costs of immediate family member (**)
  - *Recent Medical/Hospital Costs
  - Extraordinary ongoing monthly prescription costs
  - Recent Bankruptcy
  - Recent Natural Disaster Loss (uncompensated costs for fire, flood, tornado, etc.)

* Recent is defined as no more than six months from the date of the event.
** Immediate family for this purpose includes spouse, children, parents, step parents, parent-in-law, grandchildren, grandparents, brothers, sisters, and stepchildren.

WIC - when calculating income for WIC, special circumstances cannot be allowed.

25. Interim Visits:

Medicaid - Indicate "NO" if client is not receiving Medicaid benefits. Indicate "YES" if client is receiving Medicaid benefits. Status of Medicaid eligibility must be checked at every Child Health, Immunization, Family Planning, Maternity, and Care Coordination visit using the Medicaid swipe card, Web Eligibility verification or 1-800 numbers on the card, with the fee based upon the last income assessment. If after a Medicaid status check is completed and the patient is no longer eligible for Medicaid, complete a new assessment. NOTE: If the most recent Income Assessment indicates that the patient is no longer eligible for WIC services, the patient and each participating family member shall be terminated and a WIC 119, Notifications Form given. If the assessment indicates that the patient has been assessed incorrectly for fees, correct fees shall be charged.

26. VFC Eligibility – VFC eligibility must be verified every visit where the client is age appropriate for VFC (up to the 19th birthday).
Indicate "NO" if the patient is not VFC eligible.
Indicate "YES" if patient is VFC eligible. If "Yes" the qualifier should be circled.

Enter the initials and date of the person verifying information.

PATIENT REGISTRATION/INCOME ASSESSMENT

INCOME SCHEDULE

THE INCOME SCHEDULE (Poverty Guidelines):

- with the Patient Registration/Income Assessment Form (CHR-2) assesses each patient's income eligibility
- determines the percent of fees, if any, will be charged to a client for Family Planning and other clinic services
- is released each spring from the Department of Health and Human Services (DHHS)
- is based on DHHS poverty guidelines
- is effective for use upon receipt at county health department through PHALCON release
- Shows the percent of fee to charge for services based on family size and income

PERCENT OVER MAXIMUM AMOUNT OF POVERTY INCOME	PERCENT TO CHARGE FOR SERVICES
250% OVER	100%
200% - 250%	75%
150% - 200%	50%
WIC = 185% AND UNDER	**AUTOMATIC ELIGIBILITY**
100% - 150%	25%
PLAN FIRST = 133% AND UNDER	**AUTOMATIC ELIGIBILITY**
100% AND UNDER	0%

The current Income Schedule should be used with the Form CHR-2 to assess each client's income eligibility.

PATIENT REGISTRATION/INCOME ASSESSMENT

INCOME SCHEDULE

Example:

INCOME SCHEDULE

		PERCENT OF FEE CHARGED													
		100%			75%		50%		Use for WIC Eligibility 185%	Use for Plan First Eligibility 133%	25%		0%		
		SCALE CODE & PERCENT OF MAXIMUM									SCALE CODE & PERCENT OF MAXIMUM				
Family Size	Range	A = over 250%			B =200% - 250%		C = 150% - 200%				D = 100% - 150%		E = 100%	&	under
1	Annual	$27,926	&	Over	$22,341 -	$27,925	$16,756 -	$22,340	$20,665	$14,856	$11,171 -	$16,755	$11,170	&	under
	Monthly	$2,329	&	Over	$1,863	$2,328	$1,398	$1,862	$1,723	$1,239	$932	$1,397	$931	&	under
	Weekly	$539	&	Over	$431	$538	$324	$430	$398	$286	$216	$323	$215	&	under
2	Annual	$37,826	&	Over	$30,261	$37,825	$22,696	$30,260	$27,991	$20,123	$15,131	$22,695	$15,130	&	under
	Monthly	$3,154	&	Over	$2,523	$3,153	$1,893	$2,522	$2,333	$1,677	$1,262	$1,892	$1,261	&	under
	Weekly	$729	&	Over	$583	$728	$438	$582	$539	$387	$292	$437	$291	&	under
3	Annual	$47,726	&	Over	$38,181	$47,725	$28,636	$38,180	$35,317	$25,390	$19,091	$28,635	$19,090	&	under
	Monthly	$3,979	&	Over	$3,183	$3,978	$2,388	$3,182	$2,944	$2,116	$1,592	$2,387	$1,591	&	under
	Weekly	$919	&	Over	$736	$918	$552	$735	$680	$489	$369	$551	$368	&	under
4	Annual	$57,626	&	Over	$46,101	$57,625	$34,576	$46,100	$42,643	$30,657	$23,051	$34,575	$23,050	&	under
	Monthly	$4,804	&	Over	$3,843	$4,803	$2,883	$3,842	$3,554	$2,555	$1,922	$2,882	$1,921	&	under
	Weekly	$1,110	&	Over	$888	$1,109	$666	$887	$821	$590	$445	$665	$444	&	under
5	Annual	$67,526	&	Over	$54,021	$67,525	$40,516	$54,020	$49,969	$35,923	$27,011	$40,515	$27,010	&	under
	Monthly	$5,629	&	Over	$4,503	$5,628	$3,378	$4,502	$4,165	$2,994	$2,252	$3,377	$2,251	&	under
	Weekly	$1,300	&	Over	$1,040	$1,299	$781	$1,039	$961	$691	$521	$780	$520	&	under
6	Annual	$77,426	&	Over	$61,941	$77,425	$46,456	$61,940	$57,295	$41,190	$30,971	$46,455	$30,970	&	under
	Monthly	$6,454	&	Over	$5,163	$6,453	$3,873	$5,162	$4,775	$3,433	$2,582	$3,872	$2,581	&	under
	Weekly	$1,490	&	Over	$1,193	$1,489	$895	$1,192	$1,102	$793	$597	$894	$596	&	under
7	Annual	$87,326	&	Over	$69,861	$87,325	$52,396	$69,860	$64,621	$46,457	$34,931	$52,395	$34,930	&	under
	Monthly	$7,279	&	Over	$5,823	$7,278	$4,368	$5,822	$5,386	$3,872	$2,912	$4,367	$2,911	&	under
	Weekly	$1,681	&	Over	$1,345	$1,680	$1,009	$1,344	$1,243	$894	$673	$1,008	$672	&	under
8	Annual	$97,226	&	Over	$77,781	$97,225	$58,336	$77,780	$71,947	$51,724	$38,891	$58,335	$38,890	&	under
	Monthly	$8,104	&	Over	$6,483	$8,103	$4,863	$6,482	$5,996	$4,311	$3,242	$4,862	$3,241	&	under
	Weekly	$1,871	&	Over	$1,497	$1,870	$1,123	$1,496	$1,384	$995	$749	$1,122	$748	&	under
Each add'l member add	Annual	$9,901	&	Over	$7,921	$9,900	$5,941	$7,920	$7,326	$5,267	$3,961	$5,940	$3,960	&	under
	Monthly	$826	&	Over	$661	$825	$496	$660	$611	$439	$331	$495	$330	&	under
	Weekly	$192	&	Over	$154	$191	$116	$153	$141	$102	$78	$115	$77	&	under

Based on DHHS Poverty Guidelines
- Effective April 30, 2012

The Poverty Income Schedule is updated annually.

INCOME ASSESSMENTS

Question: Is a new Income Assessment completed each time a patient changes from one program to another?

Answer: Yes. Dependent on program requirements.

CHAPTER 3

FEE SCHEDULES

Revised August 2013

FEE SCHEDULES

The schedule of proposed fees and detailed description of service codes provide standardization of fees throughout the state.

- All county health departments charge fees for Family Planning Services on a sliding scale using the fee schedule in Chapter 4.

- Counties authorized to issue Health Statistics charge fees based on the Center for Health Statistics in Chapter 6.

- All other fees are charged according to each local fee bill approved by the County Commission or County Board of Health and must be on file in the County Health Department. Fee amounts are provided by your county health officer or administrator.

SLIDING SCALE FEE

All fees charged on a sliding scale have been indicated on the Schedule of Proposed Clinic Fees. To find the amount to charge for a service, follow the service line across the page to the pay class indicated from the Income Assessment. This will provide the dollar amount to charge.
Fees fall into four categories and are broken down by description, service, charging procedure, and amount of charge in the following chapters:

Clinical Services - Chapter 4

Environmental Services - Chapter 5

Health Statistics Services - Chapter 6

Schedule of Clinic Fees

The automated Day Sheet system will round the cents to the nearest dollar. This calculation should be done in the same manner if issuing manual receipts.

Service Code	Service Description	Percentage of Fee Charge				
		100%	75%	50%	25%	0%
100IN	Family Planning (FP) Initial – No method	$160	120	80	40	0
100Ia	FP Initial w/1 monthly pack of OCs. To add more monthly cycles see “Visit Charging Guide”, this chp.	$165	124	83	41	0
100Ib	FP Initial w/Injection (Depo)	$180	135	90	44	0
100Ic	FP Initial w/1 monthly cycle of Patches. To add more monthly cycles see “Visit Charging Guide”, this chp.	$173	130	87	43	0
100Id	FP Initial w/ 1 monthly cycle of Vaginal Rings. To add more monthly cycles see “Visit Charging Guide”, this chp.	$175	132	88	44	0
100Ie	FP Initial w/Diaphragm w/jelly	$188	141	94	47	0
100If	FP Initial w/Paragard IUD	$385	289	193	96	0
100Ig	FP Initial w/Mirena IUD	$480	360	240	120	0
100Ih	FP Initial w/Implant	$485	364	243	121	0
101AN	FP Annual or Extended Counseling Postpartum Visit – No method	$137	103	69	34	0
101Aa	FP Annual/Ext PP Visit w/1 monthly pack of OCs. To add more monthly cycles see “Visit Charging Guide”, this chp.	$142	107	71	36	0
101Ab	FP Annual/Ext PP Visit w/Injection (Depo)	$157	118	79	39	0
101Ac	FP Annual/Ext PP Visit w/1 monthly cycle of Patches. To add more monthly cycles see “Visit Charging Guide”, this chp.	$150	113	75	38	0
101Ad	FP Annual/Ext PP Visit w/1 monthly cycle of Vaginal Rings. To add more monthly cycles see “Visit Charging Guide”, this chp.	$152	114	76	38	0
101Ae	FP Annual/Ext PP Visit w/Diaphragm w/jelly	$165	124	83	41	0
101Af	FP Annual/Ext PP Visit w/Paragard IUD	$362	272	181	91	0
101Ag	FP Annual/Ext PP Visit w/Mirena IUD	$457	343	229	114	0
101Ah	FP Annual/Ext PP Visit w/Implant	$462	347	231	116	0
102R	FP Periodic Revisit/Deferred PE Visit – No method	$80	60	40	20	0
102Ra	FP Periodic Revisit/Deferred PE Visit w/1 monthly cycle of OCs. To add more monthly cycles see “Visit Charging Guide”, this chp.	$85	64	43	21	0
102Rb	FP Periodic Revisit/Deferred PE Visit w/Injection	$100	75	50	25	0
102Rc	FP Periodic Revisit/Deferred PE Visit w/1 monthly cycle of Patches. To add more monthly cycles see “Visit Charging Guide”, this chp.	$93	70	47	23	0
102Rd	FP Periodic Revisit/Deferred PE Visit w/1 monthly cycle of Vaginal Rings. To add more monthly cycles see “Visit Charging Guide”, this chp.	$95	72	48	24	0
102Re	FP Periodic Revisit/Deferred PE Visit w/Diaphragm w/jelly	$108	81	54	27	0
102Rf	FP Periodic Revisit/Deferred PE Visit w/Paragard IUD	$305	229	153	76	0

Schedule of Clinic Fees

The automated Day Sheet system will round the cents to the nearest dollar. This calculation should be done in the same manner if issuing manual receipts.

Service Code	Service Description	100%	75%	50%	25%	0%
102Rg	FP Periodic Revisit/Deferred PE Visit w/Mirena IUD	$400	300	200	100	0
102Rh	FP Periodic Revisit/Deferred PE Visit w/Implant	$405	304	203	101	0
104	FP GYN Problem/Lab/Counseling Visit	$92	69	46	23	0
105	BP recheck/Repeat Pap smear: • BP recheck visit(s) to rule out hypertension • Repeat Pap smear due to technical problems (i.e., unsatisfactory or No ECC result; specimen lost or broken)	$0	0	0	0	0
106I	Paragard IUD (when inserted by contracted provider; includes device and insertion fee)	$300	225	150	75	0
106J	Mirena IUD (when inserted by contracted provider; includes device and insertion fee)	$395	296	198	99	0
106L	Female Sterilization	$1000	750	500	250	0
106M	Male Sterilization	$300	225	150	75	0
106O	Implant/IUD Removal Fee – Performed by trained HD staff; or contracted provider. Requires a separate receipt when provided with other service codes on the same date of service, or after verification that procedure was performed by contracted provider.	$75	56	38	19	0
106Sa	FP Pills - Monthly	$5	4	3	1	0
106Sb	FP Patches – Monthly	$13	10	7	3	0
106Sc	FP Vaginal Rings – Monthly	$15	11	8	4	0
106Se	FP Diaphragm	$28	21	14	7	0
106Sh	FP Implant	$325	244	163	81	0
107	FP Pregnancy Test Only Service (regardless of result)	$34	26	17	9	0
If a FP client has been referred to a contracted provider for one of the contraceptive methods highlighted in gray, utilizing approved Title X funds, the client is to be charged and billed as appropriate upon completion of the procedure. The clinic is to follow-up to confirm that the procedure was performed and document this in the patient's medical record. In the interim pending the procedure, the client is to be charged for all other services/methods provided.						
112	Maternity – Postpartum Visit	$108	81	54	27	0
114	Cancer Detection – Initial/Annual	$83	62	41	20	0
116	Cancer Detection – Revisit	$33	25	16	8	0
118	Child Health – Initial/Periodic Revisits	$163	122	82	40	0
120	Child Health – Interperiodic Visits	$163	122	82	40	0
122	Child Health – Single Service Visit	$20	15	10	5	0
144	Immunizations	$15 sliding scale fee				
146	Immunization – Influenza or Pneumoccal	Flat Fee $5				
156	Immunization – Travel or Other Immunization	Flat Fee $15				
158	Injection Only – Patient Supplies Dosage	$5	4	3	1	0
166	Duplicate Immunization Record	Flat Fee $2				
168	Copies of Medical or Dental Records	Flat Fee $2				

CHAPTER 4

Clinical Services

Revised August 2013

Introduction

Charges for clinical services are allowed either by federal grant requirements or by local legislation. Some programs, like the Family Planning program, have services offered in all counties and fees charged in all counties, as described later, based on federal grant requirements.

Services under the Maternity and Child Health programs are also offered in all counties but are not as widely used. Charges for these program services are authorized only in counties with local authority and approval.

NOTE: Fees are set by the state level except for Mobile and Jefferson Counties which are required to utilize a sliding scale but use their own rates. Maternity and Child Health programs can only be charged in those counties where local authority exists.

Certification

All employees who process clinical fees must be certified to handle cash.

Cash certification procedures are detailed in Chapter 8, County Depository Account.

FAMILY PLANNING

I. **PROGRAM PHILOSOPHY** - All family planning clients must be given the opportunity to make two fundamental choices: the choice of participation and the choice of contraceptive method.

II. **PROGRAM REQUIREMENTS**

The following guidelines are designed to comply with the federal Title X regulations which require a sliding scale fee assessment based on the client's self declared income and family size. All clients are to be income assessed as described in this manual and informed that services will not be denied based on inability to pay.

The fees described in this section are applicable to the Family Planning Program and are set at the state level only based on a cost analysis which reflects the reasonable cost of providing services. The county cannot change the Family Planning service descriptions or amounts when providing these services.

The following are program mandates:

A. Provide services without regard to religion, race, color, national origin, creed, disability, or gender, number of pregnancies, marital status, age, contraceptive preference, or inability to pay.

B. Target services to low-income individuals with priority in the provision of services are given to persons from low-income families.

C. Provide services without subjecting individuals to any coercion to accept services or employ or not to employ any particular methods of family planning. Services must be provided solely on a voluntary basis and not be made a prerequisite or eligibility for, or receipt of, any other services, assistance from or participation in any other program of the applicant. Project personnel must be informed that they may be subject to prosecution under Federal law if they coerce or endeavor to coerce any person to undergo an abortion or sterilization procedure.

D. Provide services in a manner which protects the dignity of the individual.

E. Assure client confidentiality and provide safeguards of individuals against the invasion of personal privacy as required by the Privacy Act. If requested, the client has the option of not being contacted at home by phone or mail for billing purposes.

F. No charge for services provided to any persons from a low-income family except to the extent that payment will be made by a third party authorized to or under legal obligation to pay this charge.

G. Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay. This is designed to recover reasonable cost of providing services.

FAMILY PLANNING - continued

III. **INCOME DETERMINATION** – Income determination is based on family size and household income. Determination of income is by self-declaration and is documented as annualized income.

IV. **INTAKE PROCESS**

A. Inform all clients of the financial assessment process including the sliding fee scale. Indicate that the clinic charges fees, but discounts are available based on the income and family size of each client. The clinic receives money from State and Federal sources which must be used to support all aspects of the clinic and fees collected allow clinics to continue to provide services.

B. Complete an income assessment based on client's self-declared income and family size as outlined in this manual.

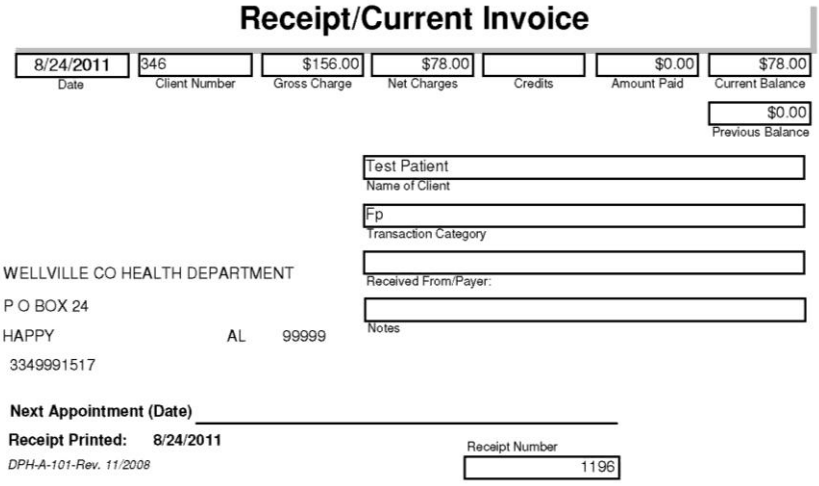
C. If client is eligible for Medicaid, initiate the application process or verify Medicaid status. For additional information, see section below for Charging Fees.

D. If non-Medicaid client, inform him/her of the pay category. Services will be provided regardless of inability to pay.

E. The charging of applicable services should ideally be done following completion of service(s); however, counties should set up the system that works best for their setting. For example, a county can opt to charge established clients for a supply visit at the beginning, however, new clients who have not chosen a birth control method may be charged at the end of the visit.

F. Inform the client of the applicable charges incurred today and ask how much she/he can pay on the bill. Enter the service on the day sheet for all non-Medicaid clients.

G. Print the receipt/invoice and review with client (see sample below). For those with a remaining balance, the clerk can provide the client with a self-addressed envelope to send back with a payment at a later date.



Receipt/Current Invoice

Date	Client Number	Gross Charge	Net Charges	Credits	Amount Paid	Current Balance
8/24/2011	346	$156.00	$78.00		$0.00	$78.00

Previous Balance: $0.00

Name of Client: Test Patient

Transaction Category: Fp

Received From/Payer:

Notes:

WELLVILLE CO HEALTH DEPARTMENT
P O BOX 24
HAPPY AL 99999
3349991517

Next Appointment (Date) _____

Receipt Printed: 8/24/2011

DPH-A-101-Rev. 11/2008

Receipt Number: 1196

FAMILY PLANNING - continued

V. **CHARGING FEES**

A. All non-Medicaid family planning clients will be assessed a fee depending on their family size, declared income, and type of visit, or service.

B. Fees are determined by the ADPH by performing a cost analysis of the services provided statewide. Fees are assessed locally by applying the schedule of discounts to the total charges based on the client's Federal Poverty Level.

C. If a client comes in for one type of visit and it is determined that another type of visit is needed at the same time, (e.g. in for GYN problem and it is determined that emergency contraception is indicated), the client should be billed for only one (1) visit, as well as any other billable services that were provided.

D. Should a client be deemed ineligible for Medicaid (example, over the income criteria), the fee for this service should be charged to the client.

If the client appears eligible for Medicaid, and the application process has been initiated, do not charge the client for services provided on that date of service. If client is denied Medicaid coverage, county is to charge fees appropriately, including all visits/services provided since the application was taken. These visits/services are to be recorded on the E-Day Sheet and the client billed as appropriate.

If the application remains pending after 45 days, the Health Department is to check with the Medicaid out stationed worker on the status prior to sending a bill. The patient is not to be charged or billed until the Medicaid status is confirmed as approved or denied. (See VII Billing/Collection Section of this chapter).

E. Clients whose income falls at or below 100% of the federal poverty level will fall into a zero % pay category. All non-Medicaid clients will have services recorded on the Electronic Day Sheet, **including those in the zero % pay category**. The transaction will generate an invoice/receipt for the client which will show the gross charge, net charge, amount paid and current balance. All clients are to be given this statement.

F. Clients who indicate they do not know their income, or decline or refuse to declare their earnings are to be shown the current income schedule/poverty guidelines and are to be asked to point to the amount that best describes their family income so that they can self declare. Clients should be informed of this process at the time of the call for appointment. At the time of the visit, the clerk is to explain that we are not a free clinic and that the purpose of the sliding fee scale is to determine the discount eligibility for the client. In addition, these fees are used to maintain the clinic, pay our staff, and enable the health department to provide services to the clients who need it. Clients may also be informed that no proof of income is required in the Family Planning Program.

FAMILY PLANNING - continued

If after assisting the client through this process, and he/she still refuses to declare an income, inform them that they will be charged the full pay fee (100% fee category), thus waiving the sliding scale assessment, but they will not be denied services if he/she will not pay. The clerk is to indicate the circumstances on the Income Assessment such as "Client refused to disclose income to determine sliding scale discount" or "Client waived sliding scale assessment" or similar language.

G. Fees charged to any client for services must be in accordance with the ADPH approved Fee Schedule.

H. No client will be refused service or be subjected to any variation in quality of services based on inability to pay.

I. Clients who return to the clinic for lost, misplaced or otherwise missing contraceptive packets of pills, patches or rings will be charged as specified on the Family Planning Fee Schedule.

J. The County Health Department or Area/Clinic supervisory staff may waive the fee for an individual "for good cause."

a. Definition of "Good Cause" - Fees may on occasion need to be waived due to unusual circumstances for clients who would be required to pay for services and/or supplies, based on their income and family size. However, these clients are unable to pay based on a temporary or one-time catastrophic financial event. The county health department Administrator or Area/Clinic supervisory staff may waive fees for services and/or supplies when the patient's circumstances indicate "Good Cause". Examples of "Good Cause" are described below. This is self declared information. Proof of cause is not required (example: hospital bill):

i. *Recent layoff from employment
ii. *Recent Funeral Costs of immediate family member (**)
iii. *Recent Medical/Hospital Costs
iv. Extraordinary ongoing monthly prescription costs
v. Recent Bankruptcy
vi. Recent Natural Disaster Loss (uncompensated costs for fire, flood, tornado, etc.)

*Recent is defined as no more than six months from the date of the event.

** Immediate family for this purpose includes spouse, children, parents, step parents, parent-in-law, grandchildren, grandparents, brothers, sisters, and stepchildren.

FAMILY PLANNING - continued

K. Sample Scripts for collecting fees:

Fee Collection #1

Entry Letter

Dear Family Planning Client:

We are pleased you have chosen our clinic for your family planning services. We assure you we will do our best to provide you with quality services to meet your reproductive health needs.

Like all human service agencies, our agency is facing some difficult financial times. Escalating operating costs and recent reductions in government funding sometimes make it difficult for agencies like ours. In order to maintain this clinic and continue to provide you with quality health care, we need your help. We will be depending on you, to a greater extent, to pay for your services here.

We use a sliding fee scale to determine your fee. The amount you pay depends on your income and the number of people supported by it. By using a sliding fee scale, you are able to receive services at a rate much lower than at other health care facilities. Please be assured, no one will be turned away because of an inability to pay for services. We realize hard times affect everyone and our fee system makes it possible for people of all income brackets to afford our services.

A Family Planning staff person will be talking with you about our fee structure. If you have Medicaid or private health insurance, be sure to discuss this with our staff person. We will be happy to answer any questions you may have about our services and fees.

Any financial help you can offer is greatly appreciated. If everyone pays their fair share, then we can continue to provide good, low cost health care services. Also, any amount you can donate is both needed and appreciated.

Thank you for supporting Family Planning.

Sincerely,
Family Planning Staff

FAMILY PLANNING – continued

Fee Collection #2

Welcome script to set the stage.

Our agency commitment is to provide quality services at reasonable prices. Despite the current economy and continuing financial setbacks to the family planning program, we intend to continue that commitment.

More than ever we are depending on the support we receive through fees for services, insurance payments (including Medicaid), and donations to continue to offer our excellent clinic care, medical supplies and counseling at the lowest possible costs.

Please understand that we are NOT a free clinic. We are a CONFIDENTIAL, non-profit agency. We use the money we receive for many things: to maintain our facility, to help educate others, to pay our staff, and to provide our services to everyone who needs them.

Today, someone will talk with you about your ability to contribute to these services. A fee will be established based on your financial situation and you will be asked to pay toward your services here.

If you have Medicaid or private insurance, please let us know. Donations are always welcome from patients, partners, parents or friends.

Thank you for understanding our position and for helping insure the excellent services we provide continue to be available to you and others in our community.

Fee Collection #3

Financial Impact Script

We would like to share some information with you regarding our financial situation. Recent budget cutbacks at the State and Federal levels suggest some severe financial cutbacks for family planning clinics across America. Whether you've been to our clinic before or are a new patient, we would like you to understand some financial aspects of our clinic.

As much as we would like to be, we are NOT a free clinic. We are a confidential, non-profit agency. We rely on patient fees, insurance payments, including Medicaid, and donations. The program does need money for many things: to maintain our facility, to help educate others, to pay for our staff and medical supplies, and to provide our services to everyone who needs them.

Now more than ever we are depending on support from you, our loyal patients. We must have your help to continue to offer excellent clinic care and medical supplies at the lowest possible costs.

Today someone will talk with you about payment based on your own financial situation. You will be asked to pay something toward your services. Anyone on our staff will be happy to discuss any questions or concerns you may have about this.

VI. DONATIONS

Voluntary donations from clients are permissible. Clients must not be pressured to make donations, and donations must not be a prerequisite for the provision of services and supplies. Donations from clients do not waive the billing/charging requirements specified above. Donation amounts should not be suggested. It is acceptable to display notice regarding acceptance of donations.

FAMILY PLANNING - continued

Sample scripts for requesting donations:

Donations #1
There are no charges for your services today because it is based on your family size and income; however, we do accept donations. These donations are used to offset the expenses used to provide services to our clients. Would you be interested in providing a donation today?"

Donations #2
Ms. _____ the services you received today cost $_____. But because of where you fall on the sliding fee scale, there will be no charge. However, we do accept donations if you would like to give one today.

Donations #3
Today you had an <annual> exam today, we did some lab work, and you received <4 packs> of <pills>, Ms._____. The services you received today would have cost $_____. But because of where you fall on the sliding fee scale your cost is $_____. I will give you a receipt. Please be aware that we also accept donations if you would like to give one in addition to your payment.

VII. BILLING/COLLECTING

A. The following information should be given to the client at the time the appointment is scheduled:
- A fee may be charged for services and supplies.
- Any fee will be based on income and family size.
- Payment is due at the time of the service, however, services will not be denied based on inability to pay.
- A fee may not be charged if client appears eligible for Medicaid and applies at the time of the visit (pending enrollment). If deemed ineligible, client will be charged appropriately from the time of the application as described in section V. Charging Fees, D.
- Clients deemed ineligible for billing based on confidentiality purposes, will not have mailings sent to their home.
- A donation will be accepted.

B. At the time of services, each client must be given an invoice containing the following information:
1. Name of Client
2. Date of service
3. Gross charges
4. Net charges
5. Amount paid this date
6. Current balance

C. Clients unable to pay in full at the time of service should be asked to make a partial payment.

D. Clients should be mailed an invoice for the unpaid balance of their bill. Clients who have requested confidential services must not be mailed an invoice or be contacted by phone unless alternative address/contact # has been established.

FAMILY PLANNING – continued

VIII. **THIRD PARTY BILLING**

A. Clerk must establish that billing third party insurance is not a breach of confidentiality for the client and if statements or bills can be received through mailings.

B. Private insurance providers will be attempted to be billed on eligible non-confidential clients. See "FP Billing Private Insurance Users Guide", later in this chapter for further details.

D. Provide patients whose encounters are being filed for public (Medicaid) or private insurance with a Family Planning Services Receipt (ADPH-FHS-645).

Alabama Department of Public Health
Family Planning Program

PHALCON LABEL

We will file your public/private insurance for the services provided below at the agreed upon rates with those entities. Services not covered by Medicaid or insurance may be billed to you as indicated below. If you are billed, the charges may be lower based on your family size and income. Services will not be denied because of inability to pay.

VISITS:	CONTRACEPTIVES:	SERVICES:
☐ Initial Visit ($XXX)	☐ OCs ($XX each x ____)	☐ Implant/ IUD removal ($XX)
☐ Annual visit or Extended Counseling Postpartum Visit ($XXX)	☐ Injection ($XX)	☐ Other _____
☐ Periodic Revisit or Deferred Physical Exam visit ($XX)	☐ Patch ($XX each x ____)	_____
☐ GYN Problem/Lab/Counseling visit ($XX)	☐ Vaginal Ring ($XX each x ____)	_____
☐ Pregnancy Test Only Visit ($XX)	☐ Diaphragm/Jelly ($XX)	_____
	☐ Paragard IUD ($XXX)	_____
	☐ Mirena IUD ($XXX)	_____
	☐ Implant ($XXX)	

Thank you for obtaining services from us today. We look forward to seeing you again soon.

This Is Not A Bill

ADPH-FHS-645

Instructions include:

Purpose

To provide the non-self pay Family Planning recipients with a receipt detailing the cost of the visit on that date of service (includes those with private insurance or public insurance such as Medicaid). The Health Department will file all appropriate third party claims on behalf of the recipient. If the claim is denied, the recipient will be charged for the services based on family size and income.

NOTE: Self pay or fee paying recipients will be entered into the electronic Day Sheet and printed a receipt from that system.

FAMILY PLANNING – continued

Procedure

1. Place a PHALCON label here.

2. Indicate which Family Planning visit type the patient received and contraceptive method as appropriate. For methods such as OCs (including ECPs), patch and vaginal rings, indicate the number of monthly packs/cycles issued on that specific date of service.

3. The receipt should be marked by the nurse or Nurse Practitioner after services have been received. The recipient may be provided the receipt by the nursing or clerical staff based on county discretion. It is not required to retain a copy in the patient's record.

IX. AGING ACCOUNTS/ WRITE-OFF POLICIES

A. All service sites will implement a method for aging of outstanding account receivables.

B. Service site accounts should be aged quarterly and aged as of the report run date. This allows the program to attempt collections from current customers while providing a mechanism to write-off accounts that are dormant or uncollectible.

C. Quarterly run the current balance (as of date run) and how old as of date run (for example, set to run automatically October 5, January 5, April 5 and July 5). Based on the totals and confidentiality, do the following (using calendar days):

If 0-30 days old, do nothing

If 31-60 days old, send a bill (county)

If 61-90 days old, send a bill (county)

If 91-120 days old, send a bill (county)

If 121 days or greater, write off

D. Any payments received should go against any outstanding balance. A "Receipt/Current Invoice" should be created as payment on account and provided/mailed to non-confidential clients.

E. If a client returns to the clinic after the account balance has been written off, the previous balance will be zero.

X. CHANGE FUNDS

Each service site will maintain a change fund to facilitate clients wishing to make payments by cash.

FAMILY PLANNING – continued

XI. RECORDS AND FORMS

Privacy Statement:

- Clients seen in service sites must be provided with a copy of the Alabama State Department of Health Privacy Statement.
- Contract agencies must develop and provide privacy statements in accordance with federal and state guidelines.

XII. MEDICAL RECORDS and CLIENT CONFIDENTIALITY

A. Family planning client records are confidential as required by medical ethics and by federal and state statutes. It is the responsibility of each service site and contract agency employee to maintain complete and total confidentiality of any and all client information collected, filed or stored by the service site or contract agency.

B. Contract agencies must develop and implement medical records policies and procedures to include obtaining authorization to release confidential information to agencies or other parties. These policies and procedures must be in compliance with federal and state guidelines.

C. Measures to assure client confidentiality include:

- Providing privacy when requesting personal information (demographic profile or equivalent, health history, current problem, etc.)
- Never leave a client in a room with any client record.
- Place client record on desks or in holders so that the name cannot be seen.
- Never call out the client's full name in the waiting area.
- Records should be secured by lock when not in use.
- Mailing information is requested during the initial interview for privacy purposes and documented in PHALCON.
- No information obtained by personnel about individuals receiving services may be disclosed without the specific written consent of the individual and as outlined in ADPH HIPAA Policy.

FAMILY PLANNING – continued

XIII. **SERVICE CODE DESCRIPTIONS**

Following are descriptions of the Family Planning service codes utilized when charging clients. In most cases, a single service code will be utilized; however, there are exceptions when two are needed. Examples: 1) Client received an IUD removal, then a Depo-Provera injection on the same day. In this case, Service Codes 102Rb and 1060 are utilized. This would result in the issuance of two receipts on the same day. 2) Client receives Depo injection on the date of service when she signed consent for a sterilization procedure and received referral. She is to be charged for the visit and Depo injection in the usual manner, then subsequently charged/billed for the sterilization procedure upon completion, resulting in two receipts on different dates of service. In this case, Service Codes 102Rb and 106L are utilized.

A. SERVICE CODE 100IN – INITIAL VISIT: NO METHOD FEE.

An in-depth evaluation of a new client requiring the establishment of medical records, comprehensive history, complete physical examination, appropriate diagnostic laboratory tests and procedures, family planning counseling using PT+3 teaching methodology and contraceptive method as indicated per protocol.

Fees charged to the client include the visit; there is no separate fee for the method if it includes abstinence, natural/rhythm method, spermicides, condoms, no method issued, or seeking pregnancy. See fee schedule for current visit rate.

B. SERVICE CODE 100I a-h: INITIAL VISIT PLUS METHOD FEE.

An in-depth evaluation of a new client requiring the establishment of medical records, comprehensive history, complete physical examination, appropriate diagnostic laboratory tests and procedures, family planning counseling using PT+3 teaching method and contraceptive method as indicated per protocol.

Fees charged to the client include the visit plus the method utilizing the following service codes:

- 100la. Oral Contraceptives (OCs)
- 100lb. Injection
- 100lc. Patch
- 100ld. Vaginal ring
- 100le. Implant
- 100lf. Mirena IUD
- 100lg. Paragard IUD
- 100lh. Implant

See fee schedule for current visit with method rates.

C. SERVICE CODE 101AN – ANNUAL VISIT; EXTENDED COUNSELING POSTPARTUM VISIT: NO METHOD FEE.

An in-depth evaluation of an established client or postpartum client requiring the establishment or update of medical records, comprehensive history, complete physical examination, appropriate diagnostic laboratory tests and procedures, family planning counseling using PT+3 teaching methodology and contraceptive method as indicated per protocol.

FAMILY PLANNING – continued

Fees charged to the client include the visit; there is no separate fee for the method if it includes abstinence, natural/rhythm method, spermicides, condoms, no method issued, or seeking pregnancy. See fee schedule for current visit rate.

D. SERVICE CODE 101A a-h: ANNUAL VISIT; EXTENDED COUNSELING POSTPARTUM VISIT PLUS METHOD FEE.

An in-depth evaluation of an established client or postpartum client requiring the establishment or update of medical records, comprehensive history, complete physical examination, appropriate diagnostic laboratory tests and procedures, family planning counseling using PT+3 teaching method and contraceptive method as indicated per protocol.

Fees charged to the client include the visit plus the method utilizing the following service codes:

- 101Aa. Oral Contraceptives (OCs)
- 101Ab. Injection
- 101Ac. Patch
- 101Ad. Vaginal ring
- 101Ae. Diaphragm with spermicide jelly
- 101Af. Mirena IUD
- 101Ag. Paragard IUD
- 101Ah. Implant

See fee schedule for current visit with method rates.

E. SERVICE CODE 102R – PERIODIC REVISIT OR DEFERRED PHYSICAL VISIT: NO METHOD FEE.

A brief evaluation of a new or established client with a new or existing family planning condition; reasons include but are not limited to: contraceptive changes, issuance/administration of supplies, follow-up re-check of IUD or Implant placement, or contraceptive problems (e.g. breakthrough bleeding or the need for additional guidance); OR a visit to defer the physical examination and lab work for Initial, Annual or postpartum clients based on program protocol.

Fees charged to the client include the visit; there is no separate fee for the method if it includes abstinence, natural/rhythm method, spermicides, condoms, no method issued, or seeking pregnancy. See fee schedule for current visit rate.

F. SERVICE CODE 102R a-h - PERIODIC REVISIT OR DEFERRED PHYSICAL VISIT: PLUS METHOD FEE.

1. A brief evaluation of a new or established client with a new or existing family planning condition; reasons include but are not limited to: contraceptive changes, issuance/ administration of supplies, or contraceptive problems (e.g. breakthrough bleeding or the need for additional guidance); OR

2. A visit to defer the physical examination and lab work for Initial, Annual or postpartum clients based on program protocol.

Fees charged to the client include the visit plus the method utilizing the following service codes:

- 102Ra. Oral Contraceptives (OCs)
- 102Rb. Injection
- 102Rc. Patch

FAMILY PLANNING – continued

- 102Rd. Vaginal ring
- 102Re. Diaphragm with spermicide jelly.
- 102Rf. Mirena IUD
- 102Rg. Paragard IUD
- 102 Rh - Implant

See fee schedule for current visit with method rates.

G. SERVICE CODE 104 – GYN PROBLEM/LAB/COUNSELING VISIT

Brief visit for services which may include but are not limited to: Assessment of breast problem, repeat lab visit (repeat Pap smear; Hgb, etc.), counseling only visit, etc.

H. SERVICE CODE 105 – BP RECHECK/REPEAT PAP SMEAR DUE TO TECHNICAL REASONS

Brief visit for the following scenarios:
Occasional case where a client has a newly identified elevated blood pressure reading and must return no sooner than 6 hours for a repeat reading to rule out hypertension. This may occur a second time if a tie-breaker BP reading is indicated. NOTE: This visit does not involve those clients who are already diagnosed with hypertension, and receive quarterly BP monitoring prior to issuance of contraceptive.

Repeat Pap smear due to technical problems (i.e., unsatisfactory or No ECC result; specimen lost or broken).
These visits are coded as a "GYN Problem/Lab/Couns" visit in PHALCON.

I. SERVICE CODE 106I - IUD/PARAGARD BY CONTRACT PROVIDER

Includes charges for clients who have been referred to a Title X contracted provider for the insertion of a Paragard IUD. The fee includes the Paragard device and insertion fee. Once it has been confirmed with the provider that the procedure was performed, the client is to be charged/billed utilizing this service code.

J. SERVICE CODE 106J – IUD/MIRENA BY CONTRACT PROVIDER

Includes charges for clients who have been referred to a Title X contracted provider for the insertion of a Mirena IUD. The fee includes the Mirena device and insertion fee. Once it has been confirmed with the provider that the procedure was performed, the client is to be charged/billed utilizing this service code.

K. SERVICE CODE 106L – FEMALE STERILIZATION BY CONTRACT PROVIDER

Includes charges for clients who have been referred to a Title X contracted provider for a female sterilization procedure. The fee includes all procedures utilized to perform the sterilization. Once it has been confirmed with the provider that the procedure was performed, the female client is to be charged/billed utilizing this service code.

FAMILY PLANNING – continued

L. SERVICE CODE 106M – MALE STERILIZATION BY CONTRACT PROVIDER
The service code 106M includes charges for clients who have been referred to a Title X contracted provider for a male sterilization procedure. The fee includes all procedures utilized to perform the sterilization. Once it has been confirmed with the provider that the procedure was performed, the male client is to be charged/billed utilizing this service code.

M. SERVICE CODE 1060 – IMPLANT/IUD REMOVAL FEE
Services include Implant or IUD removal procedures performed onsite by a trained MD or Nurse Practitioner; or via referral to a contracted provider. This code is used in conjunction with other service codes on the same date of service; or after verification that procedure was performed by contracted provider.

N. SERVICE CODE 106Sa – Pills Monthly: Includes charges for monthly cycles (packs) of oral contraceptives or ECPs. Utilize this service code for the non-covered method when the visit is covered by private insurance. See "Visit Charging Guide", later in this chapter, for calculations based on the number of packs issued.

O. SERVICE CODE 106Sb – Patches Monthly: Includes charges for monthly cycles of contraceptive patches. Utilize this service code for the non-covered method when the visit is covered by private insurance. See "Visit Charging Guide", later in this chapter, for calculations based on the number of boxes of patches issued.

P. SERVICE CODE 106Sc – Vaginal Ring Monthly: Includes charges for monthly cycles of vaginal rings. Utilize this service code for the non-covered method when the visit is covered by private insurance. See "Visit Charging Guide", later in this chapter, for calculations based on the number of rings issued.

Q. SERVICE CODE 106Se – Diaphragm: Includes charges for a diaphragm with spermicide jelly issued to patient. Utilize this service code for the non-covered method when the visit is covered by private insurance.

R. SERVICE CODE 106Sh – Implant: Includes charges for an implant administered to the patient. Utilize this service code for the non-covered method when the visit is covered by private insurance.

S. SERVICE CODE 107 – PREGNANCY TEST ONLY SERVICE
Services include a pregnancy test only (regardless of result) with counseling and referral as appropriate. This visit is coded as a "GYN Problem/Lab/Couns" visit in PHALCON.

FAMILY PLANNING – continued

Visit Charging Guide: Percentage of Fee Charge – Category A 100%

Initial Visit with Method: **Monthly cycles**

Service Code	Method	1	2	3	4	5	6	7	8	9	10	11	12	13	14
100la	OCs/ECPs	$165	$170	$175	$180	$185	$190	$198	$200	$205	$210	$215	$220	$225	$230
100lb	Injection	$180													
100lc	Patch	$173	$186	$199	$212	$225	$238								
100ld	Vaginal Ring	$175	$190	$205	$220	$235	$250								
100le	Diaphragm / Jelly	$188													
100lf	Paragard IUD	$385													
100lg	Mirena IUD	$480													
100lh	Implant	$485													

Annual/Extended PP Couns Visit With Method: **Monthly cycles**

Service Code	Method	1	2	3	4	5	6	7	8	9	10	11	12	13	14
101Aa	OCs/ECPs	$142	$147	$152	$157	$162	$167	$172	$177	$182	$187	$192	$197	$202	$207
101Ab	Injection	$157													
101Ac	Patch	$150	$163	$176	$189	$202	$215								
101Ad	Vaginal Ring	$152	$167	$183	$198	$213	$228								
101Ae	Diaphragm/ Jelly	$165													
101Af	Paragard IUD	$362													
101Ag	Mirena IUD	$457													
101Ah	Implant	$462													

FAMILY PLANNING – continued

Visit Charging Guide: Percentage of Fee Charge – Category A 100%

Periodic Revisit/Deferred Physical Visit <u>With</u> Method **Monthly cycles**

Service Code	Method	1	2	3	4	5	6	7	8	9	10	11	12	13	14
102Ra	OCs/ECPs	$85	$90	$95	$100	$105	$110	$115	$120	$125	$130	$135	$140	$145	$150
102Rb	Injection	$100													
102Rc	Patch	$93	$106	$119	$132	$145	$158								
102Rd	Vaginal Ring	$82	$97	$112	$127	$142	$157								
102Re	Diaphragm / Jelly	$108													
102Rf	Paragard IUD	$305													
102Rg	Mirena IUD	$400													
102Rh	Implant	$405													

CHARGING PROCEDURE FOR FAMILY PLANNING: Assess client for Medicaid eligibility, clients not eligible for Medicaid are charged based on their annual income assessment for services and methods as outlined in the Fee Schedule.

Single Method: Pills, Patches, Vaginal rings, Diaphragm **Monthly cycles**

Service Code	Method	1	2	3	4	5	6	7	8	9	10	11	12	13	14
106Sa	OCs/ECPs Single pack/ monthly cycle	$5	$10	$15	$20	$25	$30	$35	$40	$45	$50	$55	$60	$65	$70
106Sb	Patch (monthly cycles)	$13	$26	$35	$52	$65	$78								
106Sc	Vaginal Ring (monthly cycles)	$15	$30	$45	$60	$75	$90								
106Se	Diaphragm	$28													
106Sh	Implant	$325													

FAMILY PLANNING

Question: Do we collect for all initial and annual visits as well as revisits made by Family Planning patients who fall within a pay category on the fee schedule?

Answer: Yes

FAMILY PLANNING

Billing Private Insurance
Users Guide

Family Planning
Billing Private Insurance Users Guide

The following guidelines are to be used when assessing Family Planning clients for the processing of insurance claims. Clients must give approval in order to file a claim requesting payment of eligible medical coverage benefits to be provided to ADPH. Clients who do not want a claim submitted will be responsible for any charges utilizing the established Fee schedule.
Blue Cross/Blue Shield (BCBS) of Alabama is the primary carrier utilized at this time and is detailed when applicable throughout this section.

Why is Third Party Collection Important?
Reductions in state and federal funding; Escalating operating costs; We are not a free clinic – we are a confidential, non-profit entity; It is a requirement of Title X; It is included as a requirement in the Affordable Care Act; The money collected helps pay for the facility, salaries, medical supplies and medications and helps provide services to all clients who need it.

The Mission vs. the Business:
Our mission is providing accessible, affordable family planning services to our clients. The business is about providing services that can be competitive in terms of quality and integration with the rest of the delivery system. Bottom line, we need money to operate.

When scheduling the appointment with client over the phone:
Ask the client if she has private insurance coverage, and if so, would she agree to the Health Department filing claims for her when she comes in for services. Inform her to bring a copy of the insurance card to the appointment.

At the time of the appointment:

1. Perform the intake process in the usual manner to include the collection of the demographic information, income assessment as appropriate and insurance information. The name pulled from PHALCON for billing is from the demographics page therefore, it should be the legal name and more than likely should match the name used by Blue Cross. Keep this in mind when initiating a new CHR record and when updating existing records.

2. Complete the CHR-3, Authorization for Services form (see below). Make sure the client has reviewed the section "Permission to Bill" authorizing the Health Department to release applicable medical information to process a claim.

AUTHORIZATION FOR SERVICES AND BILLING

PHALCON LABEL

FOR ALL SERVICES RENDERED

To Receive Services:
I give permission for myself or the above named child to receive health services as indicated.
I understand that my or the above named child's medical records are strictly confidential. I hereby authorize use of these records in the provision of services by the Alabama Department of Public Health. I understand that these records may be used for statistical audit purposes without using the name of the patient.
I understand that interpretation services are available to me at no cost if I need them.

Permission to Bill:
I authorize the release of any medical information necessary to process a claim and request that payment of eligible medical coverage benefits be provided to the Alabama Department of Public Health. I understand that I am financially responsible to the Department for charges not covered by this agreement; and for any charges that may occur if I do not want a claim submitted to my medical coverage carrier.

For Routine Testing:
I understand that routine testing, including that for HIV (the virus that causes AIDS), is needed to determine what treatment, counseling or referral may be required. I understand that testing is voluntary and I hereby give my consent for testing for myself or the above named child. I may withdraw my consent for testing at any time during this visit by notifying my nurse.

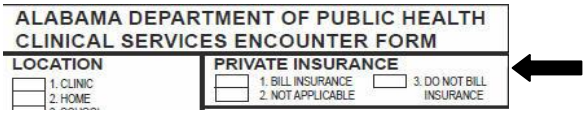
On the ADPH Clinical Services Encounter Form (ADPH-ENC-300), the clerk is to complete the section "Private Insurance" indicating the client's preference regarding the filing of an insurance claim. Valid options include: Bill Insurance, Not Applicable, and Do Not Bill Insurance - This is a required field.

- Bill Insurance - If the client agrees to file a BCBS claim, enter "Bill Insurance" into PHALCON. If this is not marked, the claim will not be submitted for payment. NOTE: If client has Medicaid and BCBS, enter all insurance information and mark "Bill insurance". Finance will process the appropriate claims to each entity.

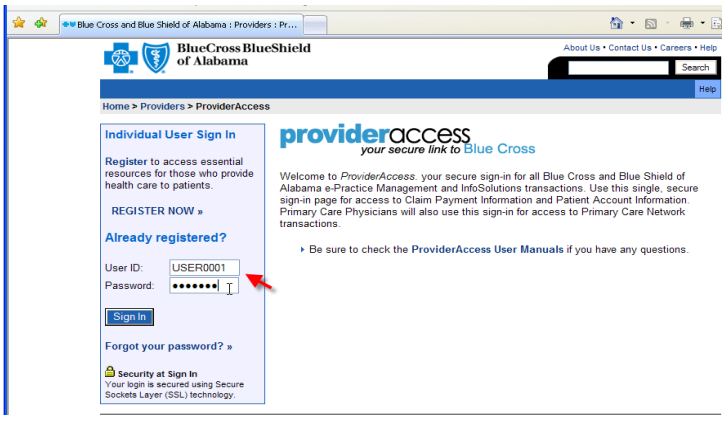
- Do Not Bill Insurance - 

We MUST protect our clients who have requested confidentiality. We do not want any client to receive an insurance claim form (EOP – Explanation of payment) from an insurance carrier in the mail by accident, so make sure they consent to the processing of the claim and the entry is made in PHALCON. If they do not want an EOP to be sent to the home from Blue Cross, we will not file a claim. These encounters will be marked as "Do Not Bill Insurance". The clients, who opt to not have a claim filed, are to be charged fees in the usual manner based on the established FP sliding scale utilizing the E-Day sheet with receipt.

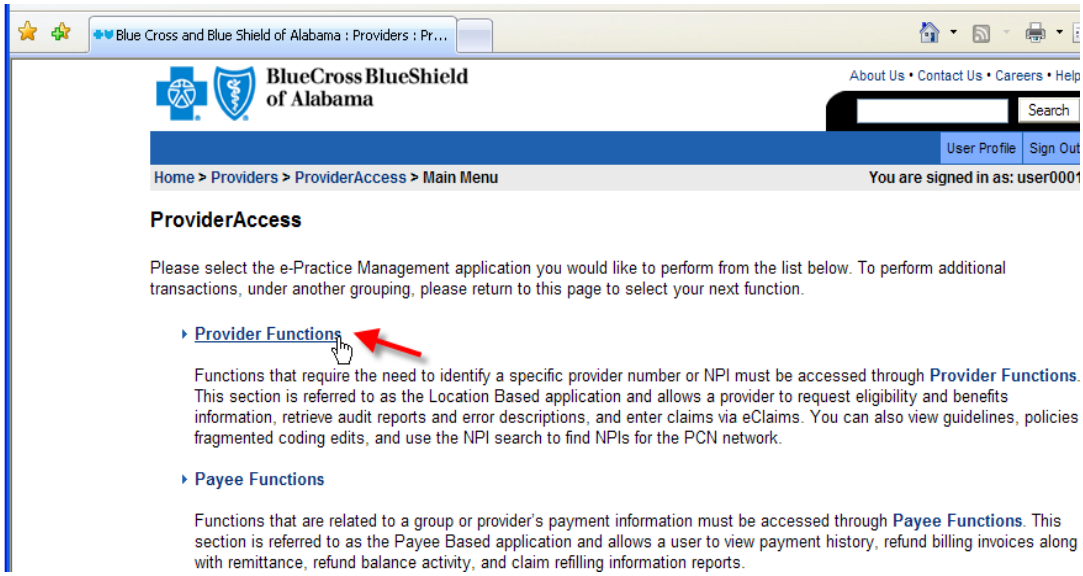
- Not applicable – Indicated if client has no insurance; has private insurance other than BCBS; is only covered by Medicaid; or the visit is not eligible for filing (ex: RN only visit with pills issued as method).



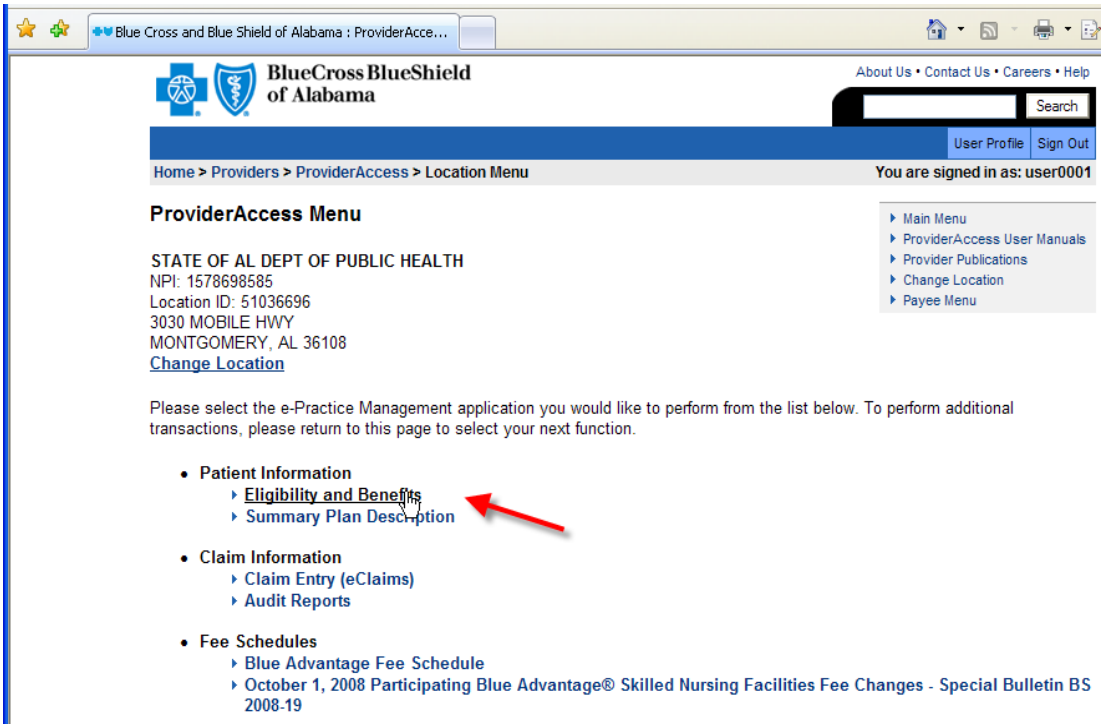
3. Accessing the Blue Cross/Blue Shield Web Portal: https://www.bcbsal.org/providers/index.cfm
Each county is to set up their User IDs and passwords on the BC/BS website for their staff in order to verify Blue Cross coverage. Request this information from your county security coordinator who will provide the user ID and a password to use the first time; then the user will be prompted to change their password.



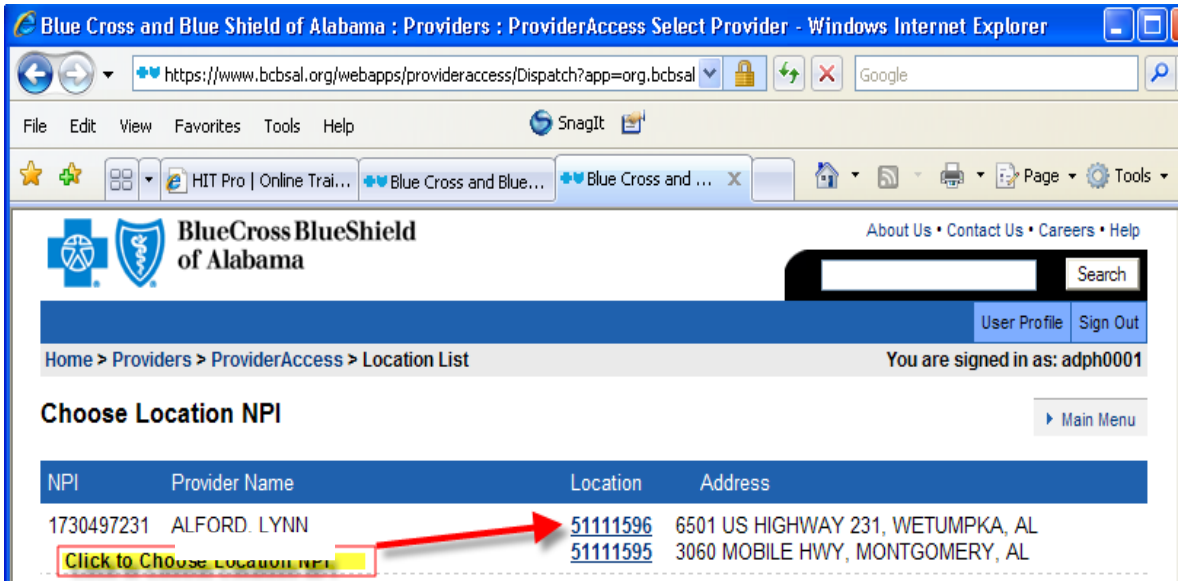
Enter User ID and Password. Press Enter.



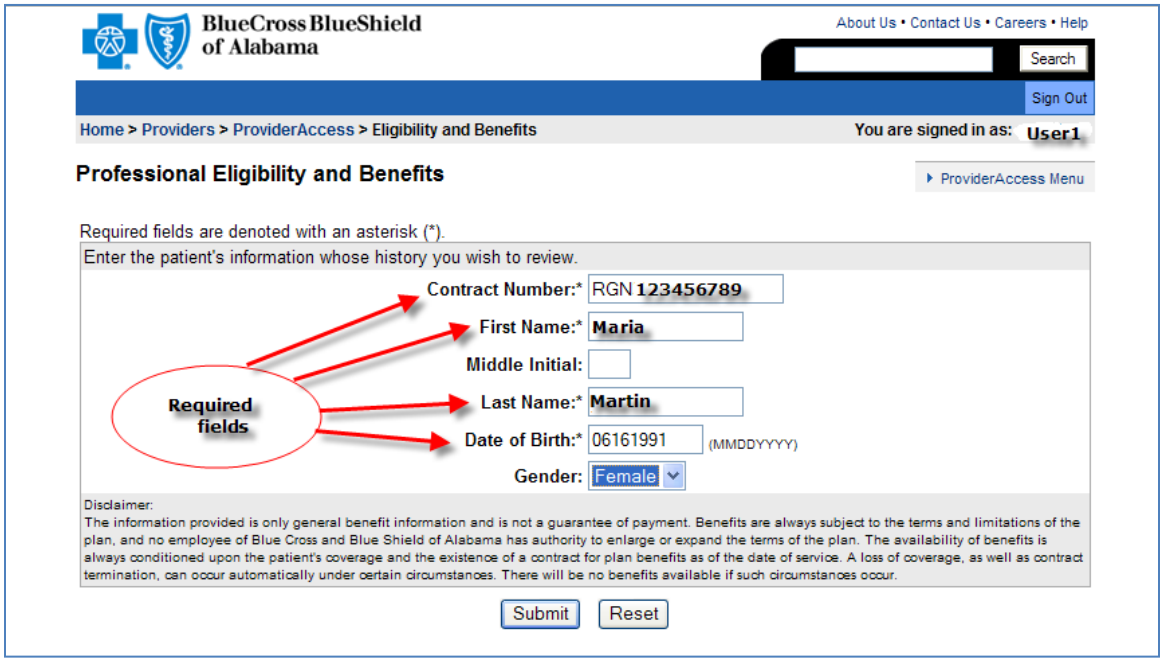
Select "Provider Functions".



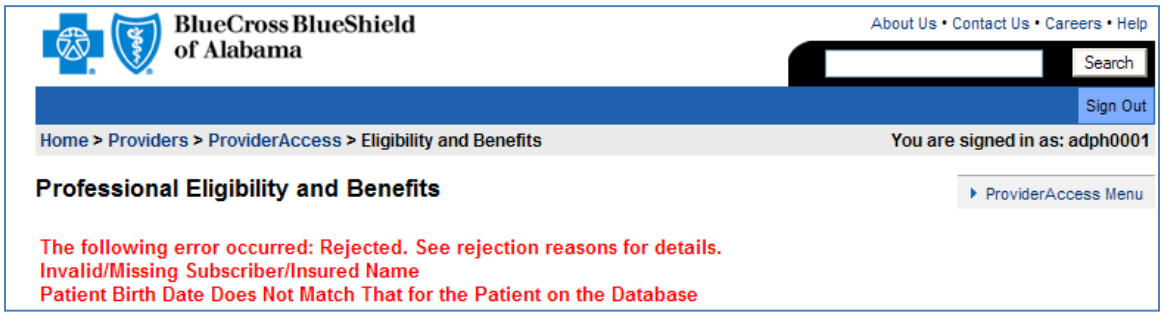
Select "Eligibility and Benefits" Note: Provider Information will display above.



Choose Location NPI. It does not have to be a particular NP to determine a client's benefits.



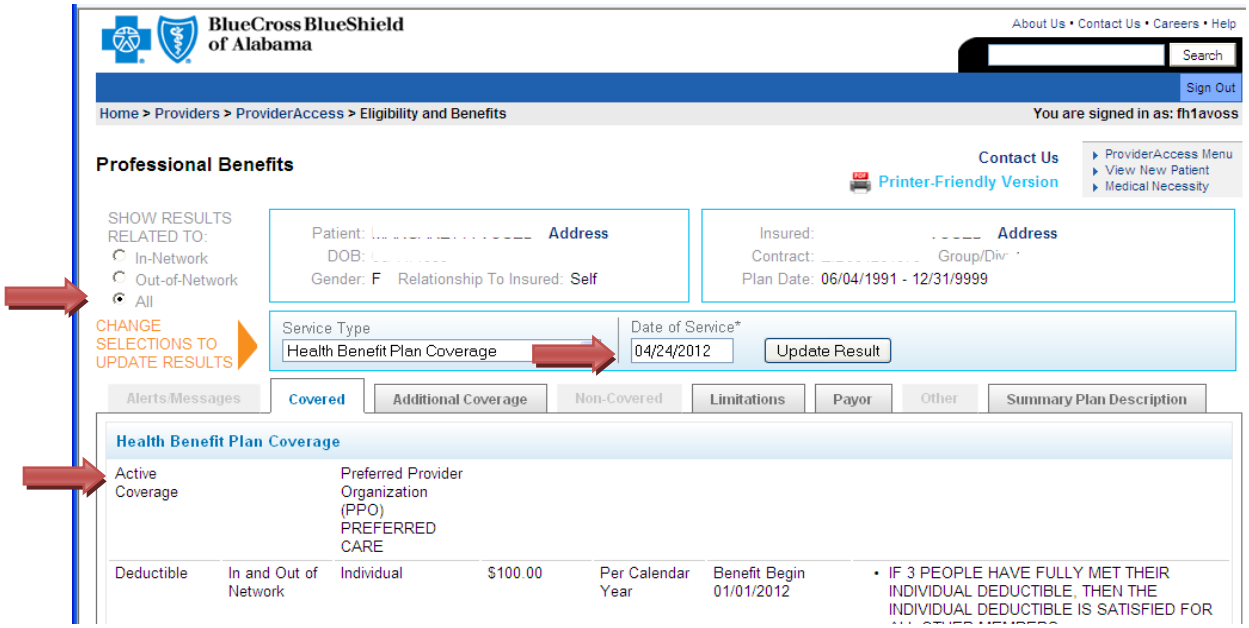
- Enter required fields as indicated above. Remember, this is the client's information, who may not be the policy holder. Enter the legal name as known by Blue Cross.
- Press Submit key for eligibility information.
- Message will appear to "Please wait while we process your request."
- If information needs correcting, you may press "Reset" to clear all the fields and start over.



If Eligibility information is incorrect or unavailable, a message will appear to indicate the reason information was not found. Complete the missing/incorrect information and resubmit.

For example:

- Invalid Missing Insured\Subscriber
- Invalid Date of Birth



Benefits screen:

- Show results related to – Click "All" to search for In-network and Out-of-network coverage if not already defaulted to "All".

- Date of Service – Make sure to utilize the correct date of service.

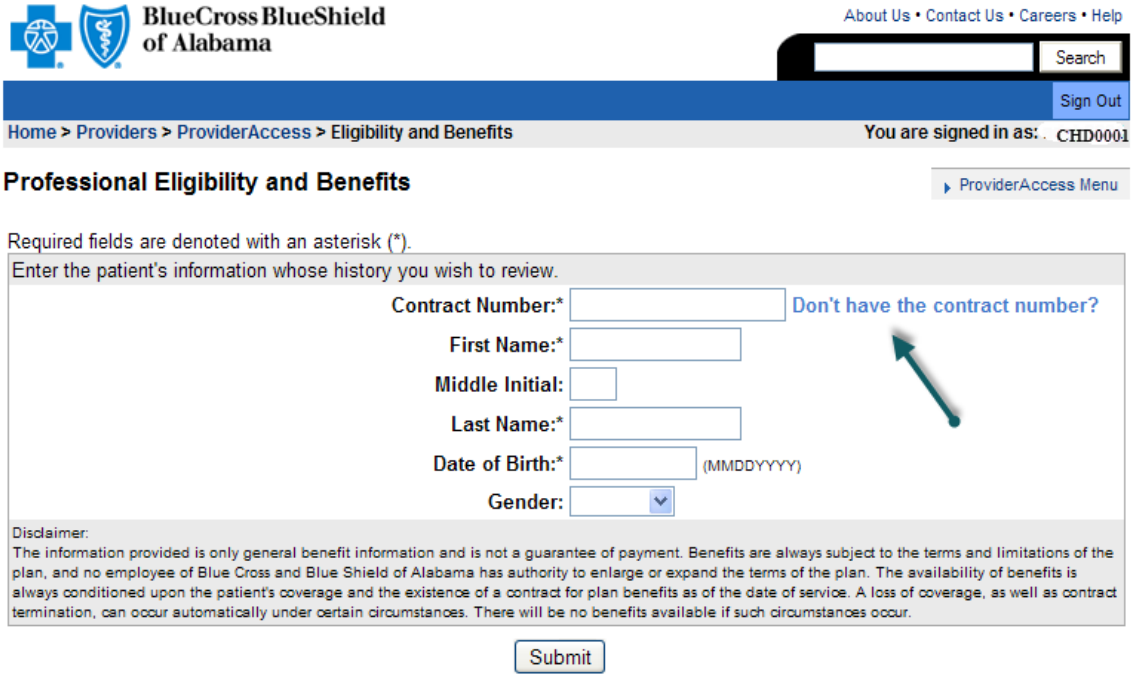
- Health Benefit Plan Coverage – check to see if client is actively covered.

- If verification is made of <u>active</u> insurance coverage, print a copy of the verification screen and put it in the medical record. NOTE: Utilize the Printer Friendly Version button and make sure to indicate "Print current page" or this will print multiple unnecessary pages. You may also choose from the toolbar to select the printer icon. See screen shot below.

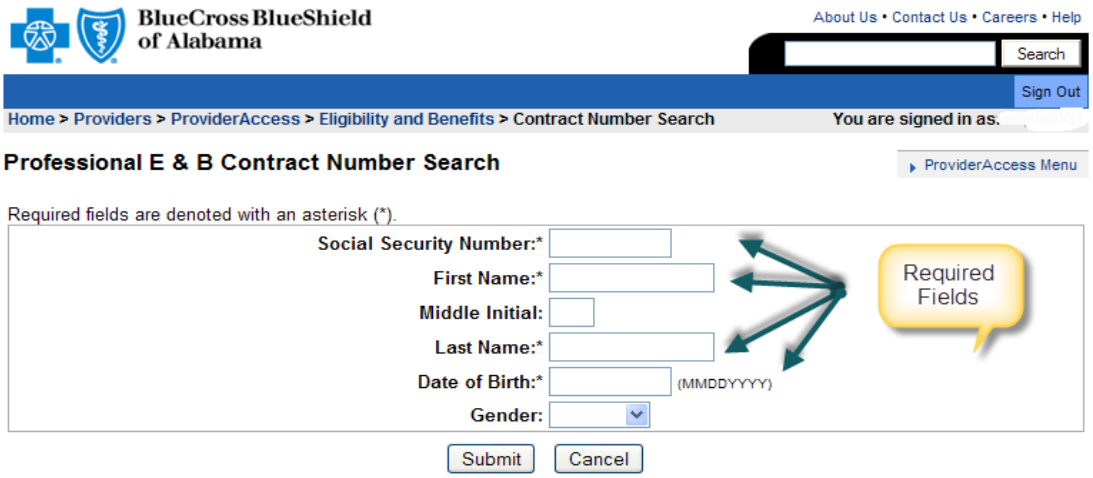
Select Printer Friendly Version

- On the left of the screen you may select "View New Patient" to search for another eligible client.

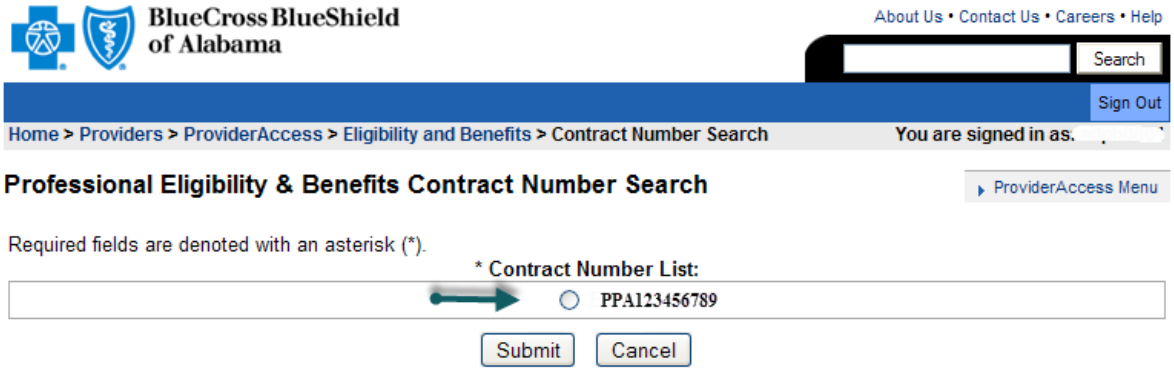
If you have a person who presents for services and they do not have their contract number, the patient may be looked up using the Social Security Number, First Name, Last Name and Date of Birth.



➔ Click on the "Don't Have the Contract Number?"

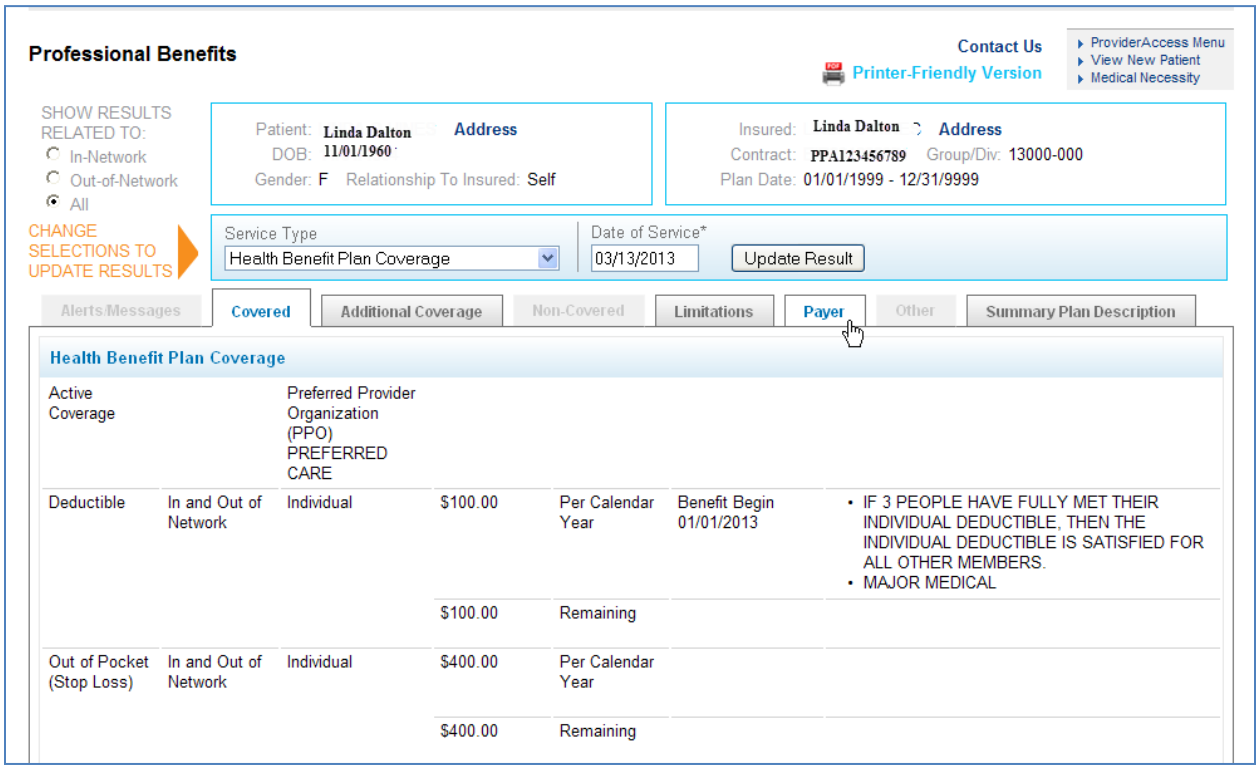


→Enter the required fields (SSN, First Name, Last Name and Date of Birth). Press Submit.



→Click on the Contract Number shown and submit.

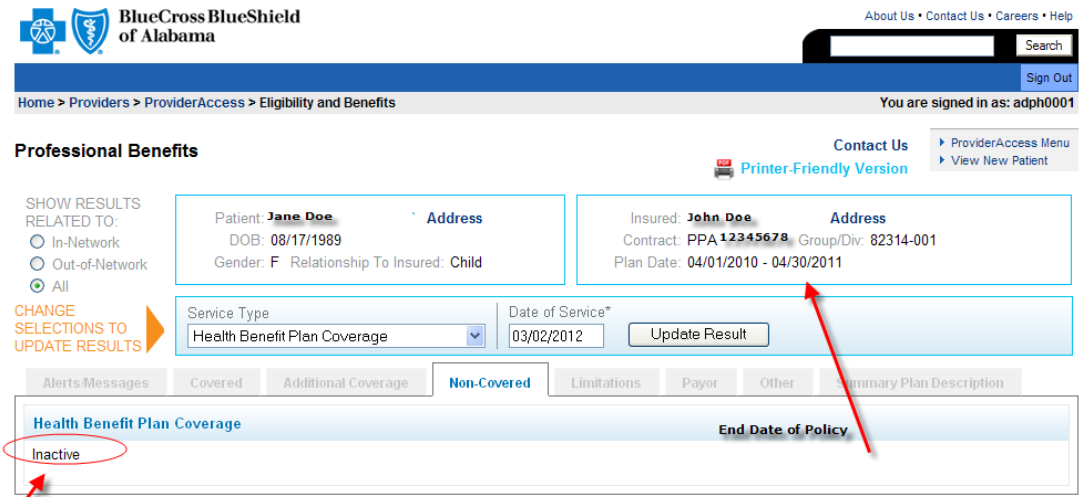
→ The Contract Number will populate the Contract number field. Press Submit. The Professional Benefits screen will appear.



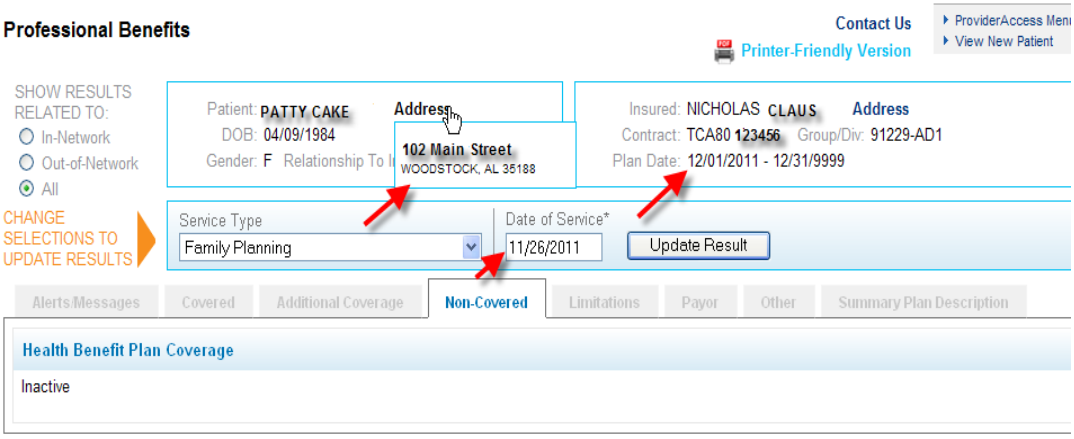
UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLE MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

Inactive Coverage:

- If eligibility screen indicates “Inactive” coverage, advice the client that their service appears to be inactive and that they will be charged according to the sliding fee scale. Print a copy for the record, select printer friendly version and then choose “print current screen”.



Example of Inactive coverage



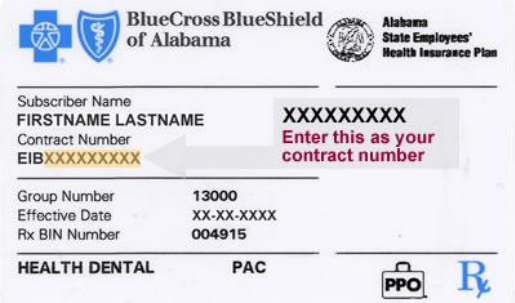
Example of active coverage but not on the correct date of service

4. Copy Card: If active coverage is identified and client has agreed to ADPH filing a claim, make a copy of the insurance card if available. Counties may keep a copy in a separate file pending payment or denial of claim.

   Note the following to look for on the card:

   a. Format for the BCBS Policy number is generally 3 character codes (such as EIB) followed by 9 digits; or "R" with 8 digits. There are some exceptions for out of state BCBS card holders. When entering the policy number in PHALCON, do not enter any dashes or extra characters in this field which could result in an invalid entry.

   b. If the client has a card with "XAD" as the first three prefixes, this is for DENTAL only and not Family Planning services. Ask the client if they have another card with XAA or PPA. If not, they are to be charged for the visit.



5. ALL Kids clients: Utilize the same process described above for BCBS. On the insurance screen, indicate "All Kids" as the insurance carrier. These encounters will be billed through the same process as BCBS.

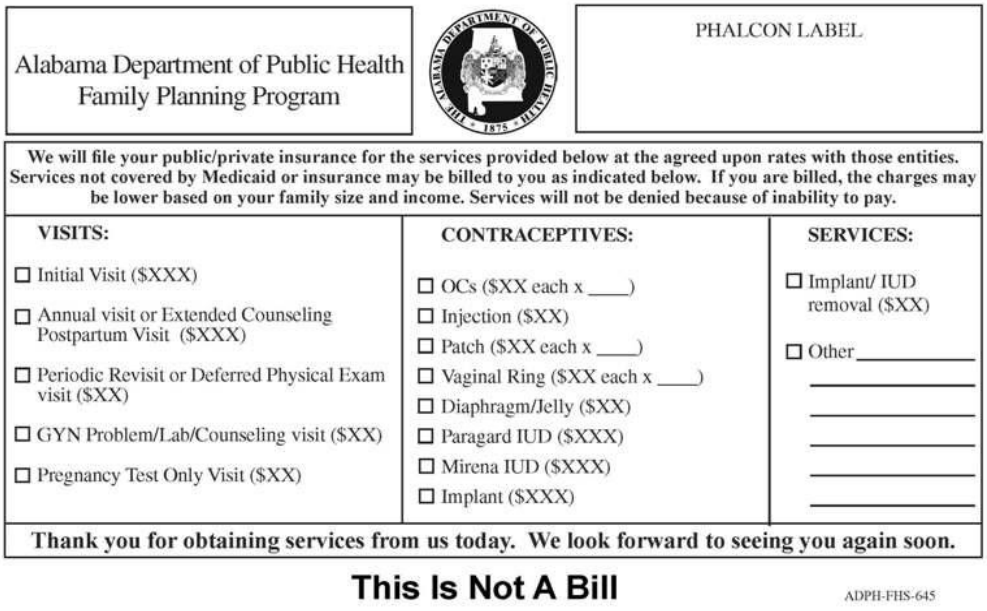
6. Assessment of Fees:
   - For clients who agree to ADPH processing a BCBS claim, inform them that if the claim is denied, they may receive a bill in the mail for the services received. Provide client with a Family Planning Services Receipt (ADPH-FHS-645). See instructions below.

Family Planning Services Receipt (ADPH-FHS-645):

Purpose

To provide the non-self pay Family Planning recipients with a receipt detailing the cost of the visit on that date of service (includes those with private insurance or public insurance such as Medicaid). The Health Department will file all appropriately approved third party insurance claims on behalf of the client (currently includes BCBS and Medicaid). If the claim is denied, the client will be charged for the services based on family size and income.

NOTE: Self pay or fee paying clients will be entered into the electronic Day Sheet and printed a receipt from that system.



Alabama Department of Public Health
Family Planning Program

PHALCON LABEL

We will file your public/private insurance for the services provided below at the agreed upon rates with those entities. Services not covered by Medicaid or insurance may be billed to you as indicated below. If you are billed, the charges may be lower based on your family size and income. Services will not be denied because of inability to pay.

VISITS:	CONTRACEPTIVES:	SERVICES:
☐ Initial Visit ($XXX)	☐ OCs ($XX each x ____)	☐ Implant/ IUD removal ($XX)
☐ Annual visit or Extended Counseling Postpartum Visit ($XXX)	☐ Injection ($XX)	☐ Other _____
☐ Periodic Revisit or Deferred Physical Exam visit ($XX)	☐ Patch ($XX each x ____)	_____
☐ GYN Problem/Lab/Counseling visit ($XX)	☐ Vaginal Ring ($XX each x ____)	_____
☐ Pregnancy Test Only Visit ($XX)	☐ Diaphragm/Jelly ($XX)	_____
	☐ Paragard IUD ($XXX)	_____
	☐ Mirena IUD ($XXX)	_____
	☐ Implant ($XXX)	

Thank you for obtaining services from us today. We look forward to seeing you again soon.

This Is Not A Bill

ADPH-FHS-645

Procedure

- Place a PHALCON label here.
- Indicate which Family Planning visit type the client received and contraceptive method as appropriate. For methods such as OCs, patch and vaginal rings, indicate the number of monthly packs/cycles issued on that specific date of service.
- The receipt should be marked by the nurse or Nurse Practitioner after services have been received. The client may be provided the receipt by the nursing or clerical staff based on county discretion.

  ➔ NOTE: If the client has questions about ADPH rates on the receipt versus what they receive on a BCBS EOP, inform them that ADPH files public/private insurance for the services at the agreed upon rates with those agencies. Services that are not covered by Medicaid or insurance may be billed to the client. If the client is billed, the charges may be lower than those listed on the receipt based on their family size and income. Services will not be denied because of inability to pay.

7. PHALCON Data Entry: 
For clients who agree to ADPH processing a BCBS claim, enter the required information into PHALCON as follows. Upon entry of the encounter into PHALCON, Health Finance will pull the applicable data for billing.

   a. Demographics Page – It is important that when initiating a CHR record, the name on the demographics page should be the legal name and more than likely should match the name used by Blue Cross.

   b. Financial Information/Insurance Screen - Enter as much insurance information as possible into PHALCON (policy and group number, policy holder name and relationship, etc.) It is critical that the information put in PHALCON is accurate for billing to be successful.

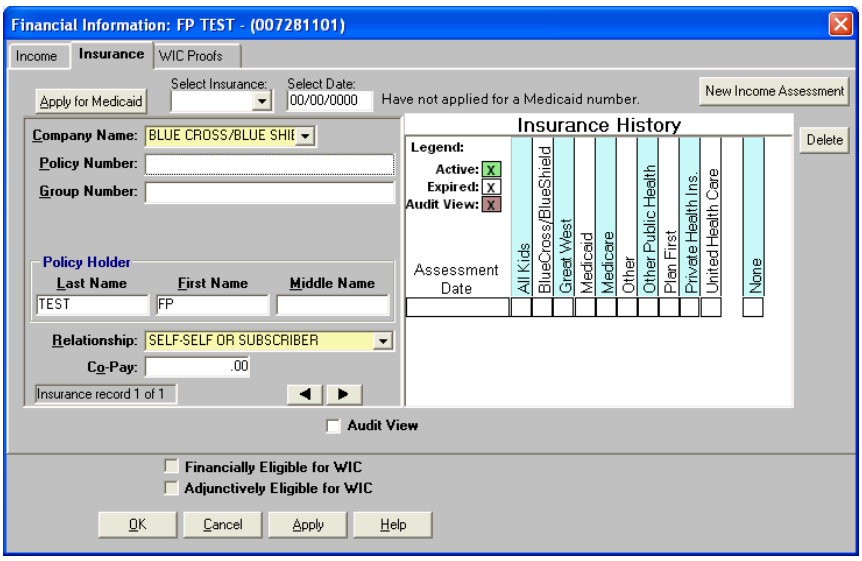
      - Company name – Enter the name of the insurance carrier to be billed for the visit/ services. Blue Cross/Blue Shield is the primary carrier at this time. We will also file claims for ALL Kids recipients. In this case, choose "ALL Kids" from the dropdown list.

        ➜ Generally, the format for the Policy number is 3 character codes (such as EIB) followed by 9 digits or "R" with 8 digits. Do not use dashes, special characters, etc.

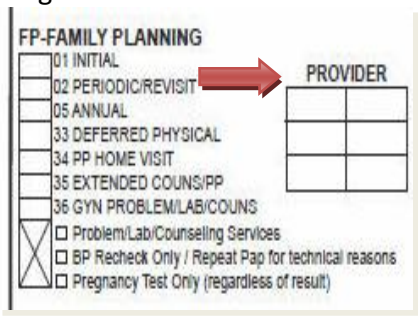
        ➜ Out-of-state BCBS Card Holders: We will attempt billing of out-of-state BCBS card holders. This will be more common for the counties that border other states.

      - Policy Holder – Enter the last, first, and middle name of the policy holder. Utilize the Blue Cross web portal to confirm the policy holder and make sure to enter the name as known by Blue Cross (the name must be spelled exactly as it is on the card). Remember - this may not be the client sitting in front of you, so make sure you use the correct person.

      - Relationship – Indicate the relationship of your "client" to the subscriber/policy holder (the person whose name is on the card). It may be child, spouse, or if the client is the subscriber/policy holder the relationship will be self. Example: Sally Doe is the client and is the daughter of Jane Doe. Jane Doe is the subscriber. The relationship in this case would be "child".



c. Encounter Form - The clinician (MD or Nurse Practitioner) performing the visit must enter their assigned 4 digit provider # on the encounter form for entry into PHALCON. This is critical for successful billing.



➜ Provider Information – In order to add a new clinician (MD or NP) or to make changes to existing providers, the designated staff person with administrative rights in PHALCON may access the "Provider Setup" through the appointment icon. This process is vital in connecting the correct provider with BCBS and the appropriate encounter. Requirements include:

1. The provider must be listed by name. Do not use generic titles such as "Visiting NP"

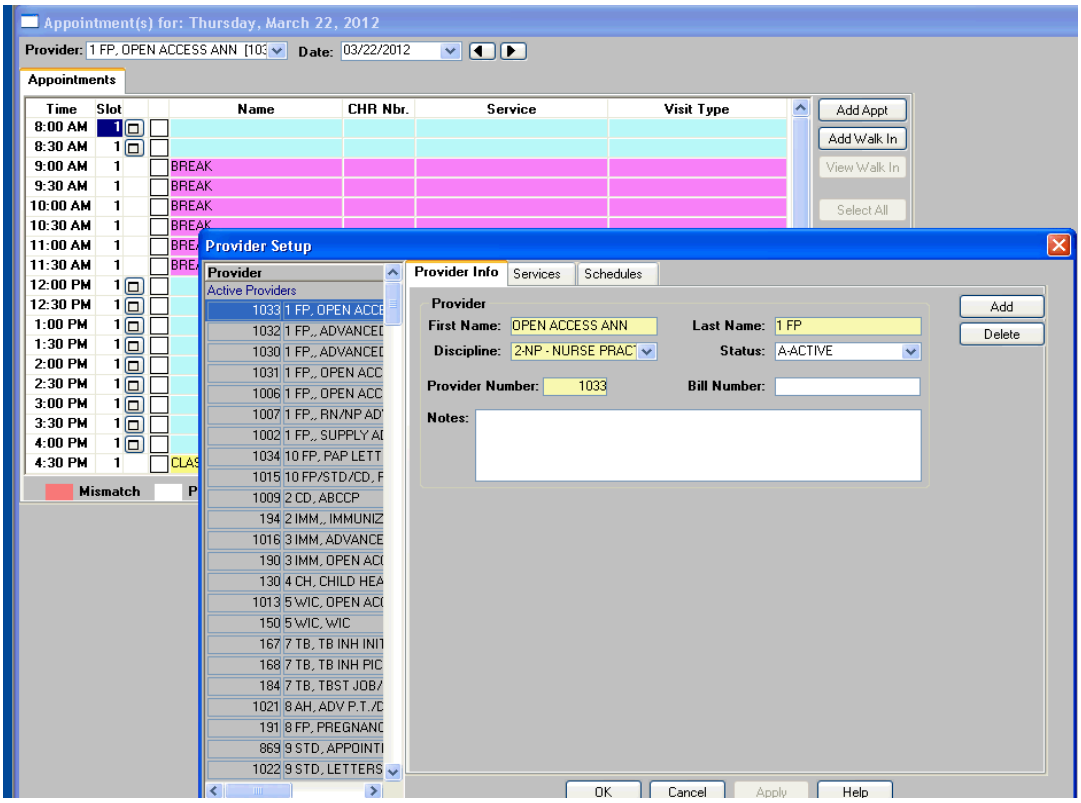
2. New NPs can be added utilizing their approved 4 digit provider # (last 4 digits of SS# preferred). If the NP provides services at different locations, he/she is to use the same 4 digit # at each site.

3. If the provider is already listed, make sure to only change their provider number to the newly assigned 4 digit number in order to preserve all prior history. All 4 digit #s must be approved through the Nurse Practitioner Director at the central office.

4. Do not create a new provider if he/she already exists. This will compromise any prior data on the provider.

5. Do not reuse a provider/record from the list such as from a NP who no longer works for the department or a generic provider such as “Floating NP”. In this case, make that provider record inactive.

Provider Information Screen



d. Billable Visits/Services:

- Visits – The billable visits to BCBS are only those where the MD/Nurse Practitioner has seen the client. This includes the Initial, Annual, Periodic Revisit and GYN Problem/Lab/ Counseling Visit. A diagnosis code should be used when a problem is identified. See e. below for additional guidance. Therefore, clients will need to be informed that RN only visits will continue to be charged to them based on family size and income.

- Services/Contraceptives:
  - BCBS will allow the billing of Depo-Provera/Medroxyprogesterone Acetate during a RN only visit under the prescriptive order of the MD/NP. In this case, the NP does not have to be present, but the appropriate provider # must be entered with the encounter in order to bill the injection. Make sure to enter the correct MD/NP (who signed the order at the time of the exam, etc.) with the encounter.

  - BCBS allows for the billing of in-office, procedure driven contraceptive methods such as IUDs (including insertion and removal), and Implants (including insertion and removal) when performed by the MD/NP.

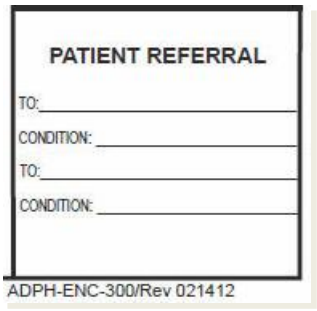
- Services/Contraceptives: continued

  - BCBS does not pay ADPH for other pharmaceutical contraceptives such as oral contraceptives, patches and vaginal rings because our agency is not considered a pharmacy provider. As a Title X provider, we will continue to provide contraceptives directly to clients in the usual manner and do not plan to send them to pharmacies for supplies.

e. Diagnosis Codes:
   - All medical insurance claims submitted to insurance companies must be accompanied by a medical code for the condition, treatments, diagnosis and any procedures performed by a healthcare provider.

     ➔ Routine screening exam visits (Initial, Annual), a problem focused visit (GYN problem, repeat Pap smear, contraceptive problem, etc.), applicable contraceptives, and billable services will be pulled from PHALCON following the completion of the encounter and must be accompanied by the MD/NP Provider #.

     ➔ Diagnosis codes are to be utilized when a condition is identified that plays a role in the care of the client such as anemia, hypertension, and weight gain, etc. The documentation in the record must reflect the diagnosis (ex: BP reading, counseling on weight, change in method, return for repeat BP, etc.) The MD/NP is to document the applicable diagnosis code(s) on the encounter form for entry into PHALCON. The MD/NP is to utilize the "Patient Referral" box in the lower right hand corner of the encounter form to document all applicable diagnosis codes.


PATIENT REFERRAL

TO: _____

CONDITION: _____

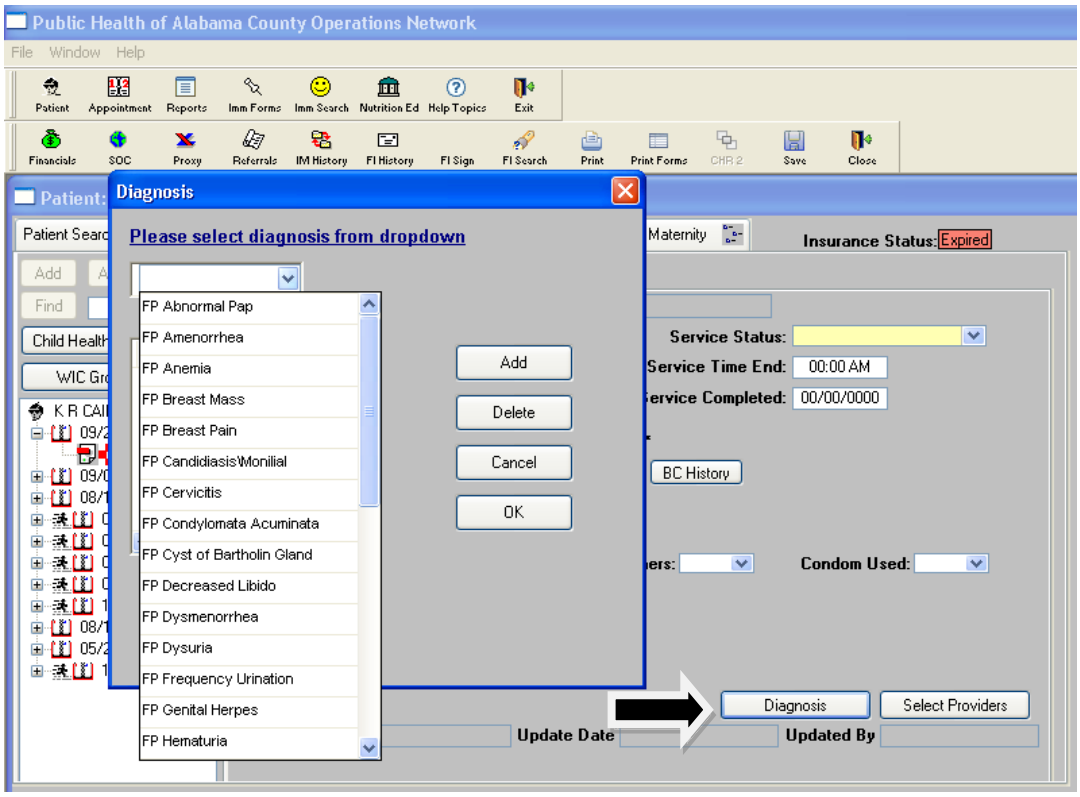
TO: _____

CONDITION: _____

ADPH-ENC-300/Rev 021412

   - Diagnosis codes can be found in PHALCON on the encounter screen. Select from the dropdown list of FP diagnosis codes. More than one may be entered if indicated.

Encounter Screen



- See Appendix A below for a listing of diagnosis codes.

f. Final Step: All aspects of the visit, services and provider numbers should be reviewed prior to completion of the encounter to ensure the billing will be successful. Upon entry of the encounter into PHALCON, Health Finance will pull the applicable data for billing. Counties will be notified regarding payment or denial of the claim. If denied, the county is to go back and charge the client for the visit and method as appropriate.

APPENDIX A – Diagnosis Codes Used by MD/NP

FP Abnormal Pap

FP Amenorrhea

FP Anemia

FP Breast Mass

FP Breast Pain

FP Candidiasis\Monilial

FP Cervicitis

FP Condylomata Acuminata

FP Cyst of Bartholin Gland

FP Decreased Libido

FP Dysmenorrhea

FP Dysuria

FP Frequency Urination

FP Genital Herpes

FP Hematuria

FP Hemorrhoids

FP Hypertension

FP Menorrhagia. Excessive

FP Morbid Obesity

FP Nausea

FP Nausea w\ vomiting

FP Obesity

FP Pelvic Pain

FP PID

FP PMS

FP Scabies

FP Stool, Abnormal finding

FP Trich

FP Urticaria Allergic

FP Uterine Fibroid

FP UTI

FP Vaginitis and vulvovaginitis

FP Weight Gain

TOOLS:

FAMILY PLANNING FINANCIAL INTAKE

BCBS

- Verify active status through web portal. May use SS# to search for patient.
- Print BCBS Screen verifying active status
- Obtain approval from patient to file claim for services (Authorization for Services).
- Enter Policy #, Group # if available, Name of insured, and relationship of patient to insured into PHALCON (most common entry is "self" or "child").
- Copy Card for record.
- Enter "Bill insurance" on the encounter form.
- At completion of services, enter the 4 digit # for NP or MD into PHALCON; and diagnosis code(s) if any are assigned by NP/MD.
- Nurse or clerk to provide patient with FP Receipt (FHS-645).
- NOTE: If the visit is not eligible for filing to BCBS, enter "N/A" on encounter form.

MEDICAID

- Ask if patient has private insurance.
- Verify active status through web portal.
- Print proof if active coverage.
- Initiate application if needed.
- Enter Medicaid # in PHALCON.
- Enter "N/A" on encounter form.
- Nurse or clerk to provide patient with FP Receipt (FHS-645).

FEE PATIENT

- Enter family size and income into PHALCON.
- Establish income pay bracket per ADPH protocol.
- At completion of visit, charge according to applicable service codes using E-Day Sheet. Print receipt for patient.

NOTE:

- Dual Coverage: If patient has BCBS and Medicaid coverage, complete all insurance screens in PHALCON and enter ”Bill Insurance” on the encounter form.
- BCBS – Dental only: If an XAD number is provided by patient, this is a dental only policy #. Verify policy # (such as XAA or PPA prefix) through web portal. If no other insurance is available, charge the patient accordingly using the Fee System.
- BCBS – No Home Contact: For patients who do not want home contact, enter “Do Not Bill” on the encounter form.

TOOLS:

Completing Encounter Form

Enter "Bill Insurance"

- If patient agrees to ADPH filing an eligible BCBS claim.
- Includes ALL Kids recipients.
- Enter Policy #.
- Enter Group # if available.
- Enter Policy Holder Name (as listed on BCBS web portal).
- Enter Relationship to insured. Typical response is "Self" or "Child".
- Enter 4 digit NP #.
- Enter diagnosis code(s) assigned by NP/MD if applicable.
- Issue FP Receipt (FHS-645).

Enter "N/A"

- If no insurance coverage;
- If patient has other private insurance besides BCBS;
- If patient has Medicaid coverage only;
- If patient has BCBS but the visit is not eligible for filing.
- Issue FP Receipt (FHS-645).

Enter "Do Not Bill"

- Patient does not want home contact.
- Charge patient using Fee System.
- Issue Fee System Receipt.

TOOLS:

Eligible BCBS Claims

NP/MD Screening Visits with or without applicable diagnosis code	• Initial • Annual
NP/MD Problem Focused OR Procedure Driven Visits	• Periodic Revisit/Deferred PE Visit with applicable diagnosis code; and/or IUD or Implant services. • GYN Problem/Lab/Couns Visit with applicable diagnosis code.
Depo Only done by Nurse	• Visit is NOT eligible for billing. • Depo is billable because it is procedure driven.

Provide a FP receipt (FHS-645) to the patient with BCBS or Medicaid.

Alabama Department of Public Health
Family Planning Program

PHALCON LABEL

We will file your public/private insurance for the services provided below at the agreed upon rates with those entities. Services not covered by Medicaid or insurance may be billed to you as indicated below. If you are billed, the charges may be lower based on your family size and income. Services will not be denied because of inability to pay.

VISITS:	CONTRACEPTIVES:	SERVICES:
☐ Initial Visit ($XXX)	☐ OCs ($XX each x ____)	☐ Implant/ IUD removal ($XX)
☐ Annual visit or Extended Counseling Postpartum Visit ($XXX)	☐ Injection ($XX)	☐ Other _____
☐ Periodic Revisit or Deferred Physical Exam visit ($XX)	☐ Patch ($XX each x ____)	
☐ GYN Problem/Lab/Counseling visit ($XX)	☐ Vaginal Ring ($XX each x ____)	
☐ Pregnancy Test Only Visit ($XX)	☐ Diaphragm/Jelly ($XX)	
	☐ Paragard IUD ($XXX)	
	☐ Mirena IUD ($XXX)	
	☐ Implant ($XXX)	

Thank you for obtaining services from us today. We look forward to seeing you again soon.

This Is Not A Bill

ADPH-FHS-645

TOOLS:

Non-eligible BCBS Claims

OCs, ECPs, Patches, Rings with eligible BCBS visit	• Visit will pay; method will not. ADPH is not considered a pharmacy provider, therefore, we cannot bill these methods.
Periodic Revisit, Deferred PE Visit, GYN Problem/Lab/Couns Visit with No diagnosis code	• We can bill procedure driven methods such as Depo; IUD removal; IUD insertion; Implant; Implant insertion; and Implant removal (see prior page). Otherwise, we must have an applicable diagnosis code validating the need for the NP/MD.

Generate E-Day sheet receipt to the patients not eligible for BCBS or Medicaid (fee only).

Receipt/Current Invoice

9/24/2009	271	$156.00	$78.00		$78.00	$0.00
Date	Client Number	Gross Charge	Net Charges	Credits	Amount Paid	Current Balance

$0.00
Previous Balance

Jane Patient
Name of Client

Fp
Transaction Category

Self
Received From/Payer:

Notes

WELLVILLE CO HEALTH DEPARTMENT
2444 PAINFUL DRIVE
HAPPY AL 99999
3349991517

Next Appointment (Date) _____

Receipt Printed: 9/24/2009

Receipt Number 1121

DPH-A-101-Rev. 11/2008

TOOLS:

COMMON BCBS ERRORS

- ❒ Not verifying BCBS through web portal.
- ❒ Policy # incomplete or numbers entered incorrectly.
- ❒ Policy # missing.
- ❒ Policy # entered with XAD (dental only).
- ❒ Entering an insurance carrier (such as Aetna) that we cannot bill in FP at this time. (Currently BCBS is the only one we are set up to bill).
- ❒ Spelling the name of the policy holder incorrectly.
- ❒ Entering the relationship to patient wrong. Example: patient is entered as "Parent", when the policy holder is the parent (should have been marked "Child").
- ❒ Flagging the encounter wrong for private insurance. Ex: marking "Bill Insurance" when there are no billable services such as a Periodic Revisit; done by nurse; OCs issued. This should be marked "N/A".
- ❒ 4 digit NP # missing.
- ❒ NP is set up incorrectly in PHALCON as a nurse.
- ❒ Diagnosis Codes are not entered into PHALCON.
- ❒ Encounters not being entered and completed in a timely manner.

Revenue Recovery Division

The function of the Revenue Recovery Division is to try to recover denied revenue on behalf of the department for billable program services filed with Medicaid and private insurance companies. The Division assists county staff with:

1. the process of reviewing and managing claims through an Explanation of Payment (EOP) or claim denial statements;
2. making appropriate changes and corrections to the claim through the use of Billing Inquiry Spreadsheets as applicable; and
3. crediting and rebilling claims as appropriate.

Each county site should assign a trained billing staff person to work the county's EOPs and handle claims' issues. Each trained billing staff person must be certified before submitting any billing inquiry spreadsheets or correspondence to the Revenue Recovery Division. Only trained and certified staff will be allowed to correspond with the Revenue Recovery Division.

Training:

Clinic EOP Training is available through LCMS. County staff may access the training materials in the Document Library under the Revenue Recovery tab. Complete and detailed instructions should be reviewed before attempting to view the modules and/or take the post test. Each video segment in the training module must be viewed and the test completed successfully before EOP certification is granted.

Blue Cross and Blue Shield (BCBS) Training is available in the Document Library. County staff may access the training materials located under the FHS-Blue Cross and Blue Shield tab. All training material should be reviewed thoroughly before county staff begins to work claim denial statements. County staff must be trained and certified in Clinic EOP Training before submitting Blue Cross and Blue Shield spreadsheets to Revenue Recovery Division.

How to Contact:

- Revenue Recovery Contacts:

  Arnita L. Shepherd, Director: (334) 206-5668

  Clinic Billing Inquiries/EOPs – (334) 206-5667

  Private Insurance (BCBS) - (334) 206-3353

MATERNITY

A. SERVICE CODE 112 - MATERNITY-POSTPARTUM VISIT

A follow-up evaluation typically performed about six weeks post delivery. This visit includes the update of medical records, comprehensive history, complete physical examination, appropriate laboratory tests and procedures, and counseling. These clients are generally no longer childbearing or have had surgery which prevents childbearing (bilateral tubal ligation or hysterectomy). Family Planning services are not provided at this visit.

If Family Planning services are provided see description for the Extended Family Planning Counseling Visit, Service Code 103.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 112	$108	81	54	27	0

B. CHARGING PROCEDURES:

Assess client for Medicaid eligibility. Clients not eligible for Medicaid benefits are charged based on their annual income assessment. The charge includes all services and laboratory work provided during this visit.

The fees listed above are determined by the MCH Block Grantee at the State level, however, only those counties with a local fee bill, with approval of this rate, may charge the client. (MCH Block Grant: 505(a)(5)(D).

CANCER DETECTION

A. SERVICE CODE 114 - INITIAL AND ANNUAL VISIT

Use code 114 for evaluation of a new or established client requiring the establishment or update of medical records, comprehensive history, and appropriate counseling. These clients are generally no longer childbearing and the focus of the visit is breast and cervical cancer screening.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 114	$83	$62	$41	$20	$0

B. SERVICE CODE 116 - REVISIT

Use code 116 for evaluation of a client with a new or existing breast or cervical cancer related problem or condition.

Examples of visits include:

- Evaluating breast problems
- Repeating necessary lab work such as Pap smear or hemoglobin
- Counseling only visit regarding abnormal Pap smear or other identified problems.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 116	$33	$25	$16	$8	$0

C. Documentation Procedure for Alabama Breast and Cervical Cancer Clients:

Counties with a fee bill and an approved fee schedule for cancer detection services would normally assess fees for cancer detection services. These counties should complete the income assessment as normal (including family size, income, and payment bracket.) “Waive Fee” should be circled at the bottom of the income assessment form and “Eligible for BCCP” should be indicated. This will identify the services that will be paid for through the Breast and Cervical Cancer Program (BCCP). The services would be listed on the day sheet with the gross charges at the 100% amount and the net charges would be 0.00, since the fee is waived. The BCCP client never actually pays for any BCCP services.

CANCER DETECTION - continued

For counties without a fee bill or with no approval to charge cancer detection services, there would be no entry on the day sheet for a BCCP eligible client who receives services, and the client would not pay for any BCCP services received.

D. Charging Procedure:

Assess client for Breast and Cervical Cancer Program (BCCP) eligibility. Clients not eligible for BCCP benefits are charged based on their annual income assessment. The charge includes all services and laboratory work provided during this visit.

The fees listed above are suggested fees. Counties with a local fee bill for these described services are to utilize their local fee schedule.

CHILD HEALTH

A. SERVICE CODE 118: INITIAL AND PERIODIC VISITS

Initial Screening indicates the first time a well child screening is performed on a client. Periodic Screenings are well child checkups performed based on a periodicity schedule. The ages to be screened are by 1month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually beginning on or after the child's third birthday. Services include a comprehensive family/medical history, physical examination, and assessment of immunization status, developmental assessment, nutritional assessment, anticipatory guidance, health education and procedures per protocol - measurements, hearing/vision/dental evaluation, laboratory tests, and counseling per protocol. Note: Immunizations are charged separately – See Immunization service codes.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 118	$163	$122	$82	$40	0

B. SERVICE CODE 120: INTERPERIODIC VISITS

Interperiodic visits are considered problem-focused and abnormal. These visits may be performed before, between, or after a periodic screening if medically necessary. Interperiodic screenings may also occur in the case of children whose diagnosed illness/condition (physical, mental or developmental) has become more severe or has changed sufficiently so that further examination is medically necessary. A referral to others or a self-referral may be issued for problems identified during the visit. Interperiodic screenings will have an abnormal diagnosis.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 120	$163	$122	$82	$40	0

C. SERVICE CODE 122: SINGLE SERVICE VISIT

A single service visit when only one service is provided to a child during the visit. Services provided depend upon the nature of the illness or problem which requires the specific service. Examples of services include: Head lice checks, Lead screening, Repeat PKU tests, Hemoglobin re-check.

Percentage Fee	100%	75%	50%	25%	0%
Service Code 122	$20	$15	$10	$5	0

D. CHARGING PROCEDURE:

- Status of Medicaid eligibility must be checked at each visit with the fee based on the last annual income assessment. Clients not eligible for Medicaid benefits are charged based on their **parent's or guardian's** ability to pay prior to receiving services. The charge includes all services and laboratory work provided during this visit as described above.
- **The fees listed above are determined by the MCH Block Grantee at the State level, however, only those counties with a local fee bill, with approval of this rate, may charge the client. (MCH Block Grant: 505(a)(5)(D).**
- **NOTE**: The DHR social worker **must** complete and sign the income assessment for both Medicaid and non-Medicaid eligible foster children.

IMMUNIZATION

A. **SERVICE CODE 144 – Immunization**

Includes administration charge to cover nursing cost and administrative services including the establishment and maintenance of immunization records. Includes any vaccine to be administered that is supplied by the Immunization Division.

CHARGING PROCEDURE:

Fees associated with an immunization are administrative only. There is no charge for the vaccine itself. Patients may not be denied vaccine due to inability to pay the administrative fee.

Immunization fees vary from county to county on local fee legislation. Depending on the county fee bill, immunization administration fees are either a $15 sliding scale, a $5 sliding scale, or a $15 flat rate for each vaccine administered.

Medicaid patients are not to be charged an administrative fee for vaccines. Children from birth up to the 19th birthday that are non-VFC may be charged according to the county's fee bill if the county has not billed the insurance company. Children in this age range who do not have health insurance or are American Indian or Alaskan Native may be charged the amount specified by the fee bill up to $19.79 per dose of vaccine. This is a federally mandated fee cap that must not be exceeded and cannot be rounded up to $20. Counties with a $20 fee cap per visit may continue to charge this amount if more than one dose of vaccine is administered at the same time.

Percentage of Fee Charge	100%	75%	50%	25%	0%
One child	$15	12	8	4	0
Two children	$30	24	16	8	0
Three children	$45	36	24	12	0
Four children	$60	48	32	16	0
Five children	$75	60	40	20	0

IMMUNIZATION

County to Complete:

_____ County Fee Schedule Rates

Fill in the fee schedule for your county rates. The rates should be based on your county's fee bill and a copy posted at the intake area. Your county only has authority to charge the fee amounts adopted by your local Board of Health.

Percentage of Fee Charge	100%	75%	50%	25%	0%
One child	$				
Two children	$				
Three children	$				
Four children	$				
Five children	$				

B. **SERVICE CODE 146 – Immunization: Influenza or Pneumoccal**
Includes the administration charge to cover costs for nursing and administrative services including the establishment and maintenance of immunization records.

Services include:
1. Provide influenza or pneumoccal vaccine.

2. Administer injection.

CHARGING PROCEDURE:
All patients are charged a flat fee of $5 per shot. If both flu and pneumoccal are given at the same visit, $10 will be charged.

AMOUNT OF CHARGE:
Flat fee of $5 per shot.

C. **SERVICE CODE 156 – Immunization: Travel or Other Immunization (County-purchased vaccines and biological)**
Includes the administrative charge to cover cost for nursing and administrative services provided plus the cost for county-purchased vaccines and biologicals.

Services include:
1. County purchased vaccines and biologicals.

2. Administer injection.

CHARGING PROCEDURE:
All patients are charged a flat fee prior to receiving services.

AMOUNT OF CHARGE:
A flat fee of $15 will be charged per person per visit plus the cost for county-purchased vaccine.

D. **SERVICE CODE 158 – Injection Only Patient Supplies Dosage**
Includes administrative charge to cover cost for nursing and for administrative services.

Services include: Administers injection.

CHARGING PROCEDURE:
All patients are charged a flat fee prior to receiving service. The charge does not include any charge for vaccine.

AMOUNT OF CHARGE:
A flat fee of $5.

E. **SERVICE CODE 166 – Duplicate Immunization Record**
Includes providing a duplicate copy of immunization records to parents or guardians.

Services include: Copy of immunization record. There is no charge for the blue slip.

CHARGING PROCEDURE:
All patients are charged a flat fee.

AMOUNT OF CHARGE:
A flat fee of $2 is charged for each copy.

F. **SERVICE CODE 168 – Copies of Medical or Dental Record**
Includes providing a copy of medical or dental records if accompanied by a release of information form signed by the patient.

Services include:
1. Make a copy of the pertinent medical record pages.
2. Mail copies to the requestor.

CHARGING PROCEDURE:
A flat fee is charged for this service. The fee is assessed only for non-medical information requests. The $2 fee should be collected prior to giving the patient the copy of his record or sending a copy to a third party. A prenumbered receipt will be issued and the fee will be posted as miscellaneous revenue on the Day Sheet. No fee is charged for copies of medical records sent to other medical providers to ensure continued quality of patient care.

AMOUNT OF CHARGE:
A flat fee of $2 is charged regardless of the number of pages copied from the medical record. In other words, whether copying one page or all pages in the record, the charge is $2.

IMMUNIZATIONS

Question: Should vaccines be charged on a sliding scale or a flat fee of $15?

Answer: It depends, if the child does not have private insurance, the county health department cannot charge more than $19.79 per dose effective January 1, 2013. If the child does have private insurance, the county can charge which ever method has been adopted by the county's local governing Board of Health.

Question: Does an Income Assessment have to be completed for an immunization only?

Answer: All children 0-18 years of age who receive vaccines at the county health department must be assessed for insurance status on the Income Assessment Form at each visit.

Question: If a patient waives the Income Assessment or is in a "no fee" county when they come in for vaccine, should we have them sign the Income Assessment form under the space where the clerk writes "Patient Waives Assessment?"

Answer: Yes, as long as the patient has been assessed at each visit.

Question: A mother brings several children in for immunizations, is a separate receipt completed for each child?

Answer: Yes. A separate receipt must be completed for each child since each has a ledger card.

Question: For travel immunizations that require vaccine costing more than the authorized flat fee of $15 per visit, can the county recoup the cost of the vaccine in addition to the $15?

Answer: Yes, as long as recouping the cost of vaccine is allowed in the county fee bill.

MISCELLANEOUS/OTHER

Question: Does Service Code 168, Copy of Medical or Dental Record, refer to the entire CHR or to a specific page within the CHR? Also, do we charge our patients for copies of their own records? Do we charge other state agencies?

Answer: A flat fee of $2 will be charged regardless of the number of pages copied from the CHR. In other words, whether copying one page only, or all pates in the record, there is a charge per page. As for the fee, refer to the specific county's approved fee schedule.

Question: Some insurance companies send more than $2 for a medical record copy. Can the county keep the extra?

Answer: Yes, post the excess as a donation.

IMMUNIZATION

Billing Private Insurance
Users Guide

Immunization
Billing Private Insurance Users Guide

The following guidelines are to be used when assessing Immunization clients for the processing of insurance claims. Clients must give approval in order to file a claim requesting payment of eligible medical coverage benefits to be provided to ADPH. Clients who do not want a claim submitted will be responsible for any charges utilizing the established County Fee Bill.

Travel immunizations will still be processed based on the County Fee Bill.

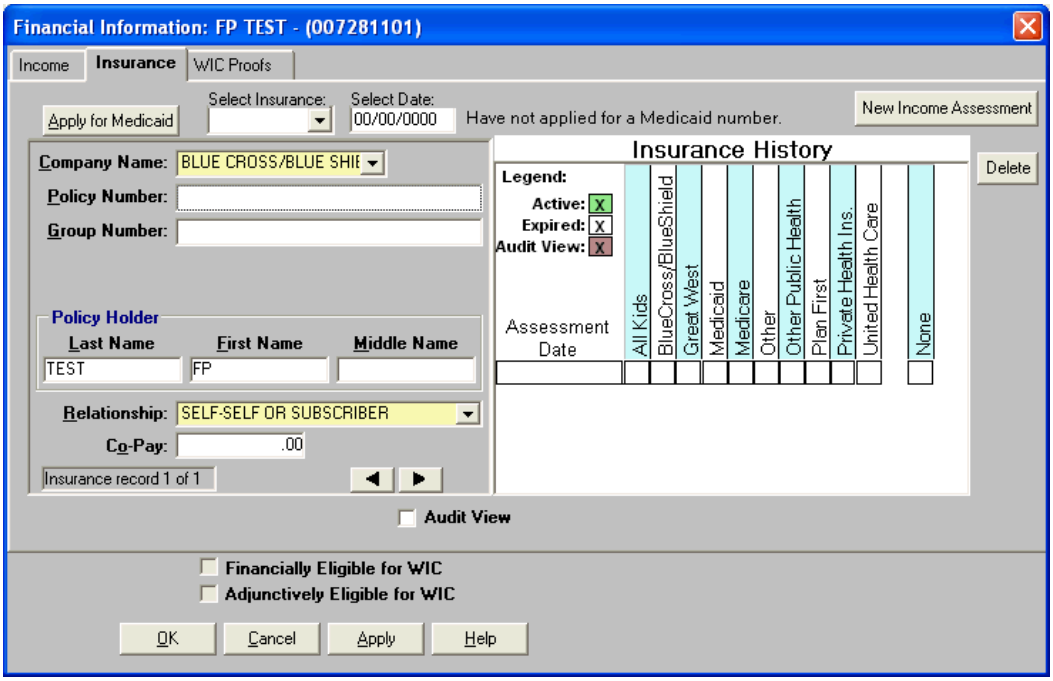
Blue Cross/Blue Shield of Alabama is the primary carrier utilized at this time and is detailed when applicable throughout this section.

When scheduling the appointment with client over the phone:

1. Ask the patient if she has private insurance coverage, and if so, would she agree to the Health Department filing claims for her when she comes in for services. Encourage her to bring a copy of the insurance card with her to the appointment.

At the time of the appointment:

2. Perform the intake process in the usual manner to include the collection of the demographic information, income assessment as appropriate and insurance information. Enter as much insurance information as possible into PHALCON (policy and group number, policy holder name and relationship, etc.)



3. Complete the CHR-3, Authorization for Services form. Make sure the client has reviewed the section “Permission to Bill”.

PHALCON LABEL

AUTHORIZATION FOR SERVICES AND BILLING

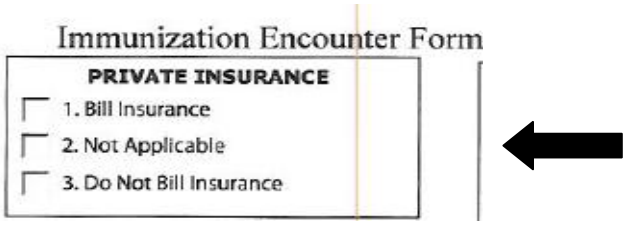
FOR ALL SERVICES RENDERED

To Receive Services:
I give permission for myself or the above named child to receive health services as indicated.
I understand that my or the above named child's medical records are strictly confidential. I hereby authorize use of these records in the provision of services by the Alabama Department of Public Health. I understand that these records may be used for statistical audit purposes without using the name of the patient.
I understand that interpretation services are available to me at no cost if I need them.

Permission to Bill:
I authorize the release of any medical information necessary to process a claim and request that payment of eligible medical coverage benefits be provided to the Alabama Department of Public Health. I understand that I am financially responsible to the Department for charges not covered by this agreement; and for any charges that may occur if I do not want a claim submitted to my medical coverage carrier.

For Routine Testing:
I understand that routine testing, including that for HIV (the virus that causes AIDS), is needed to determine what treatment, counseling or referral may be required. I understand that testing is voluntary and I hereby give my consent for testing for myself or the above named child. I may withdraw my consent for testing at any time during this visit by notifying my nurse.

4. On the ADPH Immunization Encounter Form (IMM 1482, IMM 1483, IMM-1484), the clerk is to complete the section "Private Insurance" indicating the patient's preference regarding the filing of an insurance claim. Valid options include: Bill Insurance, Not Applicable, and Do Not Bill Insurance - This is a required field.



5. We do not want any patient to receive an insurance claim form (EOP – Explanation of payment) from an insurance carrier in the mail by accident, so make sure they consent to the processing of the claim and the entry is made in PHALCON.

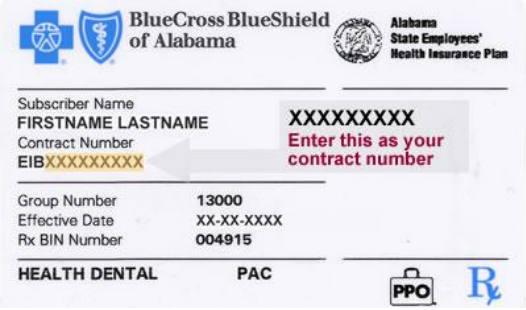
6. For clients who opt to not have a claim filed, then charge fees in the usual manner based on the Counties Fee Bill and enter into the E-Day sheet with receipt.

7. Make a copy of the insurance card if available. Counties may keep a copy in a separate file pending payment or denial of claim.

   Note the following to look for on the card (Blue Cross/Blue Shield example):
   a. Format for the BC/BS Policy number is generally 3 character codes (such as EIB) followed by 9 digits; or "R" with 8 digits. There are some exceptions for out of state BC/BS card holders. Check the card for an acceptable 3 character code on a BC/BS card (see Appendix A for Valid Prefix Codes listing at the end of this section).

b. If prefix is not on the list but appears on BC/BS web site with eligibility, these can be billed.

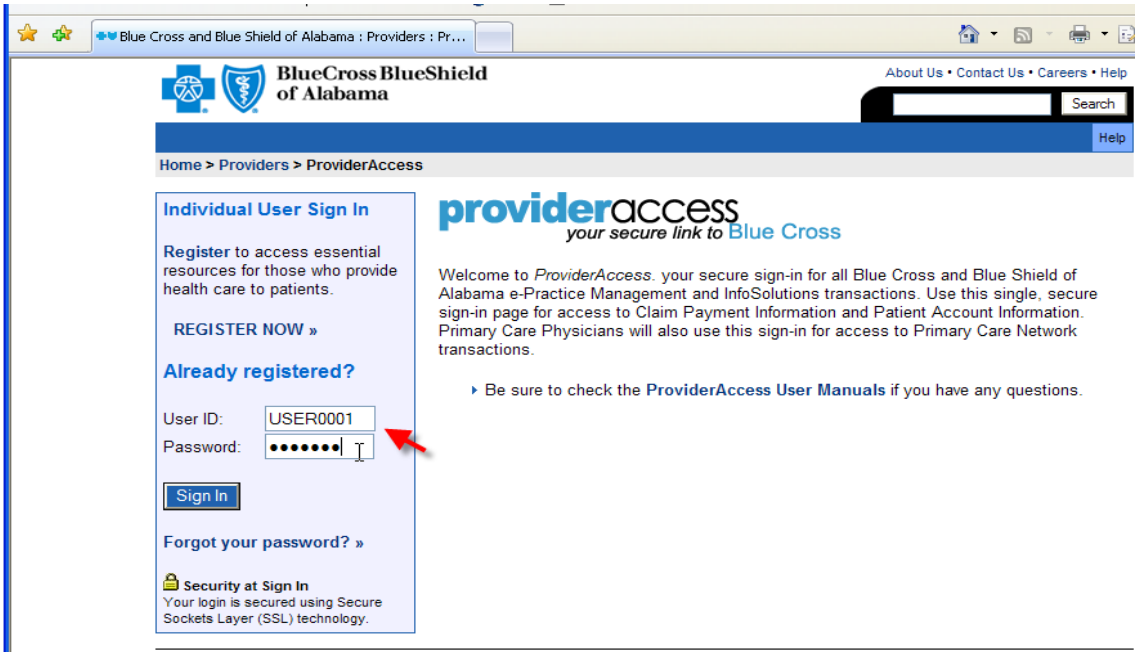
c. If the patient has a card with "XAD" as the first three prefixes, this is for DENTAL only and not Immunization services. Ask the patient if they have another card with XAA or PPA. If not, they are to be charged for the immunization.



d. We also need to know the Name and Relationship to the insured. This information will be entered on the PHALCON screen where Policy Holder and Relationship are listed, under the Insurance tab.

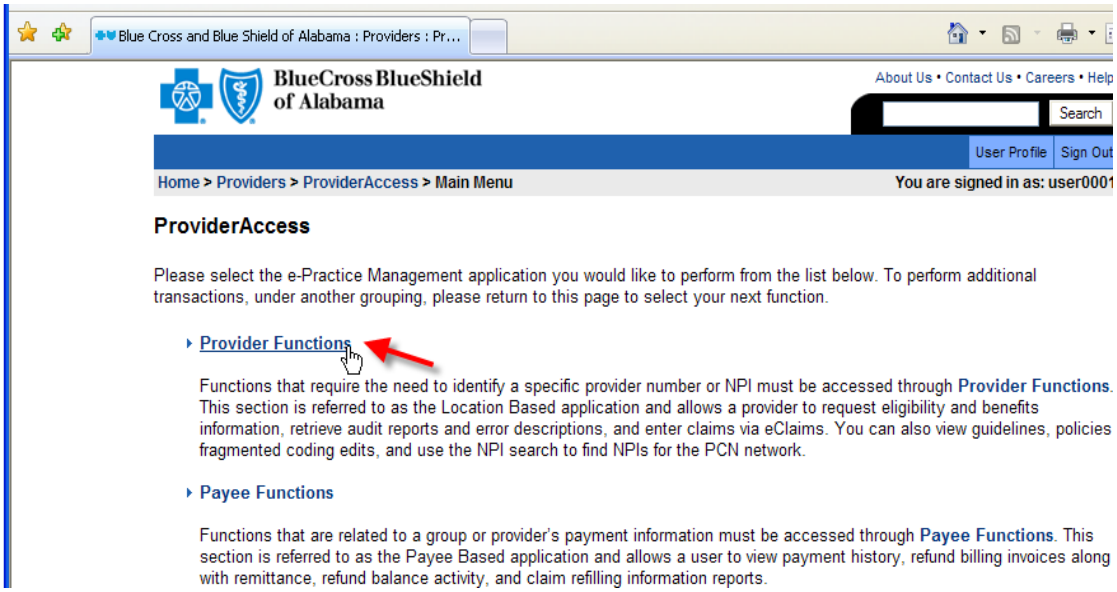
8. Access the Blue Cross website to verify eligibility for those who have given permission to file a claim at **https://www.bcbsal.org/providers/index.cfm.** See screen shots below.

   If you do not have a BC\BS user-ID, you may have your County security coordinator contact ADPH Help Desk to request a BC\BS user-ID for you.

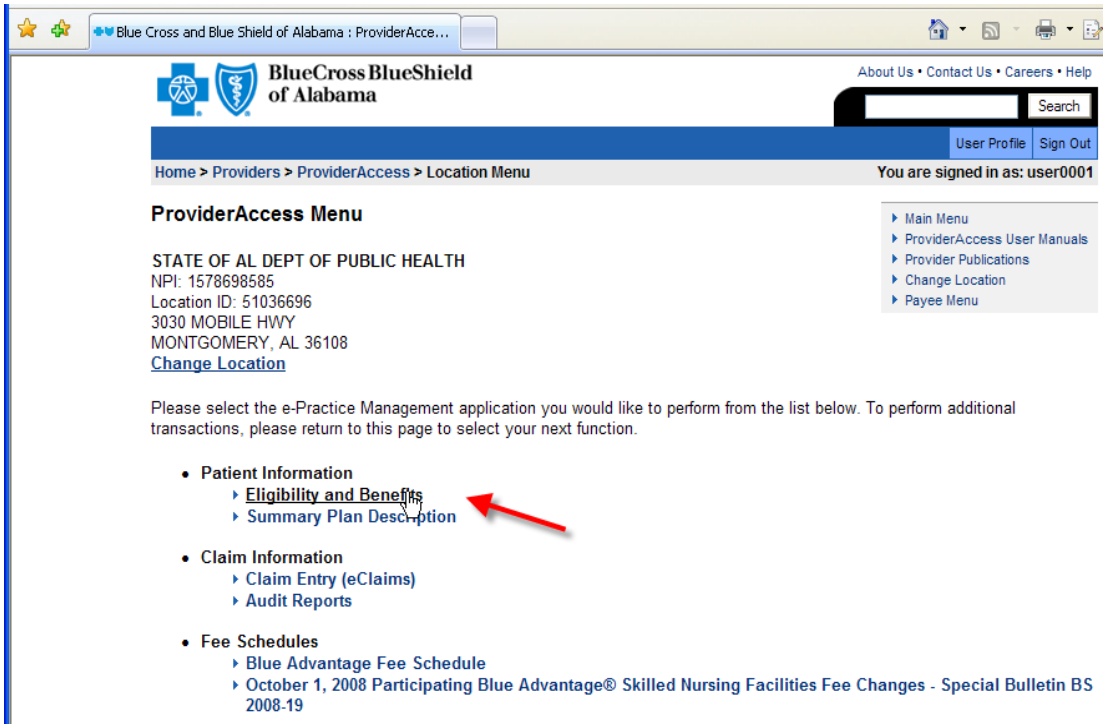


- Enter User-ID and Password. Press Enter

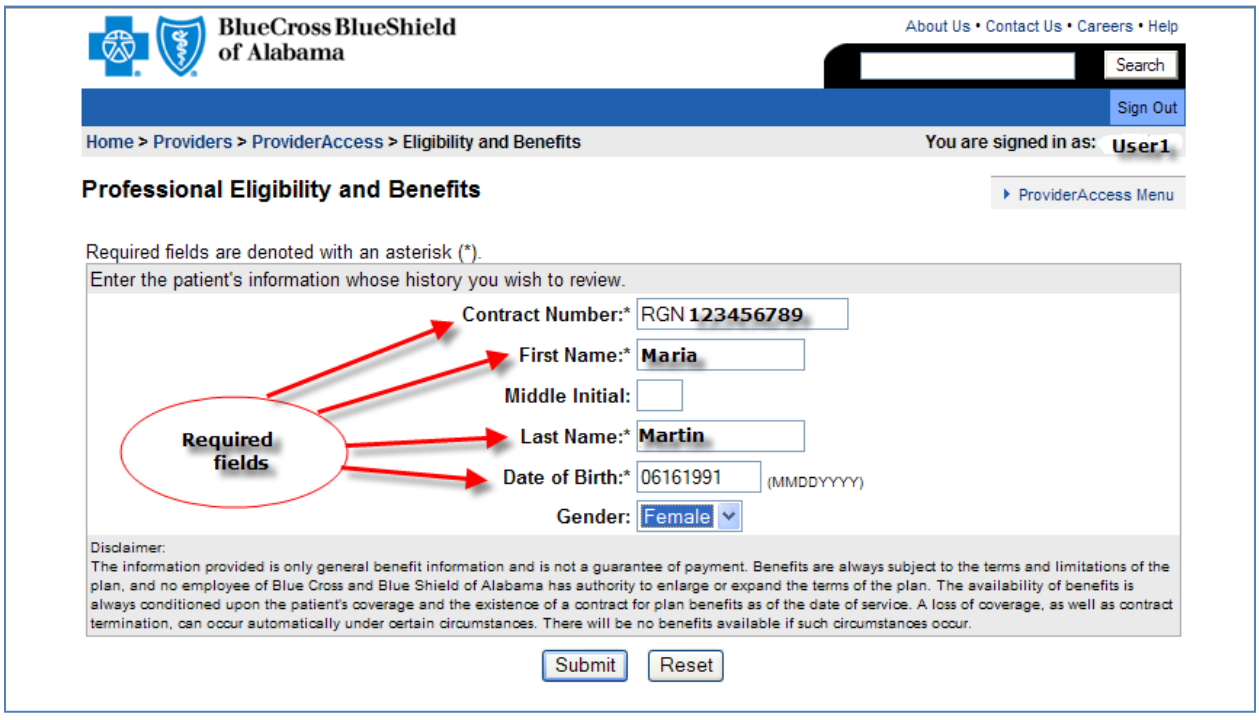
9. Once the IDs are loaded for the applicable staff, when a patient indicates that they have coverage and we have all the required information to populate the fields, the county can verify coverage. This is not intended to verify if the services are all covered, but to verify if the patient has the insurance.



10. Select “Provider Functions”.

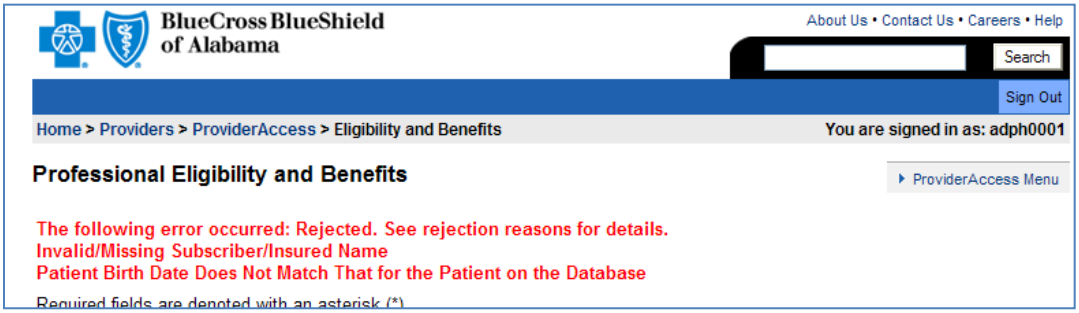


11. Select "Eligibility and Benefits". Note: Provider Information will display above



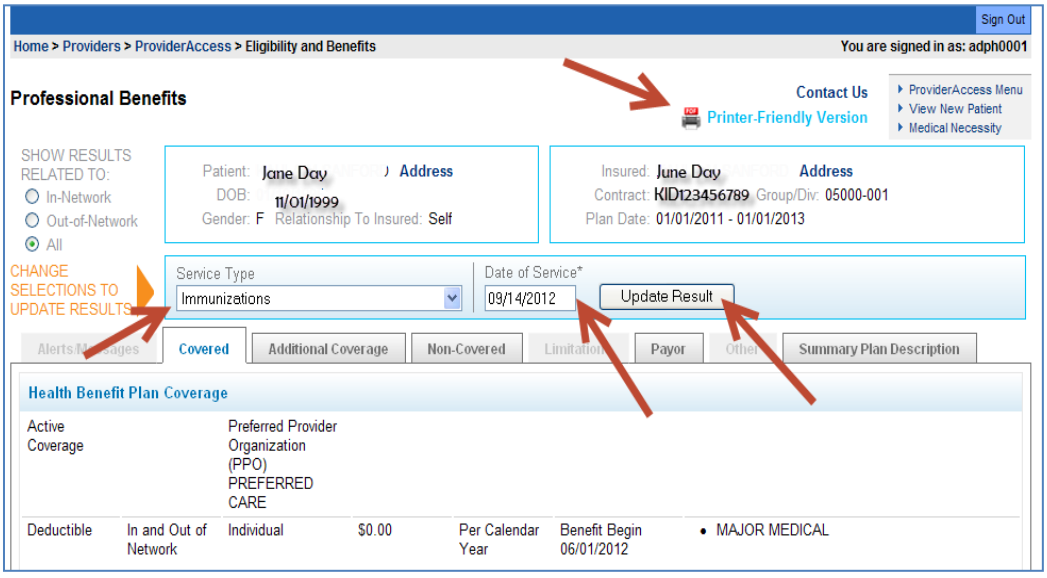
12. Enter required fields as indicated above.

- Press Submit key for eligibility information.
- Message will appear to "Please wait while we process your request."
- If information needs correcting, you may press "Reset" to clear all the fields and start over.



13. If Eligibility information is incorrect or unavailable, a message will appear to indicate the reason information was not found.
    - For example:
        - Invalid Missing Insured\Subscriber
        - Invalid Date of Birth

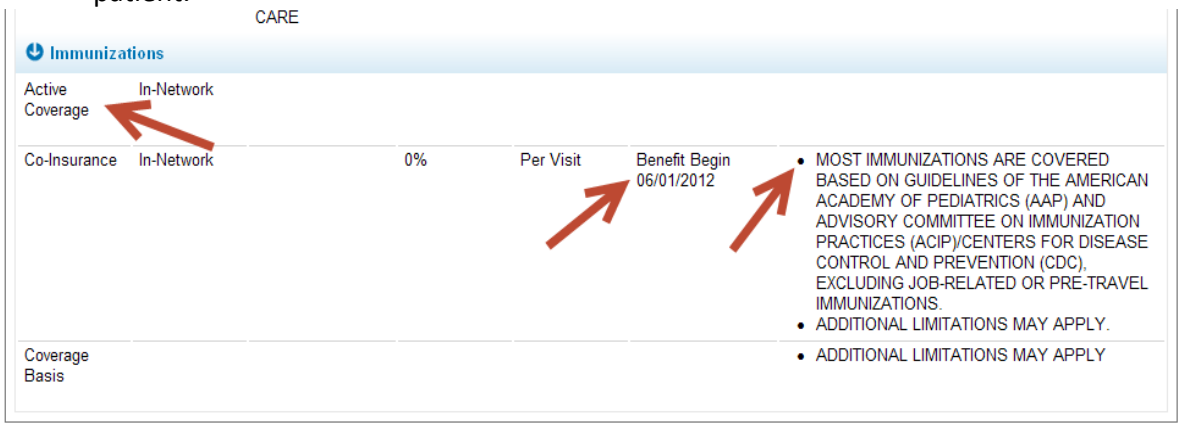
Navigating the BC\BS Eligibility Page



14. Change Service Type to "Immunizations" in the drop down box.
    - Change Date of Service, as needed.
    - Press Update Results to get screen with Immunization information.
    - The next screen will provide valuable information on the patient's coverage.
    - Plan Dates (above) show range of eligibility dates for BC/BS Eligible patients.

- **Note:** The Printer Friendly Version button is available for printing. Caution this prints multiple pages and you may only want to print page 1.

- **Note:** On left of the screen you may select "View New Patient" to search for another eligible patient.


CARE

Immunizations

Active Coverage	In-Network					
Co-Insurance	In-Network		0%	Per Visit	Benefit Begin 06/01/2012	• MOST IMMUNIZATIONS ARE COVERED BASED ON GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRICS (AAP) AND ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP)/CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), EXCLUDING JOB-RELATED OR PRE-TRAVEL IMMUNIZATIONS. • ADDITIONAL LIMITATIONS MAY APPLY.
Coverage Basis						• ADDITIONAL LIMITATIONS MAY APPLY

UNLESS OTHERWISE REQUIRED BY STATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBER'S STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLE MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED.

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- For Immunization services – Coverage shows Active.
- Benefit Begin period shows date of 06/01/2012
- Please note:
  MOST IMMUNIZATIONS ARE COVERED BASED ON GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRICS (AAP) AND ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP)/CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC), EXCLUDING JOB-RELATED OR PRE-TRAVEL IMMUNIZATIONS.

- If the county is able to verify the insurance coverage, print the page of eligibility verification, or make a copy of the verification screen and put it in the medical record.
- The Printer Friendly Version button is available for printing. Caution this prints multiple pages and you may only want to print page 1, since most information is on that sheet.
- Printing of the information can be accomplished by selecting "File", then "Print" on the Menu Toolbar. You may also select the printer icon on the left hand side of the screen.
- Health Finance will attempt billing for all eligible services (except those indicated as non-covered (see APPENDIX A)

15. Upon entry of the encounter into PHALCON, Health Finance will pull the applicable data for billing. Counties will be notified regarding payment or denial of the claim. If denied, the county is to go back and charge the patient for the immunization as appropriate.

APPENDIX A – Valid Insurance Prefix Codes

Insurance Prefix	**State**	**Description**
AYK	Alabama	
BEK	Alabama	
BGT	Alabama	
BLU	Alabama	
CGC	Alabama	
CNB	Alabama	
EBI	Alabama	
EDU	**Alabama**	**Not on School Location**
EIB	Alabama	SEIB
FBI	Alabama	
FRV	Alabama	
GEN	Alabama	
GEP	Alabama	
GPT	Alabama	
GSW	Alabama	
GYRAN	Alabama	*NON-COVERED *
GZF	Alabama	
HYN	Alabama	*Hyundai

IAR	Alabama	
IBU	Alabama	
IEV	Alabama	
INT	Alabama	
IPP	Alabama	
KID	Alabama	CHIP
LAB	Alabama	
LGB	Alabama	Local Government Plan
LWE	Alabama	
MBG	Alabama	Medicare Blue Advantage
NPT	Alabama	
NTU	Alabama	
NYS	Alabama	
PPA	**Alabama**	
PSS	Alabama	
R	Alabama	"R" with 8 digits
RGN	Alabama	
SCY	Alabama	
SEH	Alabama	
SLY	Alabama	
SSS	Alabama	
SYF	Alabama	

Insurance Prefix	State	Description
TCA	Alabama	
TEL	Alabama	
TEU	Alabama	
TIL	Alabama	
TON	Alabama	
TTI	Alabama	
UCN	Alabama	
VMC	Alabama	
WCV	Alabama	
WLA	Alabama	
WMR	Alabama	
WVR	Alabama	
XAA	**Alabama**	
XAC	Alabama	
XAD	**Alabama**	**DENTAL ONLY - Check XAA or PPA**
SURROUNDING STATES		
Insurance Prefix	**State**	**Description**
BDV	Georgia	
CIG	Georgia	
CKL	Georgia	
EOC	Georgia	

SURROUNDING STATES		
Insurance Prefix	**State**	**Description**
FOM	Georgia	
GEL	Georgia	
IMF	Georgia	
KCE	Georgia	
NDZ	Georgia	
NFB	Georgia	
NLJ	Georgia	
PKI	Georgia	
PYU	Georgia	
RIL	Georgia	
TQX	Georgia	
TYH	Georgia	
UBS	Georgia	
WJT	Georgia	
XKA	Georgia	
XKC	Georgia	
SLL	Georgia	
MPA	Mississippi	
YAG	Mississippi	
YAS	Mississippi	
YAQ	Mississippi	

SURROUNDING STATES		
Insurance Prefix	**State**	**Description**
CHH	Tennessee	
KPH	Tennessee	
EXX	Tennessee	
EYS	Tennessee	
FRZ	Tennessee	
KSW	Tennessee	
KSZ	Tennessee	
MKE	Tennessee	
NMU	Tennessee	
PVF	Tennessee	
RCF	Tennessee	
TRH	Tennessee	
TRR	Tennessee	
TVA	Tennessee	
UVB	Tennessee	
ZEB	Tennessee	Blue Advantage PFFS
ZEG	Tennessee	
ZEH	Tennessee	
ZXL	Tennessee	
ZXW	Tennessee	

WIC

WIC is the Special Supplemental Nutrition Program for Women, Infants and Children to 5 years of age. There are no fees charged to participants receiving WIC services. Proof of income, identity and residence are required for each applicant in order to assess eligibility. A nutrition assessment is performed by the nutritionist/nurse to determine participation. See instructions regarding income eligibility assessment and procedures for documentation on the Patient Registration/Income Assessment Form, CHR-2, earlier in this chapter.

COMMON QUESTIONS AND ANSWERS

WIC

Question: Are WIC participants charged for non-WIC services (such as immunizations, well child visits, etc.)?

Answer: Yes. Do not charge for any WIC services. A WIC participant can be referred to another program for services and charged accordingly.

Question: When completing an Income Assessment for a WIC applicant who receives SNAP or Family Assistance benefits, should the clerk ask to see proof of participation in SNAP or Family Assistance?

Answer: Yes. The WIC applicant must provide proof of participation in SNAP or Family Assistance. In addition, the applicant must give/state a self declared annual income. No proof is required for self declared income. The clerk enters the self declared income on the ADPH-CHR 2.

COMMON QUESTIONS AND ANSWERS

WAIVING FEES

Question: Is there any provision for waiving or reducing a fee (especially a flat fee) in certain circumstances such as with elderly patients?

Answer: Yes. Use the Special Circumstances section of the Income Assessment to justify waiving or reducing a fee. The employee making the decision must write a short explanation on the Income Assessment explaining why, and initial it with a supervisor. If there is no patient CHR, establish one. Note: This answer pertains to mainly clinic fees. There is no provision for waiving or reducing vital record fees since these fees are set by law.

CHAPTER 5

ENVIRONMENTAL SERVICES

Revised August 2013

ENVIRONMENTAL SERVICES

Environmental service fees are only charged in counties with local authority and approval. In those counties with such local authority and approval, all environmental services are charged on a flat fee basis (no sliding scale discounts). Environmental fees are not discounted based on income unless specifically allowed in the local county fee bill.

SCHEDULE OF PROPOSED ENVIRONMENTAL FEES

The schedule of proposed environmental fees is shown on pages 5-4, 5-5, 5-20, 5-21, 5-22, and 5-39. The schedule includes the following information for service:

- Service code
- Service description
- Recommended or proposed fee amount

The service codes are explained in detail on the pages numbers noted under each service description on the schedule. Each expanded service code includes the following information:

NOTE: The recommended fees are guidelines. In some cases, a range has been provided. The specific amount charged in each county may vary from one county to the next. This is dependent on the approving authority specified in the local fee bill. In some cases, the local board of health establishes the fees; in others, the county commission establishes the rates. ***Be sure to use the rate established by your local approving body.***

One-time fees: Service codes 500 to 635

A specific project which does not require periodic review would be subject to a one-time fee. An example would be a permit to install a sewage disposal system.

Annual fees: Service Codes 636 to 683

Annual fees are those fees billed on an annual basis to business establishments for a permit or license to continue their business activity for the following year. The establishments generally receive various services throughout the year.

Services provided by state level personnel: Service Codes 680 to 706

The services provided by state level personnel are of a specialized nature involving manufacturers or processing plants. The fee covers an annual permit or license to continue operations for the following year.

CERTIFICATION AND FEE INSTRUCTIONS

Environmental fees are charged, collected, recorded, and deposited in the same manner as clinic fees.

All employees who process environmental fees must be certified to handle cash.

Cash certification procedures are detailed in Chapter 8, County Depository Account.

For more information regarding environmental services, contact the Bureau of Environmental Services @ 334.206.5373.

ENVIRONMENTAL SERVICES

SCHEDULE OF PROPOSED FEES

ONE-TIME FEES
SERVICE CODE 500 – 635

ALABAMA DEPARTMENT OF PUBLIC HEALTH FEE SYSTEM MANUAL

SCHEDULE OF PROPOSED ENVIRONMENTAL FEES

FOR COUNTY HEALTH DEPARTMENTS WITH LOCAL FEE BILLS

ONE-TIME FEES

SERVICE CODE	SERVICE DESCRIPTION	RECOMMENDED FEE	COUNTY SPECIFIC FEE
500	**Application for Site Evaluation**: Individual dwelling, small-flow conventional system (County with approved site evaluation program)	$150 - $250	
502	**Application for OSS Permit – Dwelling**: Conventional small-flow system	$100 - $200	
504	**Application for OSS Permit – Dwelling**: Engineered small-flow system	$100 - $200	
506	**Application for OSS Permit – Dwelling**: Engineered small-flow advanced treatment system	$100 - $200	
508	**Application for OSS Permit – Dwelling**: Engineered large flow system	$200 - $300	
510	**Application for OSS Permit – Dwelling**: Engineered large flow advanced treatment system	$200 - $350	
512	**Application for OSS Permit – Establishment:** Conventional, small-flow system	$100 - $200	
514	**Application for OSS Permit – Establishment**: Engineered small-flow system	$100 - $200	
516	**Application for OSS Permit – Establishment**: Engineered small-flow advanced treatment system	$200 - $350	
518	**Application for OSS Permit – Establishment**: Engineered large flow system	$300 - $375	
520	**Application for OSS Permit – Establishment**: Engineered large flow advanced treatment system	$300 - $400	
616	**Preparation of Loan Forms**	$30	
618	**Private Water Consultation**	$15	
619	**Water Sample** (Collection/Field Trip)	$30 - $50	

The county cannot use a "range" on their local fee schedule. They must adopt a specific amount to charge for the environmental services offered.

SCHEDULE OF PROPOSED ENVIRONMENTAL FEES

FOR COUNTY HEALTH DEPARTMENTS WITH LOCAL FEE BILLS

ONE-TIME FEES

SERVICE CODE	SERVICE DESCRIPTION	RECOMMENDED FEE	COUNTY SPECIFIC FEE
620	**Part 1: Preliminary Large Flow Development** Review	$75 - $100	
621	**Part 2: Large Flow Development** Site Visit and Field Review	$150+	
622	**Part 3: Final Large Flow Development** Review	$50 - $100	
623	**Certification of Existing and Previously Approved System**	$50 - $100	
624	**Inspection of Existing Systems for Loan Applications** (includes excavation)	$200 - $300	
625	**Temporary License for Body Art Facility** (Required by Act No. 321-2000)	$50	$50
626	**Cemetery Review**	$75 - $100	
627	**Temporary Body Art Operator's Permit**	$25 - $50/person	
630	**Plumbing Inspection and Permit**	$50 - $75	
631	**Temporary Food Service**	$10/day, minimum $30	
632	**Plan Review** for Commercial Establishment	$50 - $100	
633	**For Future Use**		
634	**Food Handler's Permit** (where program exists)	$10/person	
635	**Record Search** for permits, records of inspection or permit application	$5 + copies of files	

Fee codes/descriptions listed in "green" are authorized in all counties.

The county cannot use a "range" on their local fee schedule. They must adopt a specific amount to charge for the environmental services offered.

Service Code 500
Application for Site Evaluation - Individual Dwelling
Small-Flow Conventional System

Description: Evaluation of site conditions includes a visit to site for soil test and other appropriate activities and may include evaluation of tests and reports prepared by a Certified Site Evaluator (Public Health Environmental 5-5 Site Specialist). A Certified Site Evaluator is a special title applied to certified public health environmentalists. Application for Site Evaluation applies only to conventional small flow onsite sewage systems for individual dwellings or commercial systems.

Procedure: All clients are charged a flat fee prior to receiving services. Fee must be submitted with application. This does not include application for Permit to Install. **Permit to install is issued under Service Code 502 for a dwelling or Service Code 512 for a commercial establishment.** A fee is paid even if site fails inspection. This service applies only to counties with an approved Site Evaluation Program.

Amount of Charge: Flat fee of $150 - $250
(Return to top)

Local Fee Amount

Service Code 502
Application for Onsite Sewage System Permit - Individual Dwelling
Conventional Small-Flow System

Description: A permit is issued to property owner for installation of a conventional sewage disposal system for a single family dwelling up to 1,200 gallons per day. Usually 1 to 2 visits are made to site for inspection prior to system approval.

Procedure: All clients are charged a flat fee per application. Fee is submitted with application before it can be processed. No refund is given if the site is disapproved. However, a new application and fee are required for re-submittal as the fee relates to a specific site. If site is changed, a new application and fee are required. Client may be given an approval or disapproval to install the system after site visit with a **Permit to Install (Repair) an Onsite Sewage Disposal System (Form ADPH CEP-4 pg.1/Rev.05/2004).** After system is installed and regulations met, the client is issued the **Approval for use of an Onsite Sewage Disposal System (Form ADPH CEP-4 pg.3).**

Amount of Charge: Flat fee of $100 - $200
(Return to top)

Local Fee Amount

Service Code 504
Application for Onsite Sewage System Permit – Individual Dwelling
Engineered Small-Flow System

Description: A permit is issued to property owner for the installation of an engineered sewage disposal system for a single family dwelling. Usually 1 to 2 visits are made to the site for inspection prior to system approval.

Procedure: All clients are charged a flat fee per application. Fee is submitted with application before it is processed. No refund is given if the site is disapproved. However, a new application and fee are required for re-submittal as the fee relates to a specific site. If site is changed, a new application and fee are required. Client may be given a **Permit to Install** or **Disapproval to Install** after the site visit. After the system is installed and regulations met, the client is issued approval to use the system.

Amount of Charge: Flat fee of $100 - $200
(Return to top)

Local Fee Amount

Service Code 506
Application for Onsite Sewage System Permit – Individual Dwelling
Engineered Small-Flow Advanced Treatment System

Description: A permit is issued to property owner for the installation of an engineered advanced treatment sewage disposal system for a single family dwelling. Usually 1 to 2 visits are made to the site for inspection prior to the system being approved.

Procedure: All clients are charged a flat fee per application prior to receiving permit. Fee is submitted with application before it is processed as the fee is for reviewing the application. No refund is given even if permit cannot be approved. However, a new application and fee are required for re-submittal. A public health environmentalist must determine if application is engineered. If system is experimental, the environmentalist must coordinate with the state level environmental staff before a decision is rendered and application is approved.

Amount of Charge: Flat fee of $100 - $200
(Return to top)

Local Fee Amount

Service Code 508
Application for Onsite Sewage System Permit – Dwelling
Engineered, Large-Flow System

Description: A permit is issued to individual property owner for installation of an engineered sewage disposal system of more than 1, 200 gallons per day. Usually 1 to 2 visits are made to site for inspection before system approval.

Procedure: All clients are charged a flat fee per application. The fee must be submitted with application before it is processed. No refund is given if site is disapproved. However, a new application and fee are required for re-submittal. Fee relates to a specific site. If site is changed, a new application and fee are required. Client may be given **Permit to Install** or a **Disapproval to Install** after site visit. After the system is installed and regulations met, client will be issued approval to use onsite sewage system.

Amount of Charge: Flat fee of $200 - $300
(Return to top)

Local Fee Amount

Service Code 510
Application for Onsite Sewage System Permit – Dwelling
Engineered, Large-Flow Advanced Treatment System

Description: A permit is issued to individual property owner for installation of an engineered sewage disposal system of more than 1,200 gallons per day. Usually more than 2 visits are made to site for inspection before system approval.

Procedure: All clients are charged a flat fee per application prior to receiving permit. The fee must be submitted with application before it is processed. No refund is given if site is disapproved. However, a new application and fee are required for re-submittal. Fee relates to a specific site. If site is changed, a new application and fee are required. Client may be given a **Permit to Install** or a **Disapproval to Install** after site visit. After the system is installed and regulations met, client will be issued approval to use onsite sewage system.

Amount of Charge: Flat fee of $200 - $350
(Return to top)

Local Fee Amount

Service Code 512
Application for Onsite Sewage System Permit – Commercial Establishment
Conventional, Small-Flow System

Description: A permit is issued to commercial property owner for installation of a conventional small-flow sewage disposal system of 1,200 gallons or less per day of sewage. Usually 1 to 2 visits are made to site for inspection before system is approved.

Procedure: All clients are charged a flat fee per application. Fee is submitted with application before it can be processed. No refund is given if site is disapproved. However, a new application and fee are required for re-submittal. Fee relates to a specific site. If site is changed, a new application and fee are required. Client is given a **Permit to Install** or a **Disapproval to Install** after site visit. After the system is installed and regulations met, client will be issued the approval to use onsite sewage system.

Amount of Charge: Flat fee of $100 - $200
(Return to top)

Local Fee Amount

Service Code 514
Application for Onsite Sewage System Permit – Commercial Establishment
Engineered, Small-Flow System

Description: A permit is issued to commercial property owner for installation of an engineered small-flow onsite sewage disposal system of 1,200 gallons or less per day. Usually 1 to 2 visits are made to site for inspection before system approval.

Procedure: All clients are charged a flat fee per application. Fee must be submitted with application before it is processed. No refund is given if site is disapproved. However, a new application and fee are required for re-submittal as fee relates to a specific site. If site is changed, a new application and fee are required. Client may be given a Permit to install or a Disapproval to install after site visit. After the system is installed and regulations met, client is issued approval to use onsite sewage system.

Amount of Charge: Flat Fee of $100 - $200
(Return to top)

Local Fee Amount

Service Code 516
Application for Onsite Sewage System Permit – Commercial Establishment
Engineered, Small-Flow Advanced Treatment System

Description: A permit is issued to commercial property owner for installation of an engineered advanced treatment small-flow onsite sewage disposal system of 1,200 gallons or less per day. Usually more than 2 visits are made to site for inspection before system approval.

Procedure: All clients are charged a flat fee per application. Fee must be submitted with application before it is processed. No refund is given if site is disapproved. However, a new application and fee are required for re-submittal as fee relates to a specific site. If site is changed, a new application and fee are required. Client may be given a Permit to install or a Disapproval to install after site visit. After the system is installed and regulations met, client is issued approval to use onsite sewage system.

Amount of Charge: Flat Fee of $200 - $350
(Return to top)

Local Fee Amount

Service Code 518
Application for Onsite Sewage System Permit – Commercial Establishment
Engineered, Large-Flow System

Description: A permit is issued to a commercial property owner for installation of an engineered large-flow sewage disposal system of more than 1,200 gallons per day. Usually more than 2 visits are made to site for inspection before system approval.

Procedure: All clients are charged a flat fee per application. The fee must be submitted with application before it is processed. No refund is given if site is disapproved. However, a new application and fee are required for re-submittal. Fee relates to a specific site. If site is changed, a new application and fee are required. Client may be given **Permit to Install** or a **Disapproval to Install** after site visit. After the system is installed and regulations met, client will be issued approval to use onsite sewage system.

Amount of Charge: Flat fee of $300 - $375
(Return to top)

Local Fee Amount

Service Code 520
Application for Onsite Sewage System Permit – Commercial Establishment
Engineered Large-Flow Advanced Treatment System

Description: A permit is issued to a commercial property owner for installation of an engineered advanced treatment sewage disposal system of more than 1,200 gallons per day of high-strength waste or 4,000 gallons per day of sewage. Usually more than 2 visits are made to site for inspection before system approval.

Procedure: All clients are charged a flat fee per application prior to receiving permit. Fee is submitted with application before it is processed as the fee is for reviewing the application. No refund is given even if permit cannot be approved. However, a new application and fee are required for re-submittal. A public health environmentalist must determine if application is engineered. If system is experimental, the environmentalist must coordinate with the state level environmental staff before a decision is rendered and application is approved.

Amount of Charge: Flat fee of $300 - $400
(Return to top)

Local Fee Amount

Service Code 616
Preparation of Loan Forms

Description: Assistance in preparing application for a VA, FHA, conventional loan or a loan from any other lending institution. This service is provided for loans on approved systems, after the **Approval for Use of an Onsite Sewage Disposal System – Form ADPH-F-CEP-7** is issued.

Procedure: All clients are charged a flat fee before completion of loan forms. If more than one lending institution is involved, the client pays only $30 provided no field visits are involved at the time of the request. Example: The loan is through both VA and a bank. There are forms for both institutions. The client only pays $30.

Amount of Charge: Flat fee of $30.
(Return to top)

Local Fee Amount

Service Code 618
Private Water Consultation

Description: Water samples are collected by property owners or occupants and sent to the state laboratory for analysis. This service provides property owners with:

1. Instructions on how to collect the sample
2. A determination if the water supply is suitable for consumption
3. Instructions on how to disinfect water supply
4. Meeting the requirements of various lending institutions such as VA and FHA

Procedure: All clients (owners or occupants) are charged a flat fee at the time they are given water sample bottles. The owner or occupant may receive additional water sample bottles at no additional charge until a suitable sample result is obtained, if re-sampling is done within 30 days.

Public water supply systems requesting water sample bottles are not charged.

Amount of Charge: Flat fee of $15

Local Fee Amount

(Return to top)

Service Code 619
Water Sample
(Collection/Field Trip)

Description: Water samples are collected by environmental staff and submitted to the state laboratory for analysis.

Procedure: All clients (owners or occupants) are charged a flat fee at the time of the request. The property owner or occupant may receive additional water sample bottles at no additional charge until a suitable water sample is obtained, if re-sampling is done within 30 days. This service code applies to public and private water supplies.

Amount of Charge: Flat fee of $30 - $50

Local Fee Amount

(Return to top)

Service Code 620
Part 1: Preliminary Large Flow Development Review

Description: Review plans for a new development and advice property owners of the minimum approval standards.

Procedure: All clients are charged a flat fee per application prior to receiving preliminary development approval or disapproval. Fee is submitted with application before it can be processed.

Amount of Charge: Flat fee of $75 - $100

Local Fee Amount

(Return to top)

Service Code 621
Part 2: Large Flow Development Site Visit and Field Review

Description: Field review for site evaluation of each lot submitted.

Procedure: All clients are charged a flat fee per submitted lot. Fee is submitted with application before it can be processed.

Amount of Charge: A flat fee of $150 minimum and $10 per lot exceeding 10 lots as shown:

10 lot subdivision = $150 fee

For subdivision exceeding 10 lots:

(No. of total lots -10) x $10 +$150 = ___ fee

Local Fee Amount

(Return to top)

Service Code 622
Part 3: Final Large Flow Development
Final Review

Description: Report is issued to developer for final development approval or disapproval.

Procedure: All clients are charged a flat fee per application. Fee is submitted with application before it can be processed.

Amount of Charge: Flat fee of $50 - $100
(Return to top)

Local Fee Amount

Service Code 623
Inspection of Existing and Previously Approved System

Description: Inspect existing onsite sewage systems upon request. May require digging up system for inspection and evaluation if documentation of previous approval is not available. The public health environmentalist makes visit and evaluates existing conditions. If onsite system is uncovered, it is the responsibility of owner and is not included in certification fee.

Procedure: All clients are charged a flat fee prior to receiving evaluation documentation. Fee must be paid before inspection is made and no refund is given if an unfavorable evaluation is given or refusal to evaluate.

Amount of Charge: Flat fee of $50 - $100
(Return to top)

Local Fee Amount

Service Code 624
Inspection of Existing Systems
Without Previous Approval

Description: Inspect existing onsite sewage systems upon request. Usually requires digging up system for inspection and evaluation if evidence exists that onsite sewage system was installed without the issuance of a permit to install and/or an approval for use.

The public health environmentalist makes visit and evaluates existing conditions. If onsite system is uncovered, it is the responsibility of owner and is not included in certification fee.

Procedure: All clients are charged a flat fee prior to receiving evaluation documentation. The fee is paid before inspection is made and no refund is given if an unfavorable evaluation is given or a refusal to evaluate.

Amount of Charge: Flat fee of $200 - $300
(Return to top)

Local Fee Amount

Service Code 625
Temporary Body Art Facility License

Description: A health license is issued for all temporary body art facilities operating in the county. This temporary license is only good for 14 calendar days (two weeks) and all body art facilities must obtain an annual license within this period to continue operating in the county. All temporary body art facilities must be located in a permanent structure or facility.

Procedure: All clients are charged a flat fee per application before receiving license. Fee is submitted with application before it is processed. No charge for inspections.

Amount of Charge: Flat fee of $50, based on Act No. 321-2000
(Return to top)

This applies to all counties without regard to local fee bills.

Service Code 626
Cemetery Review

Description: Review proposal for cemetery including site visit and analysis of land and surrounding land use. The person requesting approval may have to provide back hoe pits or soil boring for observation by the public health environmentalist.

Procedure: All clients are charged a flat fee prior to receiving report from local health department. Fee is paid before inspection is made and no refund is given if recommendation for disapproval is issued. A new fee is charged for each proposal for cemetery review.

Amount of Charge: Flat fee of $75 - $100
(Return to top)

Local Fee Amount

Service Code 627
Application for Temporary Body Art Operator's Permit

Description: A health permit is required for anybody art operator in a temporary body art facility. This includes operators performing body art activities or any related practices. The temporary operator permit shall be valid from the date of issuance and shall automatically expire at the end of the temporary facility license unless revoked sooner by the Department.

Procedure: All clients are charged a flat fee per application before receiving permit. Fee is submitted with application before it can be processed. No charge for inspections.

Amount of Charge: Flat fee of $25 - $50 per person
(Return to top)

Local Fee Amount

Service Code 630
Plumbing Inspection and Permit

Description: Issue permit and inspect plumbing projects for compliance to regulations. This applies to counties with plumbing inspection programs only.

Procedure: All clients are charged a flat fee prior to receiving permit.

Amount of Charge: Flat fee of $50 - $75
(Return to top)

Local Fee Amount

Service Code 631
Temporary Food Service

Description: A health permit is required for all temporary food services operating in the county. This application is not applicable to food service, retail food store, limited food service, and mobile food units.

Procedures: All clients are charged a flat fee per application based on days of an event before receiving permit. Fee is submitted with application before it is processed. No charge for inspections.

Amount of Charge: Flat fee of $10/day up to 14 days with a minimum fee of $30.00 per application

Local Fee Amount

(Return to top)

Service Code 632
Plan Review for Commercial Establishment

Description: A review of plan or proposal for commercial establishment including public swimming pools, motels/hotels, food service establishments, camps, body art facilities, schools, day care centers, food processors, mobile units, commissaries, and other establishments for compliance with existing environmental regulations.

Procedures: All clients are charged a flat fee prior to receiving service. Fee is submitted with the plan.

Amount of Charge: Flat fee of $50 - $100

Local Fee Amount

(Return to top)

Service Code 633
[For Future Use]

Description:

Procedures:

Amount of Charge:
(Return to top)

Local Fee Amount

Service Code 634
Food Handlers Permit
(Where program exists)

Description: A permit is issued to individuals who work for food service or food processing establishments in positions where direct contact with food is required.

This is applicable to Mobile and Jefferson County only. There is no state requirement for such a fee.

Procedure: All clients are charged a flat fee per person prior to receiving permit/card.

Amount of Charge: Flat fee of $10 per person
(Return to top)

Local Fee Amount

Service Code 635
Record Search for Permits, Records of Inspections Or Permits Applications

Description: This service includes searching for and copying environmental records pursuant to a public records request or subpoena. Records may include written inspection sheets and/or letters regarding inspections, permits applied for or issued, and complaints received and/or investigated.

Subdivision plats are not copied.

Procedure: The copy fee is collected before the information is released. One fee is charged for each record of site, establishment or investigation. The fees are charged as noted below unless otherwise provided by law or rule.

Amount of Charge:

$5.00 retrieval fee
+$1.00 per page for the first 25 pages
+$0.50 per page beyond 25 pages

Local Fee Amount

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ENVIRONMENTAL SERVICES

SCHEDULE OF PROPOSED FEES

ANNUAL FEES

SERVICE CODE 636 – 683

Revised August 2013

SCHEDULE OF PROPOSED ENVIRONMENTAL FEES
FOR COUNTY HEALTH DEPARTMENTS WITH LOCAL FEE BILLS
ANNUAL FEES

SERVICE CODE	SERVICE DESCRIPTION	RECOMMENDED FEE	COUNTY SPECIFIC FEE
636	**Application for Sewage Tank Pumper Permit**	$50/truck; $100 minimum	
638	**Application for Septic Tank Series Manufacturer**	$150	
641	**Application for Solid Waste Transfer, and Processing Facilities Permit**	$150	
642	**Application of Public Swimming Pool Permit**	$75 - $100	
643	**Solid Waste Exception Permit: Individual Household** (Limited to $10 by Act No. 89-630)	$10	$10
644	**Solid Waste Collector Permit**	$100 minimum	
645	**Application for Land Application of Septage Permit**	$150 - $250	
646	**Application for Day Care Centers Permit** Adult and Child – 40 or Fewer Residents	$100	
647	**Application for Day Care Centers Permit** Adult and Child – More than 40 Residents	$200	
648	**Food Processor** Annual Gross Sales from $0 - $999,999	$200	
649	**Food Processors** Annual Gross Sales from $1,000,000 - $4,999,999	$300	
650	**Food Processors** Annual Gross Sales from $5,000,000 – $9,999,999	$500	
652	**Food Processors** Annual Gross Sales from $10,000,000 or more	$900	
653	**License for Body Art Facility** (based on Act 321-2000)	Initial $250 Renewal $200	Initial $250 Renewal $200
659	**Hotel and Motel** From 1 to 20 rooms	$100 - $150	
660	**Hotel and Motel** From 21 to 50 rooms	$200	

Fee codes/descriptions listed in "green" are authorized in all counties.

The county cannot use a "range" on their local fee schedule. They must adopt a specific amount to charge for the environmental services offered.

SCHEDULE OF PROPOSED ENVIRONMENTAL FEES
FOR COUNTY HEALTH DEPARTMENTS WITH LOCAL FEE BILLS
ANNUAL FEES

SERVICE CODE	SERVICE DESCRIPTION	RECOMMENDED FEE	COUNTY SPECIFIC FEE
662	**Hotel and Motel** 51 and more rooms	$250 + $10/room if over 80 rooms	
664	**Camp Facilities** 0 to 50 persons	$75	
666	**Camp Facilities** 51 or more persons	$75 +$1/person over 50; $500 maximum	
668	**Food Service Establishments** From 0 to 25 Seating	$75 - $100	
670	**Food Service Establishments** From 26 to 75 Seating	$150 - $200	
672	**Food Service Establishments** 76 or more seating spaces	$250 - 300	
667	**Food Service Establishment – Priority Category 1** (May be subdivided by seating spaces)	$50 - $100 (0-25 = $50) (25-75 = $75) (75 + = $100)	
669	**Food Service Establishment – Priority Category 2** (May be subdivided by seating spaces)	$100 - $200 (0-25 = $100) (25-75 = $150) (75 + = $200)	
671	**Food Service Establishment – Priority Category 3** (May be subdivided by seating spaces)	$125-$300 (0-25 = $125) (25-75 = $225) (75 + = $300)	
673	**Food Service Establishment – Priority Category 4** (May be subdivided by seating spaces)	$175 - $350 (0-25 = $175) (25-75 = $275) (75 + = $350)	

Select only one method of charging food service establishments.

The county cannot use a "range" on their local fee schedule. They must adopt a specific amount to charge for the environmental services offered.

SCHEDULE OF PROPOSED ENVIRONMENTAL FEES
FOR COUNTY HEALTH DEPARTMENTS WITH LOCAL FEE BILLS
ANNUAL FEES

SERVICE CODE	SERVICE DESCRIPTION	RECOMMENDED FEE	COUNTY SPECIFIC FEE
674	**Retail Food Stores** 2,500 square feet or less devoted to retail food store operations (not applicable to limited food store establishments)	$50 - $75	
676	**Retail Food Stores** more than 2,500 square feet devoted to retail food store operations (not applicable to limited food store establishments)	$150 - $200	
677	**Pushcarts or Mobile Units**	$50 - $75	
678	**Frozen Dessert Machine Operating Permit**	$100/machine	
681	**Late Penalty Fee Charge**	$25 - $50	
683	**Application for Body Art Operator's Permit**	$25 - $50/ person	

Service Code 636
Application for Sewage Tank Pumper Permit

Description: An annual health permit is required for each sewage tank pumper to operate in county. This includes operators of portable toilets, and grease trap and septic tank pumpers/cleaners. The environmentalist may include inspection of vehicles pumping equipment and specified disposal locations before issuing permit.

Procedure: All clients are charged a flat fee based on the number of trucks involved prior to receiving permit. Fee is submitted with application before it can be processed. No charge for inspections.

Amount of Charge: Flat fee of $50/truck; $100 minimum

Local Fee Amount

(Return to top)

Service Code 638
Application for Septic Tank Series Manufacturer Permit

Description: An annual health permit from the local health department is required for each septic tank/grease trap series manufactured or distributed by a manufacturer. A minimum of one inspection is required each year by the local health department.

Procedure: All clients are charged a flat fee for each application prior to receiving permit. Fee is submitted with application before it can be processed. One permit is issued for each sewage tank series.

Amount to Charge: Flat fee of $150 for each tank series

Local Fee Amount

(Return to top)

Service Code 641
Application for Solid Waste Transfer and Processing Facilities Permit

Description: An annual health permit is required for each county solid waste facility which include transfer station and solid waste processing facility to operate in the county.

Procedure: All clients are charged a flat fee for each application prior to receiving permit. Fee is submitted with application before it can be processed. No charge for inspections.

Amount of Charge: Flat fee of $150 per facility

Local Fee Amount

(Return to top)

Service Code 642
Application for Public Swimming Pool Permit

Description: An annual health permit is required for operation of each public swimming pool in the county.

Procedure: All clients are charged a flat fee for each application prior to receiving permit. A new application with associated fee is required annually or when a change in ownership or change of establishment name occurs. No charge for inspections.

Amount to Charge: Flat fee of $75 - $100

Local Fee Amount

(Return to top)

Service Code 643
Application for Solid Waste Exception Permit
Individual Household

Description: A permit is issued to property owner for private hauling of trash and garbage to a permitted landfill, or disposing of trash garbage onsite.

Procedure: All clients are charged a flat fee prior to receiving permit. Fee is submitted with application before it is processed. No refund is given if permit is not issued.

Amount of Charge: Flat fee of $10. Fee is limited to $10 by Alabama State Legislature Act No. 89-630 and applies to all counties.

This applies to all counties without regard to local fee bills.

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Service Code 644
Application for Solid Waste Collector Permit

Description: An annual health permit is issued by the local health department for each collector and hauler of solid waste containing garbage.

Procedure: All clients are charged a flat fee prior to receiving permit. Fee is submitted with application before it can be processed. One permit is issued per company, but fee is based on each truck operating in the county. A new application with associated fee is required annually or when a change in ownership or a change of establishment name occurs. No charge for inspections.

Amount to Charge: Flat fee of $50/truck; $100 minimum

Local Fee Amount

(Return to top)

Service Code 645
Application for Land Application of Septage Permit

Description: An application for annual permit is issued to property owner or applicant for land application of septage. This service requires a visit to site for evaluation before permit is issued. Permit is issued from the county health department only after a review of the initial application has been conducted by both the county and State Health Departments. The State Health Department is required to review the initial application in cases where the facility or processes have been modified or significantly altered. Application of permit renewals are not required to reviewed by the State Health Department if the facility or processes have not been modified or altered from the initial application.

Procedure: All clients are charged a flat fee prior to receiving permit. Fee is submitted with application before it is processed. No refund is given even if site is not permitted.

Amount of Charge: Flat fee of $150 - $250 per site

Local Fee Amount

(Return to top)

Service Code 646
Application for Day Care Center Permit
Adult & Child – 40 or Fewer Residents

Note: Currently not regulated by the health department. Day care food service is permitted and charged under applicable risk category.

Description: An annual permit is issued to operate day care center with 40 or fewer residents.

Procedure: All clients are charged a flat fee prior to receiving permit. Charge is to day care centers licensed by the Department of Human Resources (DHR) that prepare and serve food. Day care centers not licensed by DHR are not inspected. Church day care centers are **not** exempt from fee. No charge for inspections.

Amount to Charge: Flat fee of $100

Local Fee Amount

(Return to top)

Service Code 647
Application for Day Care Center Permit
Adult & Child – More than 40 Residents

Note: Currently not regulated by the health department. Day care food service is permitted and charged under applicable risk category.

Description: An annual health permit is issued to operate day care center with more than 40 residents.

Procedure: All clients are charged a flat fee prior to receiving permit. Charge is to day care centers licensed by the Department of Human Resources (DHR) that prepare and serve food. Day care centers not licensed by DHR are not inspected. Church run day care centers are not exempt from fee. No charge for inspections.

Amount of Charge: Flat fee of $200

Local Fee Amount

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Service Code 648
Food Processor
Annual Gross Sales of $0 - $999,999

Description: An annual health permit is issued for food processors with total annual sales of under $1,000,000. Food processor fees are separate from food service fees. This refers to a specific type operation such as bottling plants, bakeries, etc.

Procedure: All clients are charged a flat fee prior to receiving permit. Fee is submitted with application before it is processed. No charge for inspections. There is one fee per permit per year unless there is a change in name or ownership. By law, permits are not transferrable. Therefore, a new application for a permit would be issued for a fee.

Amount to Charge: Flat fee of $200

Local Fee Amount

(Return to top)

Service Code 649
Food Processor
Annual Gross Sales of $1,000,000 - $4,999,999

Description: An annual health permit is issued for food processors with total annual sales from $1,000,000 - $4,999,999.

Procedure: All clients are charged a flat fee prior to receiving permit. Fee is submitted with application before it is processed. Food processor fees are separate from food service fees. This refers to a specific type operation such as bottling plants, bakeries, etc. No charge for inspections. There is one fee per permit per year unless there is a change in name or ownership. By law, permits are not transferrable. Therefore, a new application for a permit would be issued for a fee.

Amount of Charge: Flat fee of $300

Local Fee Amount

(Return to top)

Service Code 650
Food Processor
Annual Gross Sales of $5,000,000 - $9,999,999

Description: An annual health permit is issued for food processors with total annual sales from $5,000,000 - $9,999,999.

Procedure: All clients are charged a flat fee prior to receiving permit. Fee is submitted with application before it is processed. Food processor fee is separate from food service fees. This refers to a specific type operation such as bottling plants, bakeries, etc. No charge for inspections. There is one fee per permit per year unless there is a change in name or ownership. By law, permits are not transferable. Therefore, a new application for a permit would be issued for a fee.

Amount to Charge: Flat fee of $500

Local Fee Amount

(Return to top)

Service Code 652
Food Processor
Annual Gross Sales of $10,000,000 or More

Description: An annual health permit is issued for food processor with total annual sales of $10,000,000 or more.

Procedure: All clients are charged a flat fee prior to receiving permit. Fee is submitted with application before it can be processed. Food processor fees are separate from food service fees. This refers to a specific type operation such as bottling plants, bakeries, etc. No charge for inspections. There is one fee per permit per year unless there is a change in name or ownership. By law, permits are not transferrable. Therefore, a new permit would be issued for a fee.

Amount of Charge: Flat fee of $900

Local Fee Amount

(Return to top)

Service Code 653
Body Art Facility License

Description: A health license is issued for all body art facilities operating in the county. This license is an annual license and all body art facilities must obtain the annual renewal license to continue operating in the county.

Procedure: All clients are charged a flat fee before receiving initial or renewal license. Fee is submitted with application before it is processed. There is one fee per application. No charge for inspections.

Amount to Charge:

Initial license =	flat fee of $250
Annual renewal license =	flat fee of $200

This applies to all counties without regard to local fee bills.

The fees are based on Act No. 321-2000 and apply to all counties.

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Service Code 659
Hotels and Motels
From 1 to 20 Rooms

Description: An annual health permit is required for all hotels and motels with 1 to 20 rooms.

Procedure: All clients are charged a flat fee per application prior to receiving permit. Fee is submitted with each application before it can be processed. There is one fee per permit application per year unless there is a change in ownership or name or establishment. By law, permits are not transferable. Therefore, a new application for a permit would be issued for a fee. No charge for inspections.

Amount of Charge: Flat fee of $100 - $150

Local Fee Amount

(Return to top)

Service Code 660
Hotels and Motels
From 21 to 50 Rooms

Description: An annual health permit is required for all hotels and motels with 21 to 50 rooms. A minimum of two inspections per year is required.

Procedure: All clients are charged a flat fee per application prior to receiving permit. Fee is submitted with application before it can be processed. There is one fee per permit application per year unless there is a change in ownership or name of establishment. By law, permits are not transferrable. Therefore, a new application for a permit would be required with a fee.

Amount to Charge: Flat fee of $200

Local Fee Amount

(Return to top)

Service Code 662
Hotels and Motels
51 or More Rooms

Description: An annual health permit is required for all hotels and motels with 51 or more rooms.

Procedure: All clients are charged a flat fee per application prior to receiving permit. Fee is submitted with application before it can be processed. There is one fee per permit application per year unless there is a change in ownership or name of establishment. By law, permits are not transferable. Therefore, a new application for a permit would be required with a fee.

Amount of Charge: Flat fee of $250 + $10/room for room count over 80 rooms

Local Fee Amount

(Return to top)

Service Code 664
Camp Facilities – Up to 50 Persons

Description: An annual health permit is required for all resident and day camps.

Procedure: All clients are charged a flat fee per application prior to receiving permit. Fee is submitted with each application before it is processed. There is one fee per permit application per year unless there is a change in ownership or name of establishment. By law, permits are not transferrable. Therefore, a new application for a permit would be required with a fee.

No charge for inspections. The application for a camp permit does not cover the application for food service.

Amount to Charge: Flat fee of $75

Local Fee Amount

(Return to top)

Service Code 666
Camp Facilities – 51 or More Persons

Description: An annual health permit is required for all resident and day camps.

Procedure: All clients are charged a flat fee per application prior to receiving permit. Fee is submitted with each application before it is processed. There is one fee per permit application per year unless there is a change in ownership or name of establishment. By law, permits are not transferable. Therefore, a new application for a permit would be required with a fee. No charge for inspections. The application for a camp permit does not cover the application for food service.

Amount of Charge: $75 flat fee for the first 50 people + $1/person over 50 people; maximum fee $500

Local Fee Amount

(Return to top)

Service Code 667
Food Service Establishment
Priority Category 1

Description: An annual health permit is required for all food service establishments rated as a "Priority Category 1 Food Establishment" as defined by Chapter 420-3-22 Food Rules.

Procedure: All clients are charged a flat fee for each application before receiving permit. Fee is submitted with application before it can be processed. A new application with associated fee is required annually or when a change in ownership, establishment name, or increase in Priority Category occurs. No charge for inspections.

Amount to Charge: Flat fee of $50 - $100
OR ---- flat fee based on seating spaces:

0 – 25 spaces = $50
25 – 75 spaces = $75
75 or more = $100

Local Fee Amount

(Return to top)

Service Code 668
Food Service Establishment
For 0 – 25 Seating Spaces

Description: An annual health permit is issued for all food service establishments with seating capacity of 25 or less.

Procedure: All clients are charged a flat fee before receiving permit. Fee is submitted with application before it can be processed. There is one fee per permit application per year unless there is a change in ownership or establishment name. By law, permits are not transferable. Therefore, a new application for a permit would be issued for a fee. No charge for inspections.

Amount of Charge: Flat fee of $75 - $100

Local Fee Amount

(Return to top)

Service Code 669
Food Service Establishment
Priority Category 2

Description: An annual health permit is required for all establishments rated as a "Priority Category 2 Food Establishment" as defined by Chapter 420-3-22 Food Rules.

Procedure: All clients are charged a flat fee for each application before receiving permit. Fee is submitted with application before it can be processed. A new application with associated fee is required annually or when a change in ownership, establishment name, or increase in Priority Category occurs. No charge for inspections.

Amount to Charge: Flat fee of $100 - $200
OR ---- flat fee based on seating spaces:

- 0 – 25 spaces = $100
- 25 – 75 spaces = $150
- 75 or more = $200

Local Fee Amount

(Return to top)

Service Code 670
Food Service Establishment
26 – 75 Seating Spaces

Description: An annual health permit is issued for all food service establishments with seating capacity from 26 to 75 spaces.

Procedure: All clients are charged a flat fee for each application before receiving permit. Fee is submitted with application before it can be processed. There is one fee per permit application per year unless there is a change in ownership. By law, permits are not transferrable. Therefore, a new application for a permit would be issued for a fee. No charge for inspections.

Amount of Charge: Flat fee of $150 - $200

Local Fee Amount

(Return to top)

Service Code 671
Food Service Establishment
Priority Category 3

Description: An annual health permit is required for all food service establishments rated as "Priority Category 3 Food Establishment" as defined by Chapter 420-3-22 Food Rules.

Procedure: All clients are charged a flat fee for each application before receiving permit. Fee is submitted with application before it can be processed. A new application with associated fee is required annually or when a change in ownership, establishment name, or increase in Priority Category occurs. No charge for inspections.

Amount to Charge: Flat fee of $200 - $300
OR ---- flat fee based on seating spaces:

- 0 – 25 spaces = $200
- 25 – 75 spaces = $250
- 75 or more = $300

Local Fee Amount

(Return to top)

Service Code 672
Food Service Establishment
76 or More Seating Spaces

Description: An annual health permit is issued for all food service establishments with a seating capacity of 76 or more.

Procedure: All clients are charged a flat fee per application before receiving permit. Fee must be submitted with application before it is processed. There is one fee per permit application per year unless there is a chance in ownership or establishment name. By law, permits are not transferrable. Therefore, a new application for a permit would be issued for a fee. No charge for inspections.

Amount of Charge: Flat fee of $250 - $300

Local Fee Amount

(Return to top)

Service Code 673
Food Service Establishment
Priority Category 4

Description: An annual health permit is required for all food service establishments rated as "Priority Category 4 Food Establishment" as defined by Chapter 420-3-22 Food Rules.

Procedure: All clients are charged a flat fee for each application before receiving permit. Fee is submitted with application before it can be processed. A new application with associated fee is required annually or when a change in ownership, establishment name occurs. No charge for inspections.

Amount to Charge: Flat fee of $300 - $400
OR ---- flat fee based on seating spaces:

- 0 – 25 spaces = $300
- 25 – 75 spaces = $350
- 75 or more = $400

Local Fee Amount

(Return to top)

Service Code 674
Retail Food Store – 2,500 Sq Ft or Less
Devoted to Retail Food Store Operations

Description: An annual health permit is required per application for all retail food stores with 2,500 square feet or less devoted to retail food store operations. Not applicable to limited retail food store establishments. Retail food store application and permit does not cover for other food operations such as Deli, Salad Bar, etc.

Procedure: All clients are charged a flat fee per application before receiving permit. Fee is submitted with application before it can be processed. There is one fee per permit application per year unless there is a change in ownership or establishment name. By law, permits are not transferrable. Therefore, a new application for a permit would be issued for a fee. No charge for inspections.

Amount of Charge: Flat fee of $50 - $75

Local Fee Amount

(Return to top)

Service Code 676
Retail Food Store – More than 2,500 Sq Ft
Devoted to Retail Food Store Operations

Description: An annual health permit is issued for all retail food stores with more than 2,500 square feet devoted to retail food store operations. Not applicable to limited retail food store establishments. Retail food store application and permit does not cover for other food operations such as Deli, Salad Bar, etc.

Procedure: All clients are charged a flat fee before receiving permit. Fee is submitted with application before it can be processed. There is one fee per permit application per year unless there is a change in ownership. By law, permits are not transferrable. Therefore, a new application for a permit would be issued for a fee. No charge for inspections.

Amount to Charge: Flat fee of $150 - $200

Local Fee Amount

(Return to top)

Service Code 677
Pushcarts or Mobile Units

Description: A health authorization is required to operate for all establishments classified as a "Mobile Food Establishment" as defined by Chapter 420-3-22 Food Rules.

Procedure: All clients are charged a flat fee before receiving Authorization to operate. Fee is submitted with application before it can be processed. One fee per unit per year is charged. Authorizations are not transferable. Therefore, a new application for authorization would be issued for a fee when there is a change in ownership or establishment name. No charge for inspections.

Amount of Charge: Flat fee of $50 - $75

Local Fee Amount

(Return to top)

Service Code 678
Application for Frozen Dessert Machine Operating Permit

Description: An application for annual permit is issued for the operation of a frozen dessert machine. Samplers are required for each frozen dessert product in a permitted food service or store operation.

Procedure: A client is charged a separate fee for each frozen dessert machine operating in the establishment prior to local health department accepting Food Service, Food Store, temporary food, or mobile unit permit application.

Amount to Charge: Flat fee of $100/machine

Local Fee Amount

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Service Code 681
Late Penalty Charge

Description: Annual permits are issued by a certain date. Fee and application must be received prior to issuance date. Late application requires letter or phone reminder to client.

Procedure: All clients with a previous year annual permit will be charged a late penalty charge for payment of fee for the upcoming year after its due date. Fee and late charge must be submitted before a late application for permit will be accepted.

Amount of Charge: Flat fee of $25 - $50

Local Fee Amount

(Return to top)

Service Code 683
Application for Body Art Operator's Permit

Description: An annual health permit is required for each body art operator to operate in county. This includes operators performing body art activities or any related practices. The operator permit shall be valid from the date of issuance and shall automatically expire at the end of the facility license year unless revoked sooner by the Health Department. Environmentalist usually inspects the facility and instruments used in operation of body art or tattooing services.

Procedure: All clients are charged a flat fee for each body art operator application prior to receiving permit. Fee is submitted with application before it can be processed.

Amount to Charge: Flat fee of $25 - $50/operator

Local Fee Amount

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ENVIRONMENTAL SERVICES

SCHEDULE OF FEES

STATE LEVEL

SERVICE CODE 680 – 706

Revised August 2013

SCHEDULE OF ENVIRONMENTAL FEES
FOR IMPLEMENTATION & USE BY STATE LEVEL PERSONNEL
STATE LEVEL FEES

SERVICE CODE	SERVICE DESCRIPTION	ESTABLISHED FEE
680	**Frozen Desserts Manufacturers** ***Act No. 93-718***	$250
686	**Alabama Milk Processors** ***Act No. 93-718***	$250
692	**Single Service Container Plants** ***Act No. 93-718***	$250
706	**Out of State Milk Processors** ***Act No. 93-718***	$250

Service Code 680
Frozen Dessert Manufacturers

Description: A health permit is issued for all frozen dessert manufacturers located in Alabama.

Procedure: All clients are charged a flat fee before receiving permit. Fee is submitted with application before is it processed. Fee does not apply to food service establishments. No charge for inspections. Permit is issued one time only and is permanent unless revoked.

Amount of Charge: Flat fee of $250

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This fee is set by Act No. 93-718.

Service Code 686
Alabama Milk Processor

Description: A health permit is issued for all Alabama milk processors in the state.

Procedure: All clients are charged a flat fee before receiving permit. Fee is submitted with application before it is processed. No charge for inspections. Permit is issued one time only and it permanent unless revoked.

Amount to Charge: Flat fee of $250

(Return to top)

This fee is set by Act No. 93-718.

Service Code 692
Single Service Container Plant

Description: A health permit is issued for all single service container plants in Alabama.

Procedure: All clients are charged a flat fee before receiving permit. Fee is submitted with application before it is processed. No charge for inspections. Permit is issued one time only and is permanent unless revoked.

Amount of Charge: Flat fee of $250
(Return to top)

This fee is set by Act No. 93-718.

Service Code 706
Out-of-State Milk Processors

Description: An annual health permit is issued for out-of-state milk processors who ship into Alabama.

Procedure: All clients are charged a flat fee before receiving permit. Fee is submitted with application before it is processed.

Amount to Charge: Flat fee of $250
(Return to top)

This fee is set by Act No. 93-718.

COMMON QUESTIONS AND ANSWERS

Question: Do we charge for re-inspection of food service establishments if the client fails the first inspection?

Answer: No. There is no charge for re-inspection. See Service Code 668, Food Service Establishment.

Question: Please clarify when the fee for water sample bottles should be collected.

Answer: The fee is for the entire service, not just for the bottle. The fee is collected at the time the client is given the bottle. If the environmentalist is going to take the sample for the client, the client must pay the fee before the sample is taken.

Question: Please clarify if there is any additional charge for actual sample testing.

Answer: No. Even if the environmentalist does the actual work, there is still only a one-time fee.

Question: Isn't the charge for water samples too high?

Answer: The charge is not too high. The fee covers the cost for the entire service. There are many occasions when the environmentalist must take resample and provide assistance to homeowners.

Question: If the person has made a mistake in obtaining a water sample which results in an unsatisfactory lab test, can we charge another fee for the second test?

Answer: No. The fee is a one-time fee which covers the cost of all necessary resample until satisfactory lab results are obtained. If the well becomes contaminated in the future and a new cycle of testing becomes necessary, the fee will be charged at the beginning of the new testing cycle.

Question: Is there a charge for temporary food service permits (such as carnivals, church bazaars, etc.)?

Answer: Not usually, unless your local Board of Health has approved a fee for this service.

CHAPTER 6

HEALTH STATISTICS SERVICES SERVICE CODE 802

Revised August 2013

HEALTH STATISTICS SERVICES

Health Statistics fees are collected for birth, death, marriage, and divorce certificates. Records are issued at county health departments using a printer/scanner networked to work the State Registrar's office

SCHEDULE OF PROPOSED FEES

- All Health Statistics record fees are collected under Service Code 802, Vital Records.

- Vital Records fees fall into two categories: **1st copy** **$15.00 each**
  2nd copy **$**

6.00 each

LOCAL ISSUANCE

- To issue a vital record at the county health department, a registrar must be
  - Nominated by an administrator, a health officer, or area clerical director
  - Approved by the State Registrar
  - Trained and certified by the Center for Health Statistics
  - Certified to handle cash

- Once a registrar from the county health department has been trained and certified, he/she may issue vital records and process death certificates. Appropriate fees must be collected at the time an application is accepted. Health Statistics fees are entered on the day sheet and deposited daily in the same manner as other fees.

For procedures regarding issuance of birth, death, marriage, and divorce certificates, refer to protocol in the Procedures Manual for County Issuance.

For procedures regarding the processing of death certificates, refer to the Handbook on Death Registration for Registrars.

DISTRIBUTION OF COLLECTED FEES

Once a month, Financial Services - Budget Office distributes the deposited health record fees between the county health department that collected the fees and the State Registrar. The fee distribution appears on the Consolidated Statement of Revenues and Expenditures Summary monthly report. The state- level fees are used to complete automation of the Center for Health Statistics' statewide issuance project. The fees are distributed as follows:

	1st Copy	2nd Copy
County Health Department	$6.25	$3.00
State Registrar	$8.75	$3.00
	$15.00	$6.00

CERTIFICATION AND FEE INSTRUCTIONS

- Health Statistics fees are charged, collected, recorded, and deposited in the same manner as clinic fees.
- All employees who process Health Statistics fees must be certified to handle cash.
- Cash certification procedures are detailed in Chapter 8, County Depository account.

For more information regarding the collection of Health Statistics fee, contact the Center for Health Statistics at 334-206-5426.

CHAPTER 7

FINANCIAL MANAGEMENT

Revised August 2013

COMPONENTS OF THE FEE SYSTEM

The Fee System is used to charge non-Medicaid clients for services. Additionally, it serves to document the receipt of all collections from other sources not receipted and deposited into another account. Brief descriptions of the components of the Fee System are provided below.

- **Change Fund** – The change fund is used for making change for clients who pay for their services with cash. The change fund in each county was established at the beginning of the Fee System, and was based on the needs of the county. The amount was determined by the administrator or office manager with the approval from Financial Services– Chief Accountant. The amount of the change fund may be adjusted based on needs of the county, with written approval from Financial Services– Chief Accountant. The amount of the Change fund must be reported to the Office of Program Integrity.

  Contact the Budget & Receipts Office or the Office of Program Integrity for specific procedures to increase or decrease the change fund in the county.

- ***Electronic Day* Sheet System** – The *E-Day* Sheet System is the automated version of the One-Write System. System advantages include pre-populated, customized fee schedules; calculated discounts for services, and legibility of day sheets. From one point of entry, the *E-Day* Sheet System generates the Prenumbered Receipt, the Client Ledger Record, the Day Sheet, and the Monthly Recap of Fees.

  A **Prenumbered Receipt** is generated by the system when the clerk enters the visit/service transaction. The receipt is given to the client at the time services are rendered. It reflects any previous balance, the gross amount (full fee amount) of the service, the net amount of the service (the gross amount less any applicable discounts), the amount paid, and the current balance.

  Client Ledger Record is an electronic record that tracks charges and payments for services rendered by the county health department. This internal record also shows the previous balance, voided transactions, and other adjustments to the client's financial record. The client ledger record should always reflect the current balance, which is also known as the accounts receivable balance.
  The **Day Sheet** is generated at the end of the day. It summarizes the transactions that occurred during the day. This document is necessary to balance the day's activity with the daily deposit.

- **One-Write System** – The One-Write System was the original charging and accounting process used when the Fee System was established. Although it was replaced by the E-Day Sheet System for routine, day-to-day operations, it still serves as the manual back up to the E-Day Sheet System and is to be used when the E-Day Sheet is unavailable. The One-Write System consists of three parts: the prenumbered receipt, the ledger card, and the day sheet. (NOTE: Carbon paper is often needed between the ledger card and the day sheet to improve legibility of the day sheet.)

  Prenumbered Receipts are written by the clerk on the date the visit/service is rendered and the receipt is given to the client. It reflects any previous balance, the gross amount (full fee amount) of the service, the net amount of the service (the gross amount less any applicable discounts), the amount paid, and the current balance.

  Client Ledger Card is a document that tracks charges and payments for services rendered by the county health department. It also reflects voided transactions and other adjustments to the client's accounts. The ledger card is filed in the client's medical record to serve as an accounts receivable record.

  The **(manual) Day Sheet** of the One-Write System is used to capture temporarily the financial transactions for each day the E-Day Sheet System is unavailable. When the E-Day Sheet System becomes available, the transactions posted on the One-Write (manual) day sheet must be entered into the E-Day Sheet System to update the accounts receivable records. This process also ensures the accuracy of the Monthly Recap of Fees that will be electronically transmitted to Health Finance.

- **Bank Account** – All collections from the Fee System are deposited into local banks into interest bearing accounts known as fee accounts (also referred to as a fee depository accounts). The county health department can only make deposits into the account. Health Finance – Budget and Receipts Office is responsible for withdrawals from the account. Bank statements are sent directly to Budget and Receipts Office, for reconciliation.

- **Monthly Recap of Fees** – The Monthly Recap of Fees is created by the E-Day Sheet System. At the end of the month, the county office manager, or designee, will create, print, and reconcile the report. After the report has been verified, the office manager, or designee, will submit the report to Financial Services-Budget & Receipts Office who reconciles the report with the bank statements.

SECURITY POLICY

Security of Cash Drawers/Change Fund

- All cash drawers should be maintained by the office manager/designee in a single, secure location, during non-business hours. The cash drawers should be retrieved and counted by employees at the start of each business day, and returned and counted at the end of each business day.
- If feasible, single drawer accountability should be maintained.

Daily Opening Process

- Employees responsible for collection of fees, and who have access to a "change fund," must count their starting funds to verify they are starting the day with the approved change fund amount. If multiple employees make change from the same fund, designate staff to verify the starting funds.
- A signed log (see example provided) or statement attesting to the starting balance should be completed.
- This statement should be forwarded to the office manager/designee and compared to the previous day's closing balance for that change fund to verify accuracy.

Change Fund/Cash Drawer Log				
Date/Time	**Received By/From**	**Amount**	**Verified By**	**Notes**
10/10/2013 8:00 AM	Debbie Smith	100.00	Kathy Green	N/A
10/10/2013 4:00 PM	Debbie Smith	100.00	Kathy Green	N/A

Daily Closing Process

- At the end of each day, the "change fund" must be counted to ensure the approved amount is on hand. ***Important Note:*** If fee collections did not occur, the change fund must still be counted for verification.
- A signed log or statement attesting to the ending balance should be completed.
- This statement should be forwarded to the office manager/designee.

Making Change for Cash Payments

- When a customer pays by cash, take the payment, but make change before placing the money into the cash drawer. This ensures that employees will know exactly what was given to them by the customer.
- Change must be counted back correctly to the customer. The count should be done twice, once silently as the employee takes it from the cash drawer, and a second time, aloud as the employee hands it to the customer.
- Cash drawer must never be left unattended.

CREDIT POLICY

It is Departmental policy to ask a client with an outstanding balance for payment when the client returns to the clinic for services. A client who cannot pay the entire outstanding amount should be encouraged to pay whatever towards the balance. Partial payments are accepted.

MEDICAL SERVICES CANNOT BE DENIED

- **Medical services cannot be denied based on inability to pay.**

PAYMENT MAY BE REQUESTED

If a client does not make an effort to pay the outstanding balance:

- **Stress the importance of fees for clinic operations, physicians' time, supplies, etc.**
- **Encourage the client to make a partial payment on the outstanding balance.**
- **If the client refuses to make payment, informs the client that:**
  - **current services will be provided**

ACCOUNTS RECEIVABLE WRITE-OFF POLICY

County Health Departments can establish account receivable records and attempt to collect amounts charged to patients for services provided under the Fee System.

Departmental Policy allows county health departments to write off uncollected balances of terminated patients. The concept behind processing aged accounts receivable reports and writing off dormant account balances is to provide an accurate accounts receivable report. Quarterly, it is necessary to adjust a client's account balance for the outstanding balance over 120 days that will not be collected. Page 8-18 provides instructions for writing off account balances manually of terminated patients in case the E-Day Sheet system is down. When the E-day Sheet system is available then follow the instruction in the E-Day Sheet System in Chapter 9.

Refer to the Electronic Day Sheet Users' Guide for Aging and Write off instructions.

CHECK/MONEY ORDER POLICY

When a check is received for services, be sure:

- **It is made payable to the Health Department.**
  - Do not accept two-party or payroll checks.
- **It is written for the correct amount.**
  - Excess amount will be posted as donation, excluding Option II payments.
- **Identification is presented with check**.
- **Current address and telephone number is on check.**
- **Make sure the client does not have history of bad checks.**
  - If two or more bad checks, request cash.
- **In order to restrictively endorse the back of the check write FOR DEPOSIT ONLY as soon as it is received.**
  - Each check must be listed on the deposit slip by name and amount.
  -When the payer listed on the check is different than the client's name on the day sheet, both names must be on the day sheet. For example, "Client/Mom's name" in the name column. If no CHR, # is used such as with Environmental and Health Statistics, both the CHR # column and the name column can be used.

RETURNED CHECKS AND OTHER ADJUSTMENTS POLICY

Returned checks are sent directly to the county health department from Financial Services-Budget & Receipts Office. An entry must be made on the Day Sheet using the One-Write System to add the unpaid charges back to the client's account. If the check can be redeposit, an entry must be made on the Day Sheet. The entry is necessary to make the collections on the Day Sheet agree with the deposit for the day.

If the check cannot be deposited again, it should be held in the client's medical record until the client returns to the clinic. When the client returns to the clinic, payment should be requested by cash or a cashier check. When payment is received on a check that has not been turned over to the local district attorney you will give the returned check to the client. As soon as the check is made good, a new receipt is made and recorded on the Day Sheet as payment on account. If the original bad check has been turned over to the local DA then the client must contact the local DA for resolution.

Refer to the Electronic Day Sheet Users' Guide for Return Check and Payment on Account instructions.

If the check is returned NOT PAID:

- **Add unpaid charges back to client's account**.
  - Make an entry on Day Sheet and Ledger card.
- **Post the returned check to Monthly Recap if electronic system is down**
  - On the date it was received from Financial Services-Budget & Receipts Office
- **If insufficient funds, redeposit check**.
  - Post entry on Day Sheet, Ledger Card, and Receipt
- **If the returned check cannot be deposited again:**
  - Hold in client's medical record for future collection and per policy number 2013-001 you must upon receipt of notice that payment has been refused by an account holder's bank, issue notice by certified mail to the account holder's address printed on the check. (See sample letter on page 7 - 9.) If payment has not been made upon the expiration of 10 days from the account holder's receipt of the certified mailed letter, forward the check and copy of the letter with the confirmation of the certified mail delivery to your local district attorney for criminal prosecution. A person who has presented an unresolved NSF check to the Department shall not be denied needed health services. However, non-health services such as environmental licenses or permits should not be provided to a person or entity who has issued an unresolved NSF check. Questions regarding these procedures may be directed to the Bureau of Financial Services at (334)206-5253.

- If you are unable to contact the client by certified mail, hold the returned check and contact the Bureau of Financial Services at (334) 206 - 5253 for instructions.
- If unable to contact by letter, hold returned check until client returns to clinic.
- When payment is received:

- Post on the Day Sheet, Ledger Card, and Receipt
  See example entry on page 9-20 thru 9-25.
- Give the returned check to client if it has not been turned over to the local DA. If the original bad check has been turn over to the local DA then the client must contact the local DA.

RETURNED CHECK NOTICE TO CLIENT

March 12, 2012

Mrs. Gloria Smith
1020 ABC Street
Anywhere, AL 35099

Dear Mrs. Smith:

SUBJECT: Outstanding Balance of $65
Patient: Janie Smith
CHR No. 1234567

On January 23, 2012, you made a payment for services received at the Anywhere County Health Department. Your check, in the amount of $65, has been returned from the bank as "NOT PAID" and cannot be deposit again.

Please make payment on this check with either cash or a cashier's check by March 25, 2012. If you have any questions, please contact office manager at telephone number 334-567-8900.

Sincerely,

Jane Doe, Administrator
Anywhere County Health Department

REFUND POLICY

It is the Department's policy to collect fees prior to rendering services. However, some instances may lend themselves to charging and collecting for the service after it has been provided.

If fees are collected and services are not provided, a refund may be given. Refunds can only be given when service cannot be provided. If service has been provided, no refund can be given.

CASH REFUND

A cash refund will be made only if the client paid cash. If the Day Sheet has been balanced and closed at the end of the day or if the deposit has already been made, a cash refund cannot be made.

CHECK/MONEY ORDER REFUND

If the original payment was in the form of check or money order, the refund is made by returning the check or money order. If the E-Day sheet (cash drawer) has been closed for that day, a refund can be made in the form of a field voucher.

SAME DAY REFUND

If patient requests refund before bank deposit is made and does not want to return for services at a future date:

- **Verify services were paid for and not provided.**
- **Obtain prenumbered receipt from client.**
- **Follow the instructions for the e-day sheet in Chapter 9 for voiding an entry. If the electronic system is unavailable void the entry on the Day Sheet, Ledger Card, and Receipt manually by doing the following:**
  - Draw one red line through Day Sheet entry.
  - Write "VOID" on the Day Sheet, Ledger Card, and Receipt in red ink.
  - Initial voided transaction in red ink.
  - Obtain initials of witness in red ink.
- **Staple Voided receipt to the back of the Day Sheet.**
  - If no receipt, provide explanation on the back of Day Sheet.
- **If payment is:**
  CASH, refund cash
  CHECK or MONEY ORDER, return to client.

If patient agrees to return for services at a future date:

- Refund may not be given and payment will stand.
- Make appointment for client.
- Document Patient Log in CHR or patient's receipt and clinical record.

REFUND AFTER DAY SHEET HAS BEEN CLOSED

If patient requests refund after day sheet has been closed and does not want to return for services at a future date:

- **Verify services were paid for and not provided**

- **Obtain prenumbered receipt from client.**

- **Verify check has cleared bank.**
  - Refunds are not given until check clears the bank.
  - It usually takes about 7-14 working days for check to clear the bank.

- **Prepare a Field Voucher (Form HF-2) with the following information:**
  - County Health Department name
  - Program name
  - Current date
  - Payee's name and address
  - Client's name
  - Date fee was paid
  - Specified paid service
  - Refund amount
  - Receipt number
  - CHR number
  - Brief explanation why refund is necessary
  - Mailing addresses for refund
  - Authorized signature

- **Attach a copy of Client's Receipt to HF-2**.
  - If no receipt, write explanation on HF-2.

- **Maintain a copy of the HF-2 and Client's Receipt.**

- **Mail HF-2 and Client's Receipt to:** Alabama Department of Public Health
  Financial Services – Budget & Receipts Office
  201 Monroe Street
  Montgomery, AL 36104-1701

- **The Budget & Receipts Office will process the HF-2 and a state warrant will be mailed directly to client, unless instructed otherwise.**

STATE OF ALABAMA
STATE HEALTH DEPARTMENT

FIELD VOUCHER

Date January 1, 1996

Anywhere Health Department

Immunization Program

To (Payee) Mary Doe

Address Route 1, Box 2

Anytown, Alabama (zip) 35123

Articles or Services (Itemized)	
Name: James Doe Address: Route 1, Box 2, Anytown, Alabama 35123 Date Fee Paid: December 23, 1999 Specific Service: Immunization Refund Amount: $20.00 Receipt Number: 098765 CHR Number: XXXXXX Ms. Doe paid $20.00 for her child's immunization and then the child did not receive the service due to a slight fever. She returned on January 1, 2000, and requested that her payment be refunded. The child was going to the doctor to get the immunizations. Ms. Doe has requested that the refund be sent to the Health Department office as she is having a problem with her mail being tampered with. She will pick the check up at this office.	$20.00
TOTA L	$20.00

I certify that the items listed on this voucher were purchased and received and/or Service performed in the official business of the Health Department and are approved for payment.

Jane Smith
AUTHORIZED SIGNATURE
Office Manager

Paid by
Voucher Number

A sample Field Voucher (HF-2)

CHAPTER 8

COUNTY DEPOSITORY ACCOUNT AND ONE-WRITE SYSTEM

Revised August 2013

COUNTY DEPOSITORY ACCOUNT

Cash control and certification procedures are applied to all bank accounts maintained and operated by the county health departments. Documentation to support monies collected in the county depository account must be available upon request for auditing purposes.

Example: *Fees collected for environmental services must have the receipt number, date, and amount collected cross-referenced to the application. This procedure also applies to Health statistics fees. Audit procedures will be applied to ensure compliance with security, authorization, recording, collecting, and processing requirements of all funds.*

A county depository account provides a checking account for fees and other local money for accumulation until it is transferred to the Financial Services-Budget & Receipts Office, who is responsible for monitoring the Fee Account, for monthly bank reconciliations and makes all withdrawals from the account.

Deposits include:

- **All fees collected for**
  - -ADSS/COA
  - - Clinic
  - - Environmental
  - - Health Statistics
  - - Home Health
  - - Immunization
- **Local appropriations from city, county, etc.**
- **Other payments**
  - - Except money required to be in a separate bank account such as Child Restraint Program rentals or deposits

ONE-WRITE SYSTEM (BACKUP SYSTEM TO E-DAY SHEET)

The One Write System is an efficient manual accounting system with built-in disciplines ***that is used as a backup to the E-Day Sheet***. It provides consistent recording, depositing, and reporting of collected fees. The system has three major component's Client's Prenumbered Receipt, Ledger Card, and Day Sheet.

Fees should be collected at the beginning of each visit. At intake, the clerk will complete the One-Write System.

The One-Write System:

- **records all moneys collected for services provided under the Fee System**
- **provides consistent recording of collected fees.**
- **provides consistent depositing of all collected fees.**
  - All funds are deposited in a local bank account daily.
- **is completed together with three major components:**
  - **Client's Prenumbered Receipt is:**
    Used when collecting fees for county depository account
    issued for all money collected
  - **Ledger Card is:**
    Completed on each client
    A record of all charges, payments, and balance
    Maintained in client's medical file
  - **Day Sheet is:**
    Completed daily for all business transactions
    Permanent accounting record for audit by:
    ADPH Office of Program Integrity,
    Area staff, and
    Alabama Department of Examiners of Public Accounts

CLIENT'S PRENUMBERED RECEIPTS

Prenumbered receipts are used when collecting fees for the county depository account. Always:

- **Issue a prenumbered receipt for all money collected.**
- **Account for all prenumbered receipts.**
- **Use the prenumbered receipts in numerical order.**
  - If a break in sequence occurs, note the reason.
  - A log must be maintained to document:
    - The numbers received from supply
    - The numbers dispersed
    - The date dispersed and
    - To whom dispersed
- **Retain all voided receipts.**
  - Mark VOID and staple the voided receipt to the back of the Day Sheet.
  - Do not put voided receipts in patient's folder.

After the receipt is completed on top of Ledger Card and Day Sheet, it is given to the client.

It provides the client with a record of:

- The type of visit
- Date of visit
- Client number (CHR number)
- Services provided
- Net charges
- Amount paid
- Current balance owed
- Appointment date

Each Client's Prenumbered Receipt is:

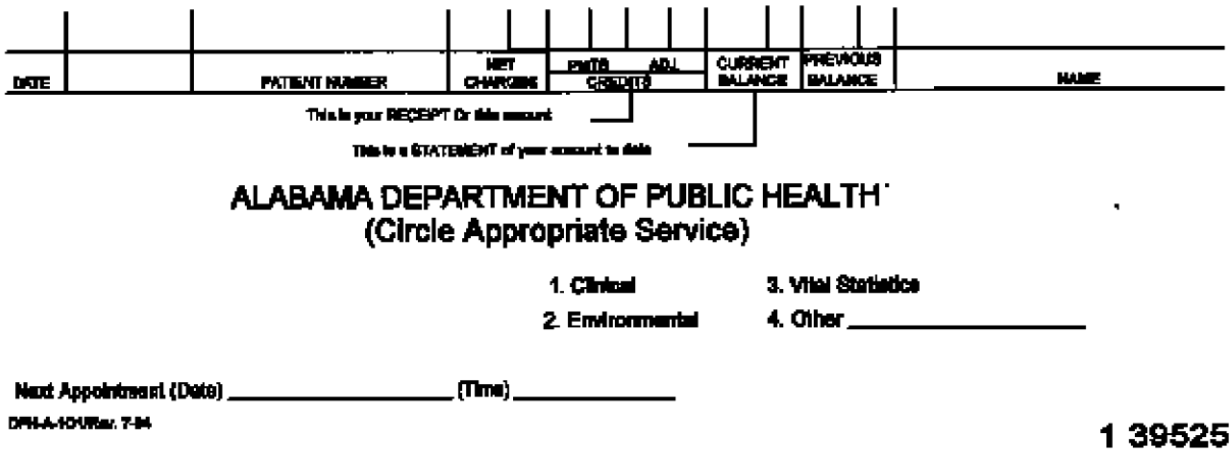
- Used when collecting fees for county depository account
- Issued for all money collected
- Used in numerical order
  - break in sequence, note reason
- Pre-numbered and carbonized
- Completed on each client with a ball point pen
- Placed on top of the Ledger Card and Day Sheet
- Removed from Day Sheet after all columns are posted
- Given to client after completed

CLIENT'S PRENUMBERED RECEIPT (Continued)

Client's Prenumbered Receipts (Form ADPH-A-101) may be requisitioned on an HF-60 from:

ADPH Warehouse Operations - Forms Unit
1635 Mitchell Young Road
Montgomery, AL 36108

An example client's receipt is shown below.



LEDGER CARD

A Ledger Card is placed between the Client's Prenumbered Receipt and Day Sheet. Carbon paper should be placed between the Ledger Card and Day Sheet so information will copy clearly.

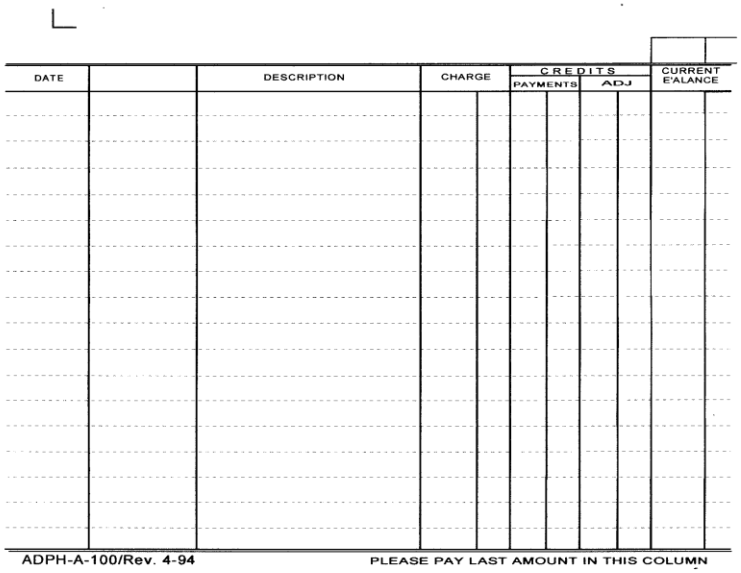
The Ledger Card is:

- Completed on each client
- Placed between the Client's Receipt and Day Sheet
- Carbon copy of client payment information
- A record of all charges, payments, and balance
- Maintained in client's medical file It should be securely placed in an envelope in back of the patient's CHR folder or where authorized, in an alphabetical file

Ledger Cards (Form ADPH-A-100) may be requisitioned on an HF-60 from:

ADPH Warehouse Operation - Forms Unit
1635 Mitchell Young Road
Montgomery, AL 36108

A Ledger Card sample is shown below.



DATE		DESCRIPTION	CHARGE	CREDITS PAYMENTS	CREDITS ADJ	CURRENT BALANCE

ADPH-A-100/Rev. 4-94 PLEASE PAY LAST AMOUNT IN THIS COLUMN

THIS IS A PHOTO COPY OF YOUR ACCOUNT AS IT APPEARS ON YOUR LEDOER CARD

DAY SHEET

The Day Sheet is a daily log of all moneys collected at the County Health Department for services provided under the Fee System.

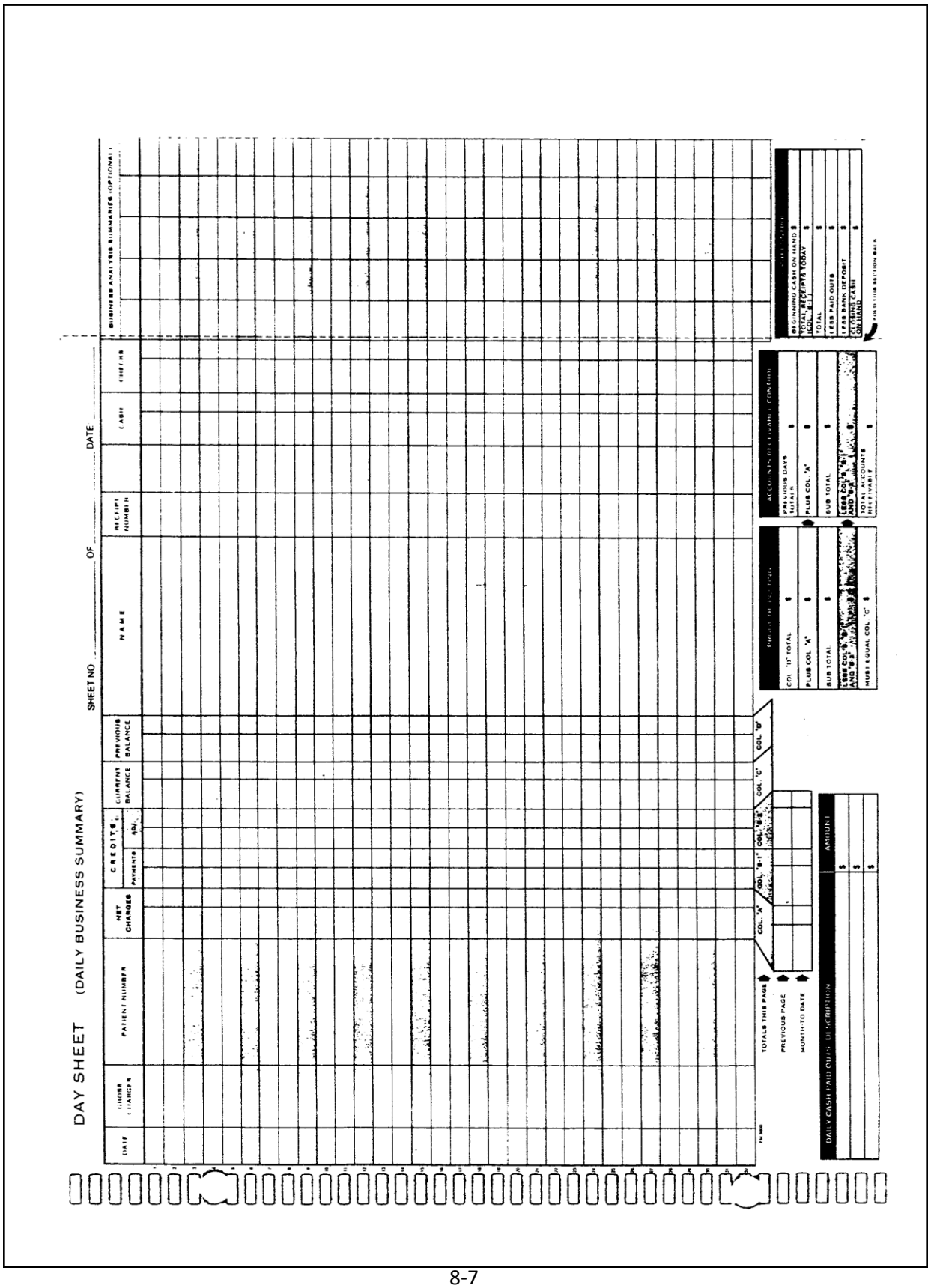
The Day Sheet is:

- Completed daily for all business transactions.
- Placed on the bottom of Ledger Card and Client's Prenumbered Receipt.
- Carbon copy of client payment information.
- Permanent accounting record for audit by:
  ADPH Office of Program Integrity,
  Area staff, and
  Alabama Examiners of Public Accounts
- Kept by date, month, and fiscal year for a minimum of 3 years or until audited by Alabama Department of Examiners of Public Accounts. Refer to ADHP's RDA for retention period and for update instructions.

Day Sheets (Form ADPH-A-102) may be requisitioned on an HF-60 form:

ADPH Warehouse Operations - Forms Unit
1635 Mitchell Young Road
Montgomery, AL 36108

A Day Sheet sample is shown on page 8-7.


DAY SHEET
(DAILY BUSINESS SUMMARY)
SHEET NO. _____ OF _____ DATE _____
DATE
PATIENT NUMBER
NAME
CREDITS
PAYMENTS
ADJ.
CURRENT BALANCE
PREVIOUS BALANCE
CASH
CHECKS
BUSINESS ANALYSIS SUMMARIES (OPTIONAL)
TOTALS THIS PAGE
PREVIOUS PAGE
MONTH TO DATE
COL. "A"
COL. "B"
COL. "C"
COL. "D"
DAILY CASH PAID OUT DISTRIBUTION
AMOUNT
ACCOUNTS RECEIVABLE CONTROL
PREVIOUS DAYS TOTAL
PLUS COL. "A"
SUB TOTAL
LESS COL. "B" AND "C"
TOTAL ACCOUNTS RECEIVABLE
MUST EQUAL COL. "D"
BEGINNING CASH ON HAND
TOTAL RECEIPTS TODAY (COL. "B")
TOTAL
LESS PAID OUTS
LESS BANK DEPOSIT
LESS PETTY CASH
CASH ON HAND

ONE-WRITE SYSTEM INSTRUCTIONS:

Place on Peg Board in the following order:

- Client's Prenumbered Receipt
- Ledger Card
- Carbon Paper
- Day Sheet

Top
↓
Bottom

Circle the services to be provided on the Client's Prenumbered Receipt:

1. Clinical
2. Environmental
3. Vital Statistics
4. Other _____

The following information should already be posted on the Ledger Card.

- **PATIENT'S NAME**
- **PATIENT'S ADDRESS**
- **PREVIOUS BALANCE BROUGHT FORWARD from other visits.**

Post the following information on Client's Prenumbered Receipt with carbon entries on the Ledger Card and Day Sheet:

- **DATE** of service and collection of money.
- **GROSS CHARGES** record gross charges for all family planning and other clinic services.
- **PATIENT NUMBER** (CHR Number without prefix) and name.
  If no CHR number, enter patient's entire name.
- **NET CHARGES**
  - Review last Income Assessment (CHR-2) for pay class.
  - Find pay class on Income Schedule for fee charge.
  - Post fee charge. It should be consistent with Service Code.
- **PAYMENTS** received for service.
  - Cash, check or money order
- **ADJUSTMENTS** for account receivable only.
- **CURRENT BALANCE** - Prior Balance + Net Charges - Payments + (-) Adjustments

Remove Ledger Card from Client's Prenumbered Receipt and Day Sheet.

ONE-WRITE SYSTEM INSTRUCTIONS (continued):

Post the following information on Client's Prenumbered Receipt with carbon copy entry on the Day Sheet:

- **PREVIOUS BALANCE,** Outstanding balance on client's ledger card before current transaction.
- **NAME**
  - If payment is cash, patient's name on CHR-2.
  - If payment is check or money order, payers name to match deposit slip.
  - If payer and patient are not the same, enter both names (Patient/Payer)

Post the following information directly on the Day Sheet

- **RECEIPT NUMBER** from Client's Prenumbered Receipt
- **SERVICE CODE** taken from fee schedule. Identifies service provided
- **CASH**, if received
- **CHECKS**, if received
- **BUSINESS ANALYSIS SUMMARIES SECTION**
  - **Family Planning** - Required to be reported separately due to program requirements. Service Codes 100-107
  - **Other Clinic** - All other clinical services other than Family Planning Service Codes 108 - 168 and 00110 - 09952
  - **Environmental Fees** - Environmental Services. Service Codes 600 - 706
  - **Health Statistics Fees** - Issuance of certified copies of vital records. Service Code 802
  - **Miscellaneous Receipts** - All other collections, appropriations, donations, and miscellaneous Home Health receipts

Remove the Client's Prenumbered Receipt from Day Sheet and give to client. For each client, repeat the One-Write Instructions.

ONE-WRITE SYSTEM INSTRUCTIONS (continued):

The Cash Control Section must be completed each day to

- reduce the change fund to the approved amount and
- prepare daily deposit.

ACTION	AMOUNT
Enter beginning cash on hand	$
Add total receipts today	+
Total	$
Less Paid Outs	
Less Bank Deposit	-
Closing Cash on Hand (must equal Change Fund)	$

CHANGE FUND

At the close of each business day, the change fund is reduced to the approved amount by depositing all funds in excess of the approved amount.

The change fund is used only for making change to clients who pay fees with cash.

- No borrowing
- No IOUs
- No cashing of check
- No purchases are paid from this account

The standard amount is $100.

- All new and adjusted change funds must be approved in writing by Financial Services – Chief Accountant and reported to the Office of Program Integrity.

ADJUSTMENTS

Adjustments are any transactions that affect the client's balance other than the assessment of fees for current services.

Anytime an entry is made on the Day Sheet, a client prenumbered receipt must be given.

The following type of transactions can be made on Day Sheet.

TRANSACTION	COLUMN ENTRY	
Returned check	Adjustments	*See Example later this chapter*
Write Off terminated client's account balance	Adjustments See *Example on Page*	*See Example later this chapter*
Redeposit on returned check	Payments	*See Example later this chapter*
Payment on account balance	Payments	*See Example later this chapter*
Adjustment for Overcharge or Undercharge	Net Charge Decreased Net Charge Increased	*See Example later this chapter*

ERROR CORRECTIONS

Error corrections are incorrect entries on the Day Sheet which you did not intend to make. For example, if you record money collected from the client in the Adjustments Column, an error has been made because the entry should have been placed in the Payments Column. Another type of error would be writing the wrong amount such as $10.00 instead of $12.00.

To make an error correction before the receipt is given to the patient:

- Draw one red line through the error on the Receipt, Ledger Card, and Day Sheet.
  Do not cross it out, white it out, write over it, or erase it.
- Write the correction in red ink on all documents.
- Initial the error in red ink on all documents.
- Obtain the initials of a witness in red ink on all documents.

If the error is discovered after the receipt is given to the patient,

- Draw one red line through the error on the Ledger Card (if applicable) and Day Sheet.
- Make the correction in red ink on both documents.
- Initial the error in red ink on both documents.
- Obtain the initials of a witness in red ink on both documents.

Illegible entries are treated as errors, follow the error correction procedures identified above.

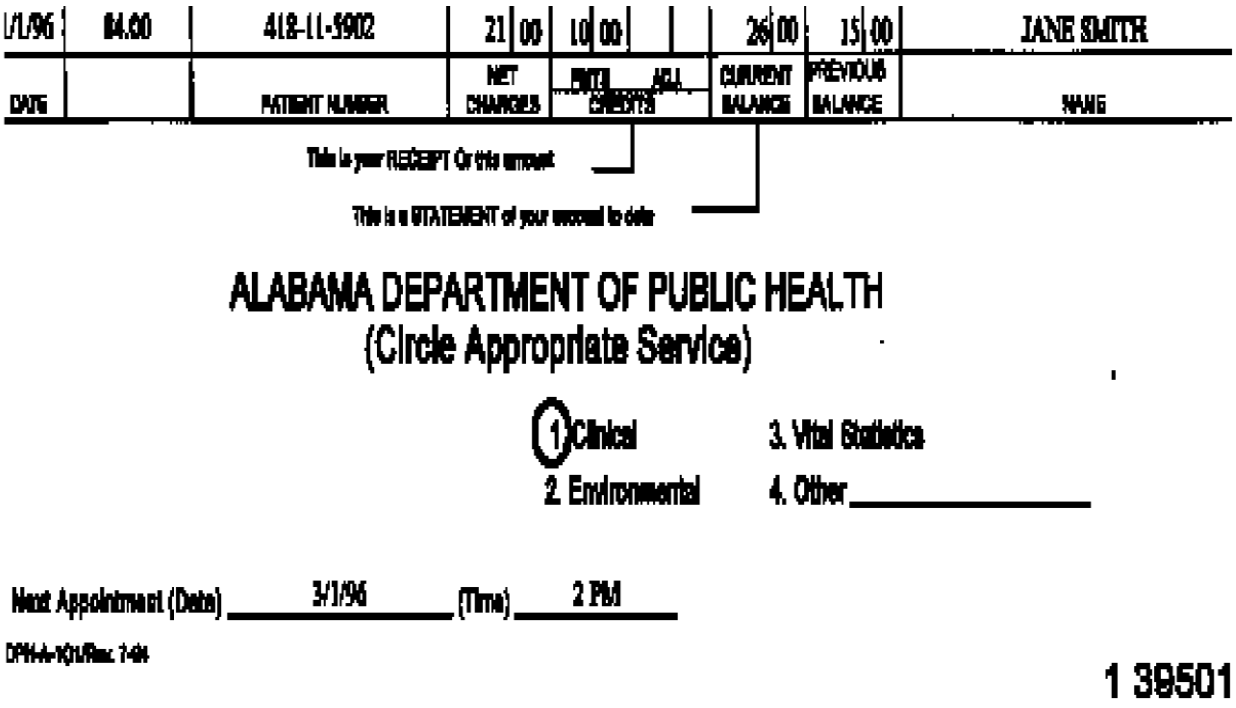
Void transactions - Void transactions are incorrect entries on the Day Sheet. For example, if a client is charged for a service but it cannot be delivered and a refund was requested, the transaction must be voided so money can be returned to client.

Void procedures must be performed in the following manner on all parts of the One-Write System:

- Verify that the service was not provided or that a void is necessary.
- Draw one red line through the transaction (Receipt, Ledger Card, and Day Sheet).
- Write the word “VOID” in red (receipt, ledger card, and day sheet).
- Initial the voided transaction (Receipt, Ledger Card, and Day Sheet).
- Obtain the initials of a witness (Receipt, Ledger Card, and Day Sheet).
- Attach voided receipt to the back of the Day Sheet.

THREE COMPONENTS OF ONE-WRITE SYSTEM

1. **CLIENT'S PRENUMBERED RECEIPT**



1/1/96	84.00	418-11-9902	21 00	10 00		26 00	15 00	JANE SMITH
DATE		PATIENT NUMBER	NET CHARGES	PAID ADJ CREDITS		CURRENT BALANCE	PREVIOUS BALANCE	NAME

This is your RECEIPT for this amount

This is a STATEMENT of your account to date

ALABAMA DEPARTMENT OF PUBLIC HEALTH
(Circle Appropriate Service)

(1) Clinical 3. Vital Statistics
2. Environmental 4. Other _____

Next Appointment (Date) 3/1/96 (Time) 2 PM

DPH-4-10(1/Rev. 7-94

1 39501

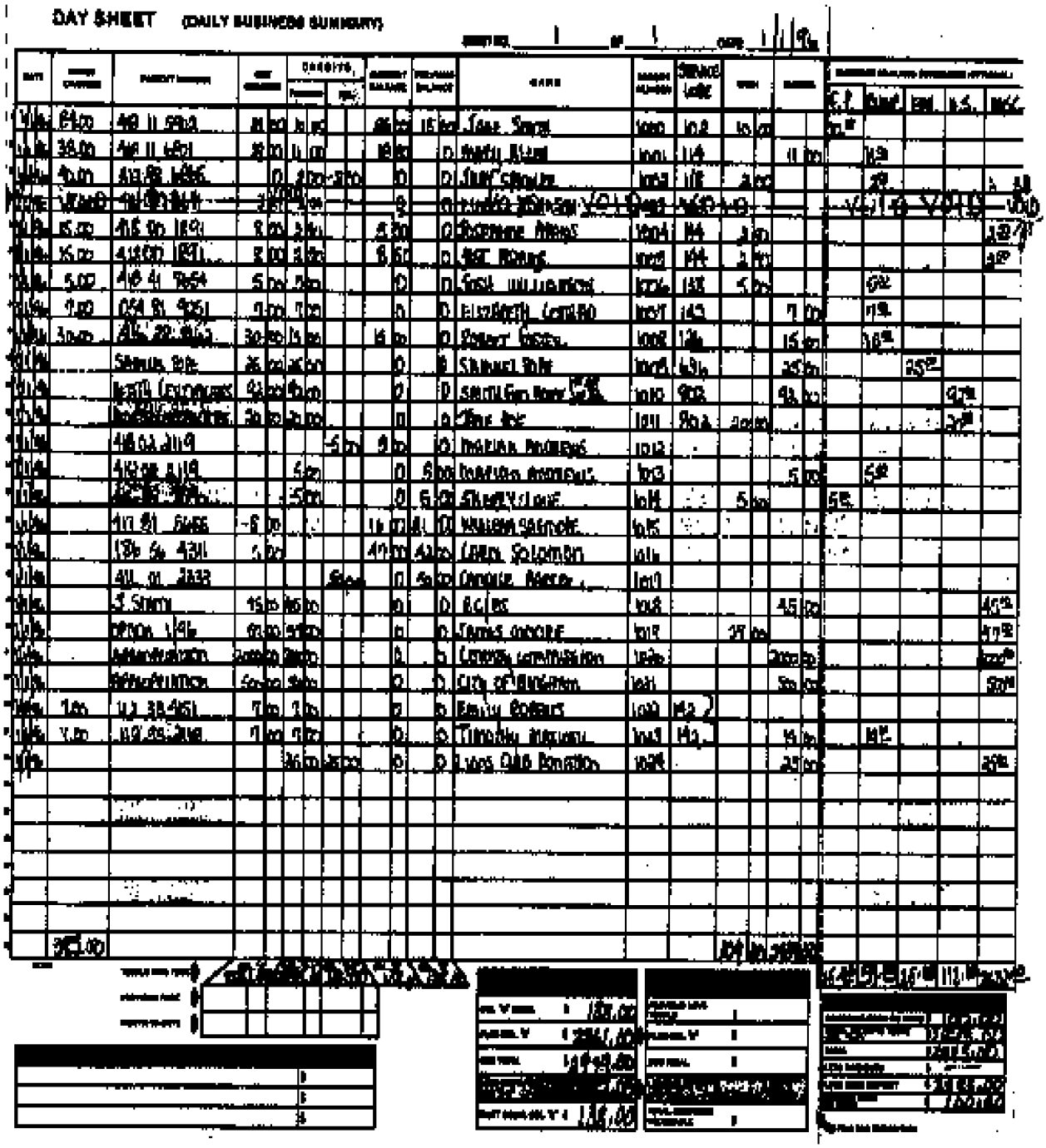
2. **LEDGER CARD**

JANE SMITH
502 HAPPY STREET
DECATUR, AL

										15	00
DATE		DESCRIPTION	CHARGE		CREDITS PAYMENTS		CREDITS ADJ			CURRENT BALANCE	
1/1196	84.00	418-11-5902	21	00	10	00				26	00

ADPH-A-100/Rev. 4-94 PLEASE PAY LAST AMOUNT IN THIS COLUMN

3. DAY SHEET



The following are examples only. The service codes may change and amounts may differ in each county depending on the visit/service.

SERVICE CODE 100Ib
(FAMILY PLANNING INITIAL VISIT WITH DEPO)
Client has been assessed in the 25% charge on the fee schedule. Gross charges are $180 and net charges are $44. The client could only pay $10 in cash. The client's previous balance was $15. The $44 for the current visit is added to the previous balance and the $10 payment is subtracted, leaving a balance of $49.

SERVICE CODE 114
(CANCER DETECTION INITIAL VISIT)
Client is assessed in the 75% charge on the fee schedule. Gross charges are $83 and net charges are $62. There is no previous balance. The client paid $11 by check at visit, leaving a current balance of $51.

SERVICE CODE 118
(CHILD HEALTH INITIAL PERIODIC VISIT - DONATION FROM ZERO-PAY PATIENT)
Client is assessed in the 0% pay category charge on fee schedule. Gross charges are $163 and net charges are $0. The client did not have a previous balance but made a voluntary $2 cash donation. Record the donation by posting $2 in the Payment Column; -$2 in the Adjustment Column; and $2 in the clinical column referring to the Business Analysis Summary.

SERVICE CODE 144
(IMMUNIZATION $15 SLIDING SCALE)
A family with two children has come in for childhood immunizations. The basic charging procedure is to charge all clients $15 per person, per visit applied on a sliding scale. The client has been assessed in the 50% pay category. Gross charges are $30 and net charges are $16. The client did not have a previous balance and was able to pay $5 in cash, leaving a balance of $11. If two children are immunized, two entries should be made for each net charge of $8 for a total net charge of $16.

SERVICE CODE 158
(INJECTION ONLYPATIENT SUPPLIES DOSAGE)
This service is charged to all clients who receive the service regardless of pay class or other health program enrollment. The charge is a flat fee of $5. Gross charges and net charges of $5 are posted. The client does not have a previous balance and pays the $5 by check, leaving a current balance of zero.

SERVICE CODE 636
(ENVIRONMENTAL FEES-SEPTIC TANK PUMPER PERMIT)
All Environmental Fees are charged on a flat fee basis. The client submitted a check with an application for permit. Net charges of $25 were posted. The client paid by check. Gross charges are not posted for Environmental fees. Ledger cards for Environmental annual fees may be used as one continuous ledger card for each type of business establishment with all entries posted to the card.

SERVICE CODE 802
(HEALTH STATISTICS-DEATH CERTIFICATES) MULTIPLE APPLICATIONS - ONE PAYER

John Smith of Smith Funeral Home writes one check for $126 for copies of death certificates for four individuals. See breakdown below:

NAME OF DECEASED	COPIES NEEDED	1ST COPY	2ND COPIES	$TOTAL
John Cody	5	(1 x $15)	(4x $6)	$39
Joe Tyler	1	(1 x $15)		$15
Mary Abbott	6	(1 x $15)	(5 x $6)	$45
Sally Jones	3	(1 x $15)	(2 x $6)	$27
	15	(4 x $15)	(11 x $6)	$126
	First Copies	4 x $15	=	$60
	Second Copies	11 x $6	=	$66
				$126

SERVICE CODE 802
(HEALTH STATISTICS-DEATH CERTIFICATES) SINGLE APPLICATION - ONE PAYER

All charges are on a flat fee basis of $15 for first copy plus $6 for each second copy ordered at the same time. The client was charged $15 for first certificate copy and $12 for 2 second copies for a total of $27. All charges were paid in cash.

Establish one continuous ledger card for Health Statistics transactions and post all entries to this card. For audit purposes, a clear trail must exist between the Day Sheet and the applications for death/birth certificates. Applications must be filed by the month the fees were collected. For example, all applications processed in July 2011 would be filed in a folder labeled “Applications-July 2011.”

RETURNED CHECK CHARGE-BACK

A returned check is received from the bank which was deposited on a previous day. Review the original day sheet to ensure the check belongs to the County health department. The charge back is recorded on the day it is received from the Bureau of Financial Services – Budget and Receipts Office. To record a bad check charge-back, complete a new receipt documenting the returned check amount. Enter the amount in the Adjustment Column as a negative amount. Post the amount as a positive amount to the Current Balance Column.

If the client did not have a previous balance, the current balance would be the amount of the check. If the client had a previous balance, the bad check amount would be added to the previous balance to arrive at a new current balance.

REDEPOSIT OF RETURNED CHECK

When a returned check is deposit again, it is handled as a payment on account. Record the amount of check in the Paid Column and reduce the previous balance by the amount of payment. A receipt should be made to record the payment and update the current balance.

Returned checks are classified in the appropriate column in the Business Analysis Summaries section. In this example, the returned check was for clinic services.

PAYMENT ON ACCOUNT

To record a payment on account, such as mail-in payments or amounts received directly from patients, complete a receipt to record the amount paid in the Paid Column and reduce the client's previous balance. The amount paid must be classified in the Business Analysis Summaries section. In this example, payment was made for Family Planning.

CORRECTION OF AN OVERCHARGE

Correction of an overcharge is made by completing a new receipt and posting a negative amount in the Net Charges Column and reducing the previous balance by the amount of the net charge to get the current balance. A full explanation should be given on the receipt.

CORRECTION OF AN UNDERCHARGE

The correction for an undercharge is made by completing a new receipt to record the additional charge. Record the additional amount in the Net Charges column and add to previous balance to get the new current balance.

WRITE-OFF OF TERMINATED CLIENT (manually in case electronic system is down for an extended period of time)

To write off a terminated client's balance, complete a receipt and post the amount to be written off in the Adjustment Column. The previous balance will be reduced by the amount of the write-off to arrive at the new current balance.
Anything done in the manual system will have to be repeated in the electronic system once the electronic system is available.

THIRD PARTY INSURANCE COMPANY CHECK

A check was received for $xx for Home Health services. In the Name Column, post the payer's name. Before the money is deposited, the receipt column must agree with the deposit slip.

CASH RECEIVED OF HOME HEALTH PATIENT

Cash of $xx was received from a Home Health patient. Record program and date of service in the Patient Number Column. Record patient name in Name Column and show the fee as Miscellaneous Home Health Receipts.

COUNTY COMMISSION APPROPRIATION

Received a check for $x,xxx from County Commission. Complete a receipt and record the amount in the Net Charges Column, Payment Column, and the Miscellaneous Column. Record as County Commission in the Patient Name Column.

CITY APPROPRIATION

Received a check for $500 from the City of Bingham. Complete a receipt and record the amount paid in the Net Charges Column, the Payment Column, and the Miscellaneous Column. Record as City of Bingham in Name Column.

ONE PAYMENT FOR TWO PATIENTS

Two clients came to the clinic for premarital blood tests. Both services were paid for with one check. Complete individual receipts for each client and make an entry on your day sheet to show both services were paid with the same check.

DONATION

Record receipt of a donation from a local civic organization. There are no gross or net charges to record. Enter the amount of the donation in the Payment Column and as a negative amount in the Adjustment Column. Show the name of the donating payer in the Name Column. Also enter the amount as a miscellaneous donation.

DAILY DEPOSITS

Daily close-out of Day Sheet
Each Day Sheet must be balanced and closed out so that the bank deposit can be prepare daily and deposited no later than by noon of next working day.

The bank deposit should be prepare daily and deposited no later than by noon of next working day.

Daily deposits are required.
Deposits must be made daily. To determine the amount of deposit:

- Remove money from the cash box
- Count out the amount of approved change fund
- Put change fund back in the cash box
- The remaining money is deposited and should equal the Payments Column total

If the deposit does not agree with the Total Payments Column of the Day Sheet, an error has been made and may be due to:

- The PAYMENT column was added incorrectly
- Change fund was counted incorrectly
- A non-cash entry was posted in the PAYMENT column
- An error was made in making change by giving too much or too little change
- Money was put in cash box without making an entry on the Day Sheet
- Money was removed from cash box

When an overage or shortage occurs in the cash box, the error should be reported immediately to the supervisor. The supervisor will assist in determining the error and will sign and date the Day Sheet. The clerk will also sign with the supervisor. Overages must be deposited with the fee collections. All overages and shortages must be reported on the Monthly Recap of Fees.

Each deposit must:

- **be intact**
  (Do not hold out checks or cash from the deposit)
- **list each check individually on the deposit slip by payer's name**
- **include a carbon copy of the deposit slip and retain in the office**
  (No machine copies)

Bank deposits are made in duplicate. The original deposit slip is sent to the bank and the carbon copy is attached to the Day Sheet. The deposit slip must list all checks individually by payer's name to match entries on the Day Sheet. Both names (client's and payer's) must be on the Day Sheet if they are different.

DAILY DEPOSITS (continued)

SHORTAGES

If there is a shortage on the Day Sheet

- **Report it immediately to the supervisor**
- **The shortage will be investigated**
  - Depending on the outcome of the investigation, the employee responsible for cash will reimburse the fee account.
- **The clerk balancing the Day Sheet and the supervisor will initial and date the Day Sheet, if the shortage is not resolved.**
- **Post the shortage on the Monthly Recap of Day Sheets if electronic system is down for an extended period of time**

OVERAGES

If there is a overage on the Day Sheet

- **Report it immediately to the supervisor**
- **If the overage cannot be identified**
  - Deposit it
- **The clerk balancing the Day Sheet and the supervisor will initial and date the Day Sheet, if the overage is not resolved.**
- **Post the overage on the Monthly Recap of Day Sheets if electronic system is down for an extended period of time.**

DAILY CLOSEOUT OF DAY SHEET

Procedures for daily close-out of the Day Sheet: (which may occur next morning if day sheet is closed at the end of the day)

At the close of each business day, prepare the Close-out Section of the Day Sheet by totaling the following columns:

- Gross Charges
- Net Charges
- Payments
- Adjustments
- Current Balance
- Previous Balance
- Cash – Deposit Section
- Check – Deposit Section
- Family Planning Fees Paid
- Other Clinic Fees Paid (include Dental fees)
- Environmental Fees Paid
- Health Statistics Fees Paid
- Miscellaneous Receipt

PROOF OF POSTING

The Proof of Posting Section:

- must be completed each day
- is a mathematical equation that must balance
- must be completed for each Day Sheet to quickly locate posting errors, if multiple Day Sheets are used

The Business Analysis Summaries section total must match the Payment Column.

- Post the Column Totals at the bottom of the Day Sheet if electronic system is unavailable for an extended period of time, complete the following:
- If no total lines for columns, post totals at the bottom of sheet
- Post the totals on the Monthly Recap of Day Sheets

Co**mplete the Proof of Posting Section to test accuracy of daily posting,**

COLUMN	AMOUNT
Enter Column D Total	$
Add Column A Total	+
Subtotal	$
Minus Column B-1 Total	
Minus Column B-2 Total	-
Total	$
Must equal Column C	$

MONTHLY RECAP OF DAY SHEETS

The Monthly Recap of Day Sheets summarizes the monthly fee collections and is sent to Financial Services – Budget & Receipts Office at the beginning of the next month. **Each day's collections are:**

- listed separately
- identified by the specific revenue source code
  Revenue Codes are revenue line items in AFNS financial accounting system maintained by the Financial Services – Budget & Receipts Office and are NOT service codes listed on Day Sheet.

The Monthly Recap of Day Sheets:

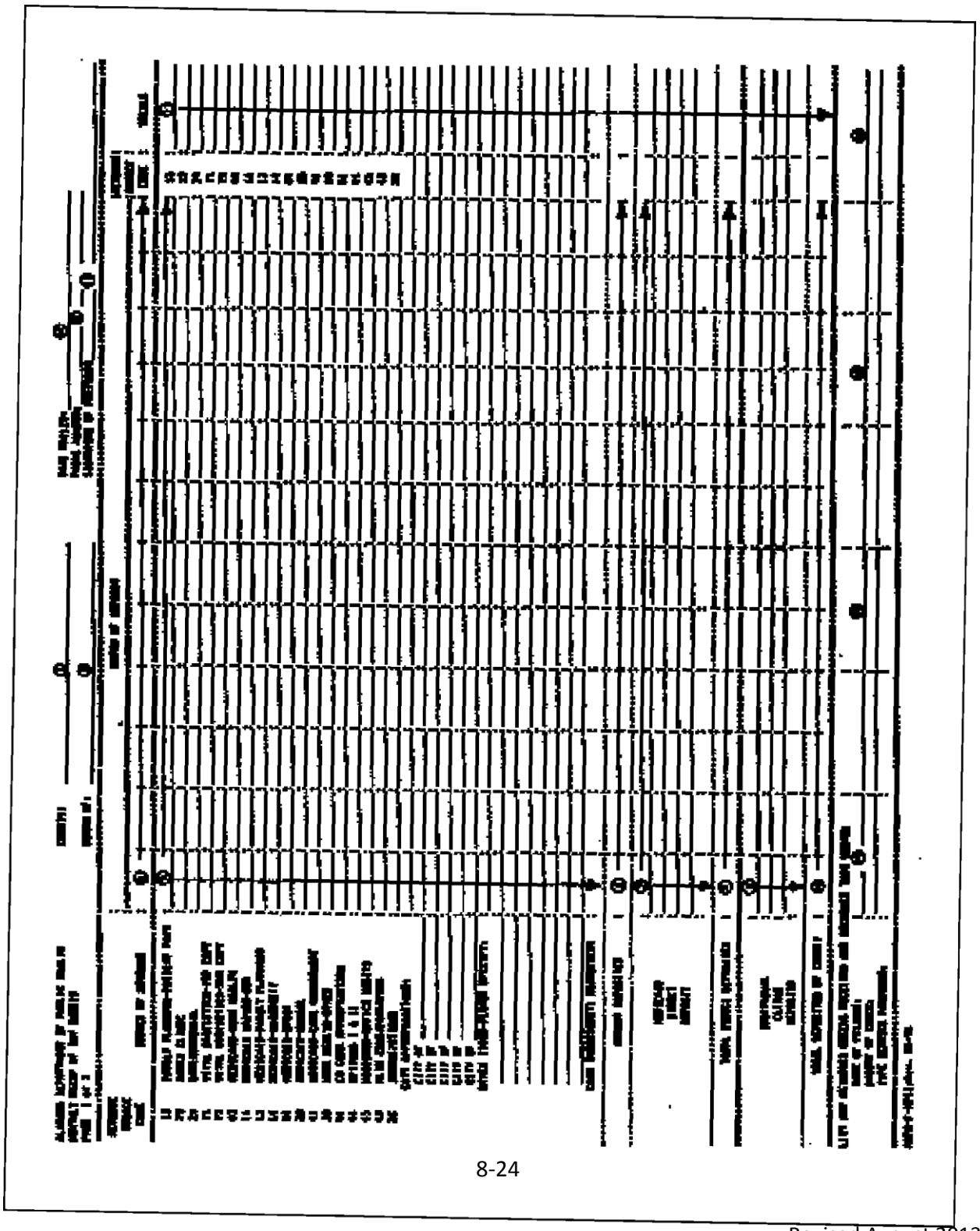
- **must be completed on a daily basis after Day Sheet has been totaled and deposit prepared**

- **must be completed and submitted by the 10th of the following month to:**
  Alabama Department of Public Health
  Financial Services-Budget & Receipts Office
  201 Monroe Street
  Montgomery, AL 36104

  Financial Services – Budget & Receipts Office:
  - reconciles the Monthly Recap with the bank statement
  - enters the deposits into the Financial System AFNS
  - reports deposits on the County Fund Balance Report

- **Copy must be maintained at the county health department.**

- **Automated template is available from the Area Clerical Director if electronic system is down for a significant time period.**

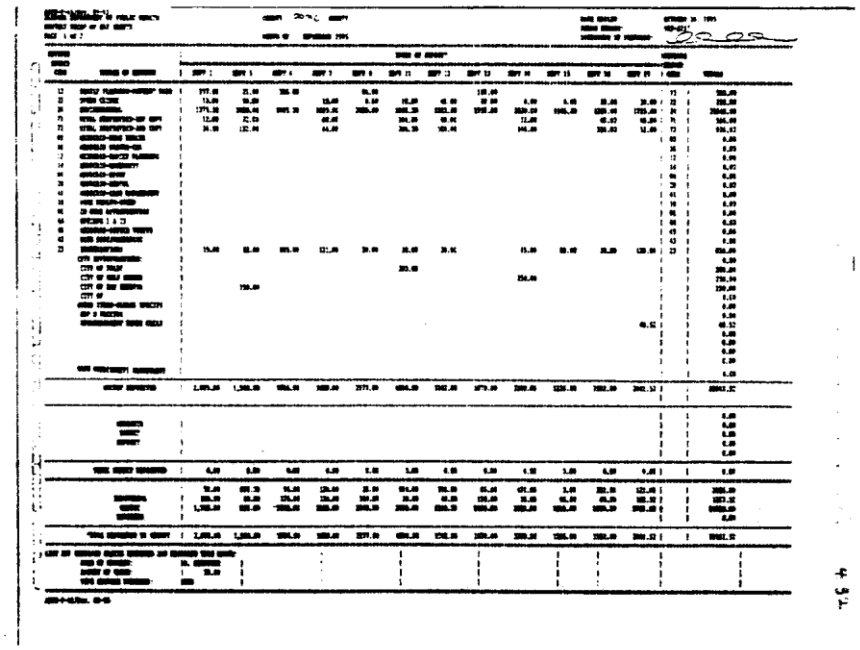


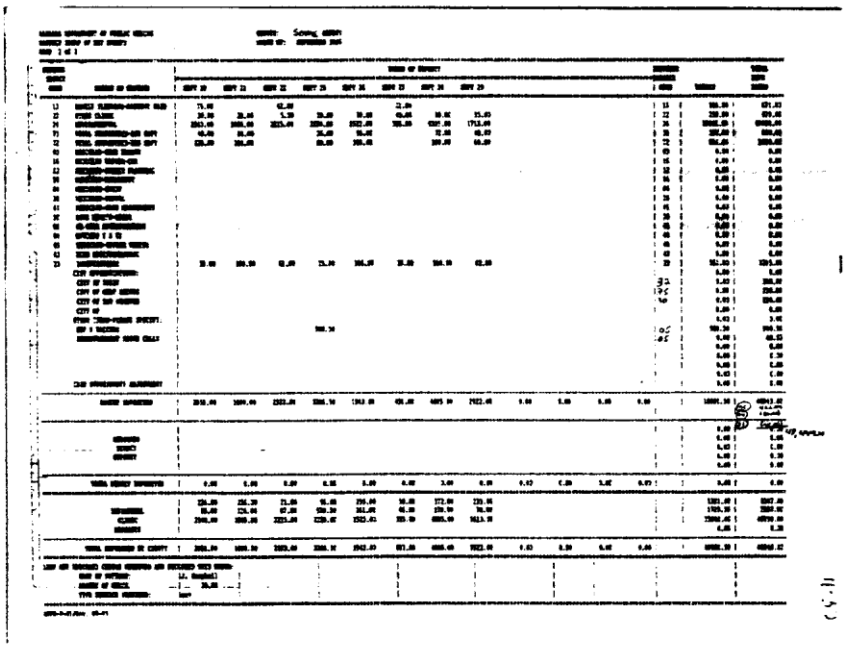
MONTHLY RECAP INSTRUCTIONS:

Enter the following information on the Monthly Recap

1. **COUNTY**
   - Enter the county name
2. **MONTH OF**
   - Enter the month and year
3. **PHONE NUMBER**
   - Enter work phone number
4. **DATES OF DEPOSIT**
   - Enter the dates of deposit from left to right
5. **AMOUNT OFDEPOSIT BY REVENUE SOURCE CODE**
   - Enter the amount of deposit by appropriate revenue source code
   - Include cash over or cash shortage adjustment, if applicable
   - Post deposits from top to bottom of column
6. **AMOUNT DEPOSITED**
   - Enter the total amount deposited daily
7. **INDIVIDUAL CLINIC DEPOSITS**
   - Enter individual daily deposits made by clinic(s)
   - Complete if only one site
8. **TOTAL DEPOSITED BY CLINIC**
   - Enter sum total deposited by clinic for each date
9. **TOTALS**
   - Enter the sum total amounts for each line entry by revenue source code from left to right on each page
   - If you only complete page 1
   - If page 2 is completed, repeat the above steps and continue with the steps below.
10. **TOTAL BOTH PAGES**
    - Sum totals for both pages
    - Place page 2 faces up and fold from left to right until page 1 overlaps page 2
    - Stop folding page 1 at XXXXX in lower section of revenue source code column on page 2
    - Enter sum totals for each line entry by revenue source code of both pages
11. **LISTANY RETURNED CHECKS RECEIVED AND RECORDED THIS MONTH**
    - Enter the name of patient, amount of check, and type of service provided
12. **DATE MAILED**
    - Enter the date Recap is mailed to Budget & Receipts Office
13. **SIGNATURE OF PREPARER**
    - Preparer reviews and signs recap

front and back
blank F-41





SEPARATION OF DUTIES

Separation of duties helps prevent and detect errors. Duties must be separated as much as possible with available staff. This may mean rearranging duties and/or cross-training employees.

One person should not perform the following tasks related to the fee account:

- Open the mail AND record mail receipts on the Day Sheet.
- Collect and record fees on the Day Sheet AND balance and close-out the Day Sheet
- Collect and record fees on the Day Sheet AND prepare the deposit **(Required)**
- Balance and close-out the Day Sheet AND prepare the Monthly Recap of Day Sheets
- Balance and close-out the Day Sheet AND prepare the deposit
- Prepare the deposit AND prepare the Monthly Recap of Day Sheets
- Prepare the deposit AND take the deposit to the bank. **(Required)**

Designate one employee who:

- **Prepares daily bank deposit**
  - Balance change fund
  - Deposits remainder into bank
- **does not:**
  - Prepare receipt or charge slip as intake clerk
  - *Make E-Day Sheet or One-Write entries*

Office manager or designee is responsible for:

- Running the Monthly Recap process which posts totals from the E-Day Sheet to the Monthly Recap report and file
- verifying that total payments and bank deposit agree.
- transmitting the Monthly Recap file to the Budget Office for reconciliation.

CASH ACCOUNTABILITY PLAN

A cash accountability plan must be prepared and maintained on-site by each county health department. You must update the cash accountability plan when there are changes in staff assignments. A sample cash accountability plan is shown on pages 8-29 and 8-30. Each cash accountability plan must be reviewed and signed by the area clerical director and area administrator. Each plan identifies:

- The tasks to be performed
- The primary employee responsible for the tasks
- The alternate employee
- When certification was accomplished

BLANKET FIDELITY BOND

All merit system employees are covered by the blanket fidelity bond. The bond basically covers mismanagement or embezzlement of funds. If this occurs, the Health Department collects any damage from the bonding company and the bonding company prosecutes the employee.

FEE ACCOUNT
CASH ACCOUNTABILITY PLAN

_____COUNTY HEALTH DEPARTMENT

_____LOCATION _____DATE

Page 1 of 2

ANYONE INVOLVED WITH THE FEE ACCOUNT MUST BE CERTIFIED.

1. Is responsible for shortages:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

2. Collect fees during intake process and record onto day sheet:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

3. Collect fees during intake process and record onto day sheet:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

4. Balance and close out day sheet:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

5. Prepare bank deposit:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

6. Take deposit to bank:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

7. Prepare Monthly Recap of Day Sheets report for ADPH Financial Services Budget Offices:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

FEE ACCOUNT
CASH ACCOUNTABILITY PLAN

_____COUNTY HEALTH DEPARTMENT

_____LOCATION

_____DATE

ANYONE INVOLVED WITH THE FEE ACCOUNT MUST BE CERTIFIED.

8. Open mail, prepare a list of money received, and deliver to cashier:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

9. Receive, sign for and record money received in mail onto day sheet:

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

10. Collect fees other than patient fees and record on day sheet (Example: death certificates and environmental fees):

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

11. Other (explain)

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

12. Other (explain)

Primary Responsible Person: Alternate:

_____ _____

Date Certified: _____ Date Certified: _____

Signed: _____ Area Clerical Director
Date: _____

Signed: _____ Area Administrator
Date: _____

CERTIFICATION

All employees performing duties pertaining to the county depository account must be certified to handle cash including:

- Administrators
- Nurses
- Clerks
- Environmentalists, etc.

Certification procedures involve:

- Assigning responsibility,
- Certifying responsible staff, and
- Preparing a cash accountability plan.

Before certification can be accomplished, the tasks to be performed must be defined:

- Collecting fees and posting entries to E-Day Sheet
- Balancing and closing out the day's business
- Preparing the bank deposit and making the deposit
- Preparing the monthly reports
- Reconciling the bank account

After the tasks have been defined, a primary and alternate employee must be identified on the appropriate cash accountability plan.

When the employee has been identified he/she must be formally trained, tested, and certified to handle cash.

- Testing material is available from the county office manager or area clerical director.
- Training, testing and certification take place at the county health department
  - The Fee System Manual is reviewed with the training agenda before the test is given to each employee.
  - A passing score of 102 or above on the entirety of the test must be obtained for certification
  - The rated test is placed in the employee's file at each county health department for review by the Office of Program Integrity.

TESTS ARE RATED BY	FOR
County Office Manager	County Employees
Area Clerical Director	County Office Managers
Clerical Director	Area Clerical Directors

COMMON
QUESTIONS AND ANSWERS

Question: Is an entry made on the day sheet for patients within the zero pay categories?

Answer: Yes. Record the gross and net charges, even when the net charge is zero. Health Care Financing Administration (HCFA) considers the "write off" amounts when determining grant money for the department.

Question: Can two services be recorded on one receipt and the payment totaled for both services?
Answer: No. However if paying for multiple permits under same service code can be recorded on one receipt.

Question: How would you record the following: A husband and wife each get flu shots, they each have a CHR, and write one check for both shots?
Answer: Write a separate prenumbered receipt for each individual. Indicate in column 13 (labeled checks) that the check was for both individuals.

Question: How do we distribute the charge for immunizations among the children ledger cards when one check is written to cover several children?
Answer: Divide the charge equally among the children.

Question: For Environmental and Health Statistics fees, shouldn't the entry on the day sheet list the person paying for the service and the person receiving the service?
Answer: Yes

Question: Should counties not on the state fee system code their services on the day sheet?
Answer: Yes, always use service codes. If your county has adopted a fee schedule other than the statewide fee schedule, use the service code from the statewide schedule which most accurately fits the services.

Question: Can the payment columns on the day sheet be made wider?
Answer: No. Widening the columns could only be achieved by purchasing custom-made day sheets.

ELECTRONIC DAY SHEET USER'S GUIDE

CHAPTER 9

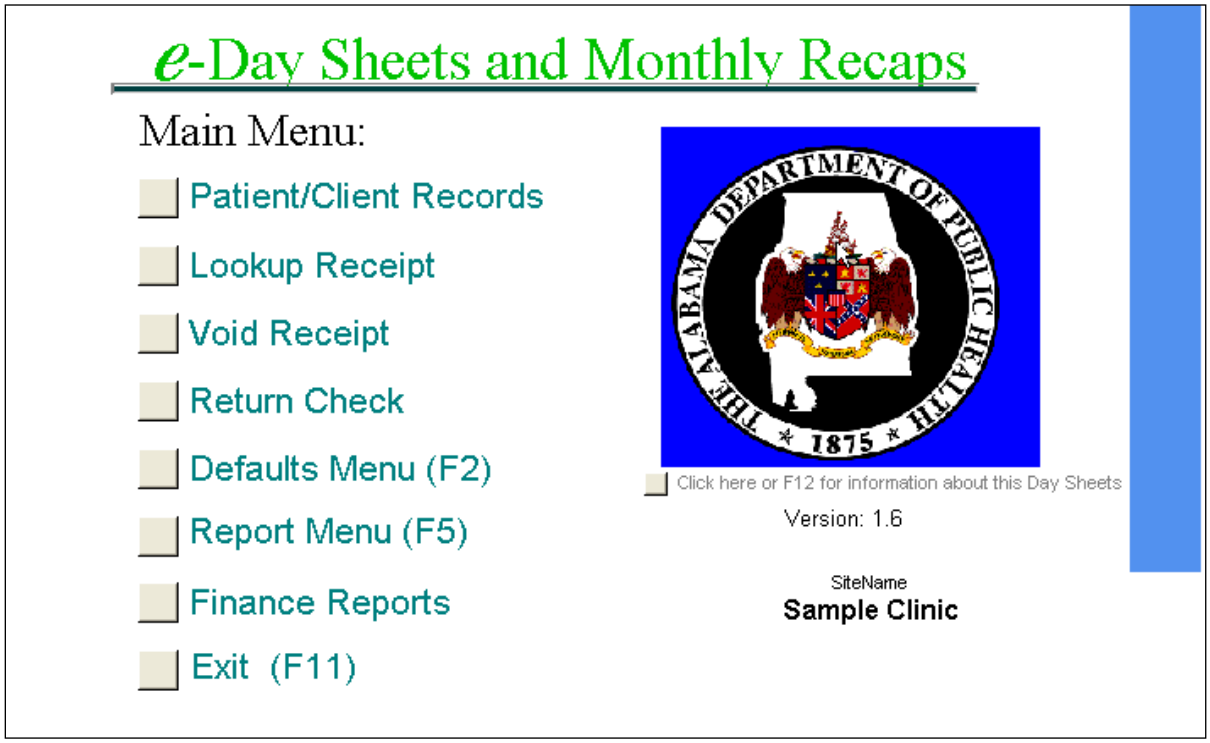
Revised August 2013

E-DAY SHEET SYSTEM INSTRUCTIONS

The Electronic Day sheet is an efficient electronic accounting system with built-in disciplines. It provides consistent recording, depositing, and reporting of collected fees. The guidelines which are mentioned in Chapter 8 must be followed with an electronic version of the Electronic Day Sheet.

Main Menu (F10)

This is the Main Menu for the Electronic Day Sheet system.
On this menu are the submenu items you will be using to issue receipts.

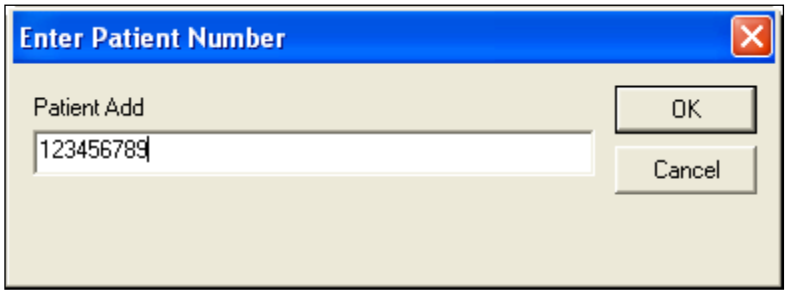


To return to this menu from one of the sub menu items press the F10 key.

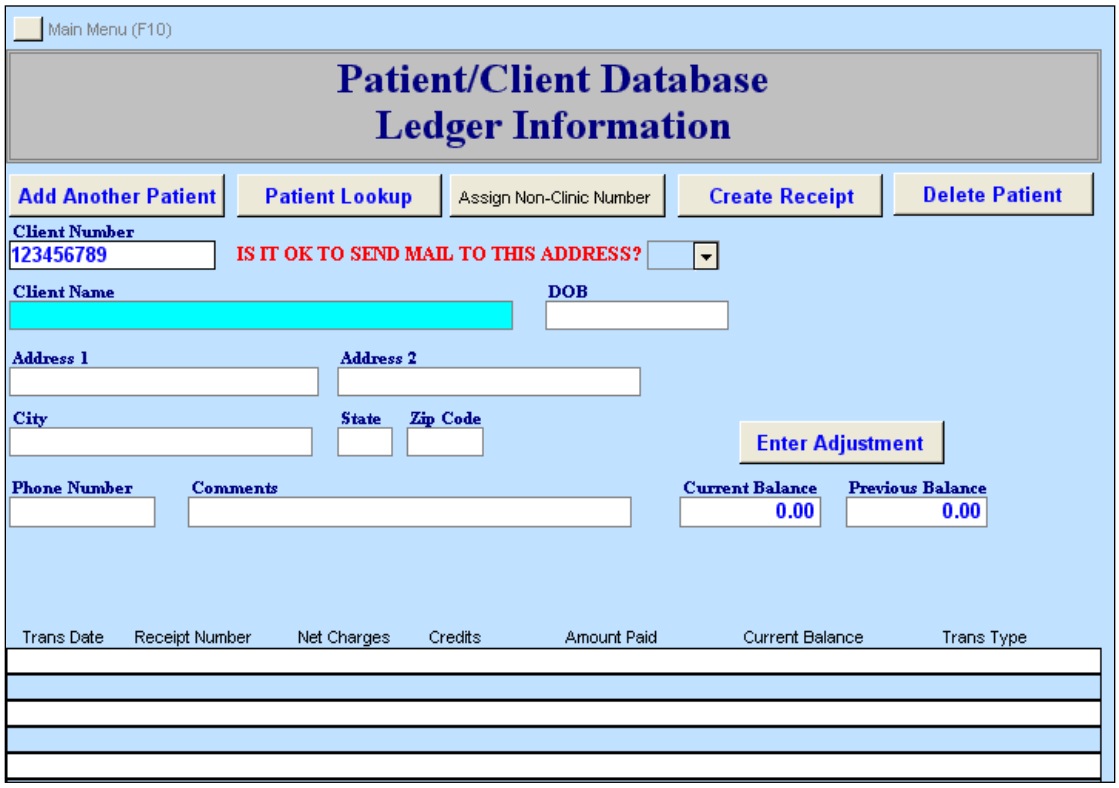
Patient/Client Records

From this sub menu item you may Add Another Patient, do a Patient Lookup, Assign a Non-Clinic Number, Create Receipt, Delete Patient or Enter Adjustment.

Add another Patient
ENTER THE CLIENT'S CHR and click on OK to begin entering the patient information.
This information must be 9 characters and all numeric.



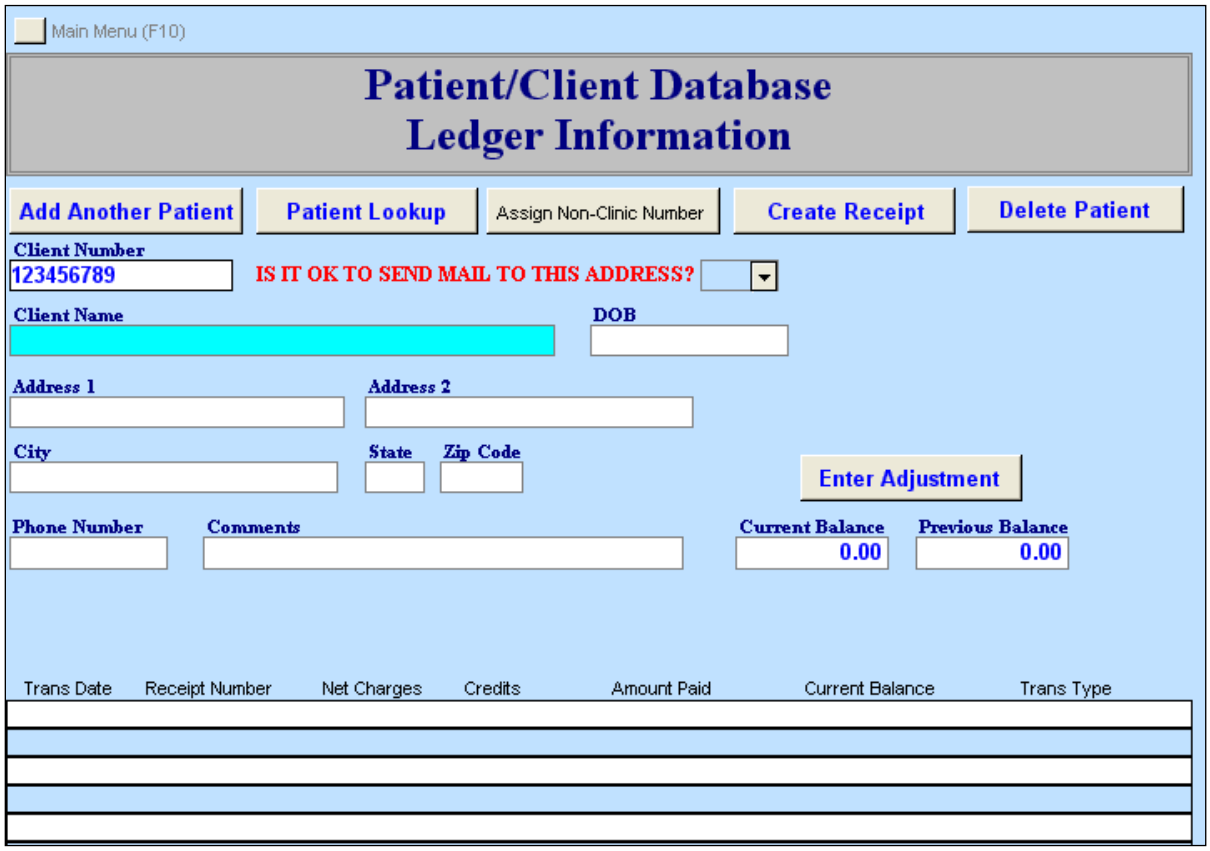
Once OK has been clicked the following screen is displayed and you will need to complete the information on the screen



NOTE: The requirement for entering a zero has been removed. Zero will be automatically put in the Current Balance field for new Clients. It can be changed if a balance is to be entered.

Client/Patient Privacy

In order to preserve and protect our Client's privacy a REQUIRED selection box is located on the Patient/Client Database screen. This box requires a Yes or NO selection for all new Client's added. The question "IS IT OK TO SEND MAIL TO THIS ADDRESS?" must be answered based on the Client's privacy wishes. No receipt can be entered until a selection is made.



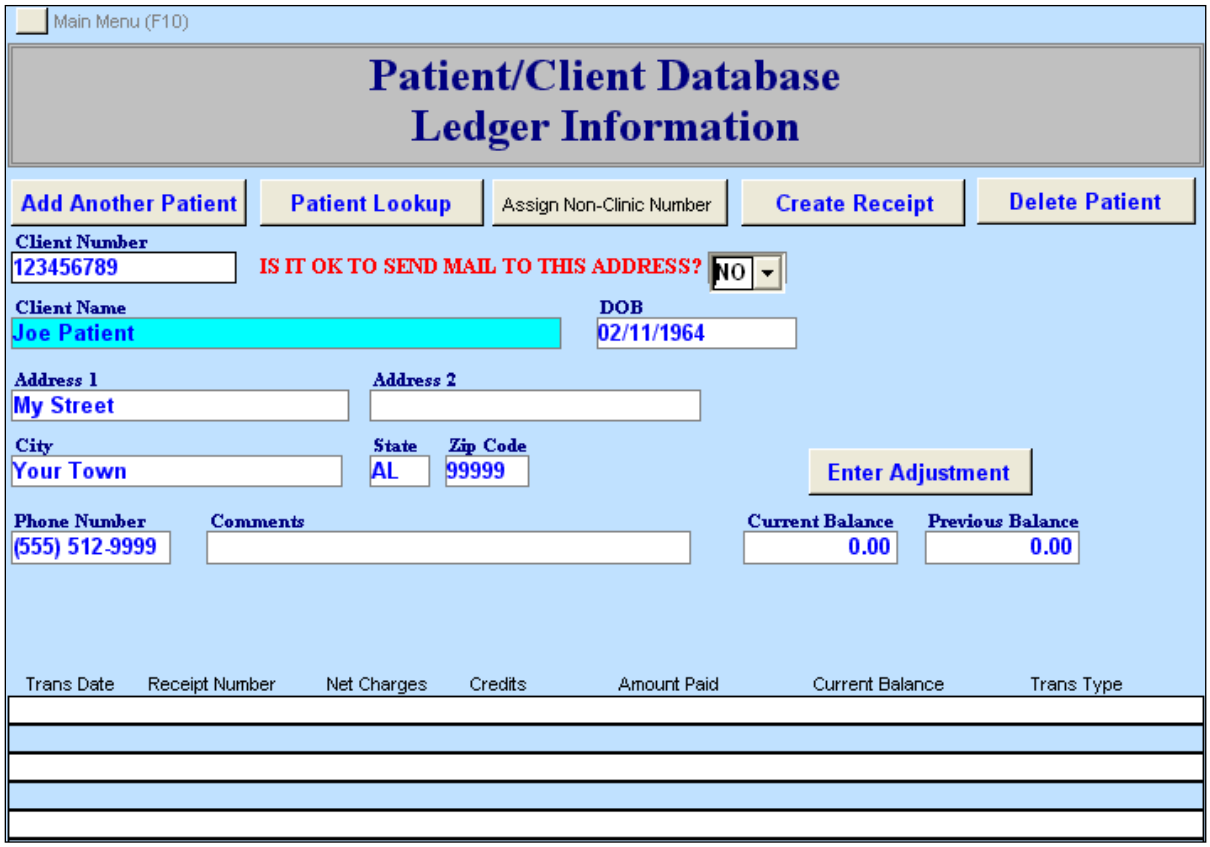
The question: "IS IT OK TO SEND MAIL TO THIS ADDRESS?" requires a selection from a drop down box. You must select Yes or No to be able to create a receipt.

If a patient does not want to be contacted for privacy reasons select NO in the drop down box, otherwise select YES.

When No is selected the system will not print an invoice for those clients.

Vital Statistics and Environmental should always have YES selected.

In the following example a Client is being entered for services and they DO NOT wish to be contacted (receive mail) due to privacy issues, so it is NOT ok to mail them an invoice.

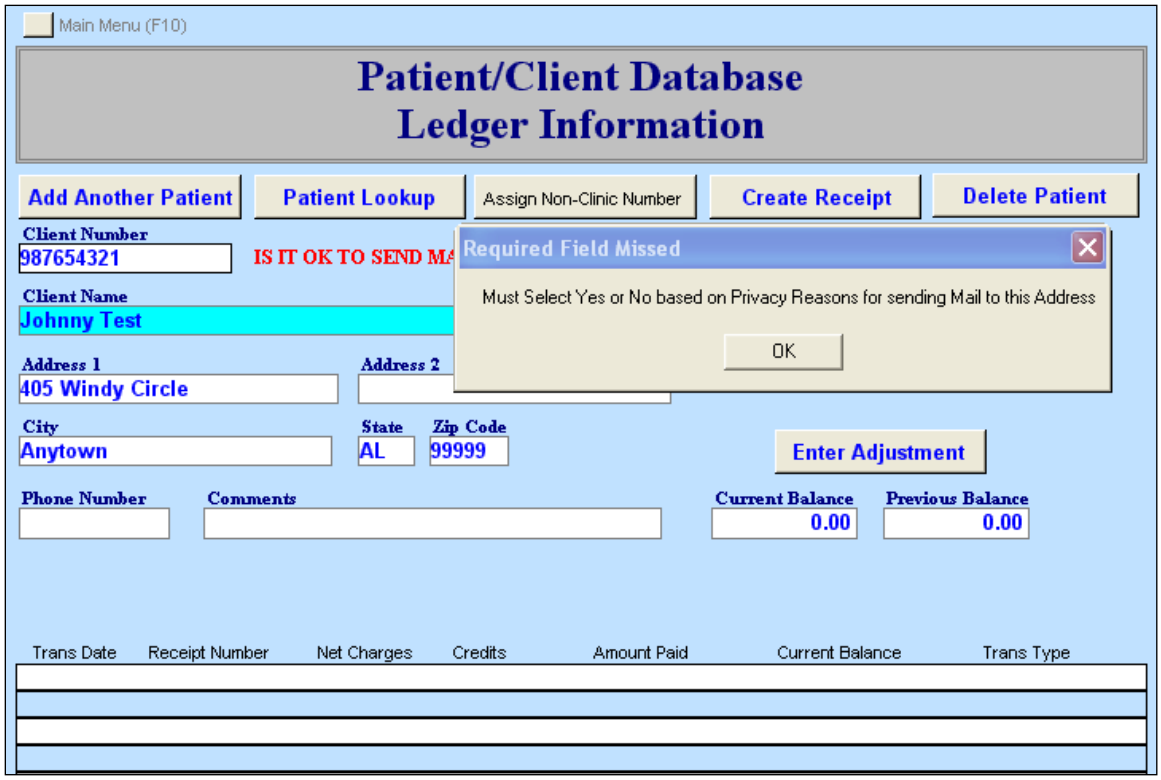


Notice the NO in the drop down box has been selected.

Notice the address information has been entered. This will be useful in printing Mailing Labels for Clinic patient's invoices. If more space is needed to capture the address both Address 1 and Address 2 can be used and both will print on the Mailing Label.

All of this information should be reviewed with the patient on each visit and updated if there is a change.

In the example below "**IS IT OK TO SEND MAIL TO THIS ADDRESS?**" was left blank and the Create a Receipt button was selected.

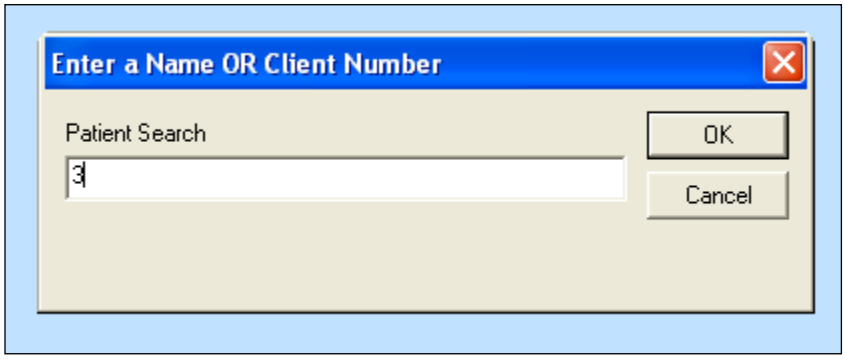


Notice there is a pop up box with an error for Required Field Missed information. You would answer OK and select the appropriate response regarding if it is ok to send mail to this address.

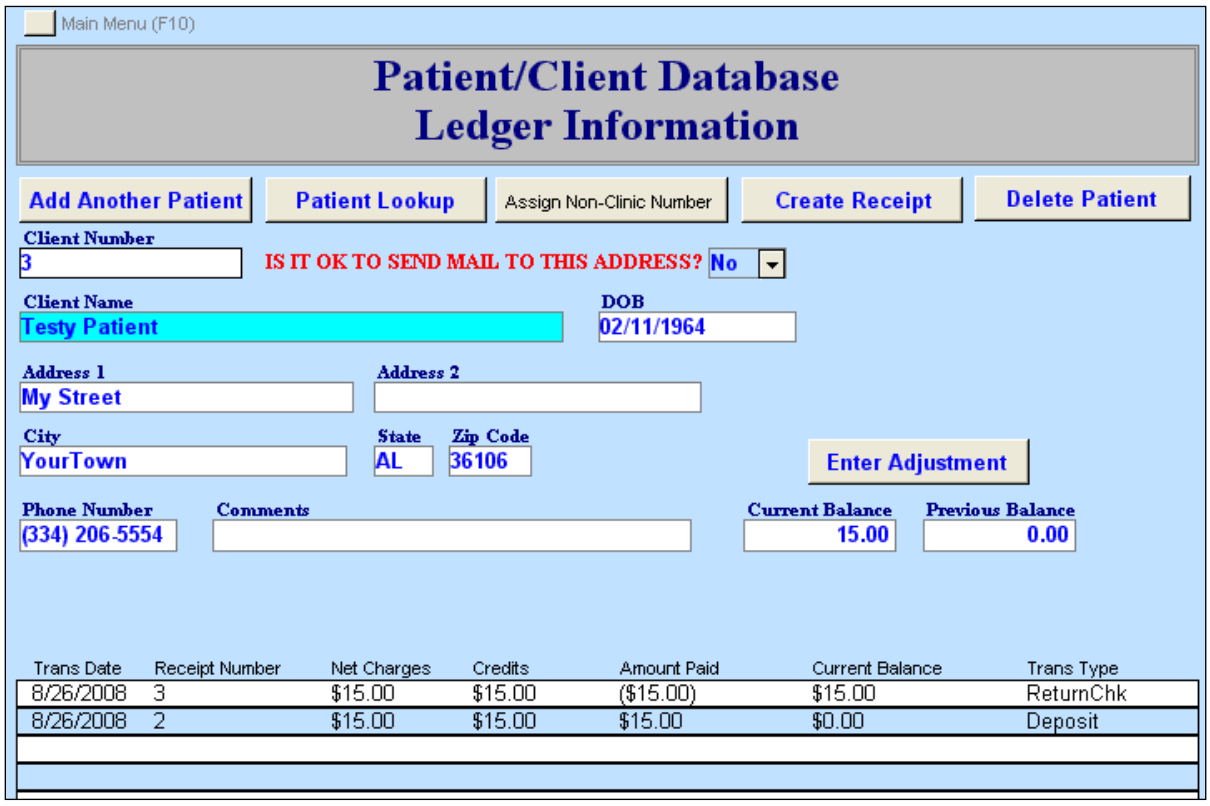
The "IS IT OK TO SEND MAIL TO THIS ADDRESS?" should be verified on each visit prior to issuing a receipt. If the client's privacy wishes change the answer to the question should be changed.

THIS DOES NOT REPLACE ANY DOCUMENTATION REQUIRED IN THE PATIENT'S CHART.

Patient Lookup is for already existing patients and can be performed by entering either the entire Client number or by entering all or part of the client's name.



After OK is pressed the Client/Patient information and ledger card will be displayed.
See example below.

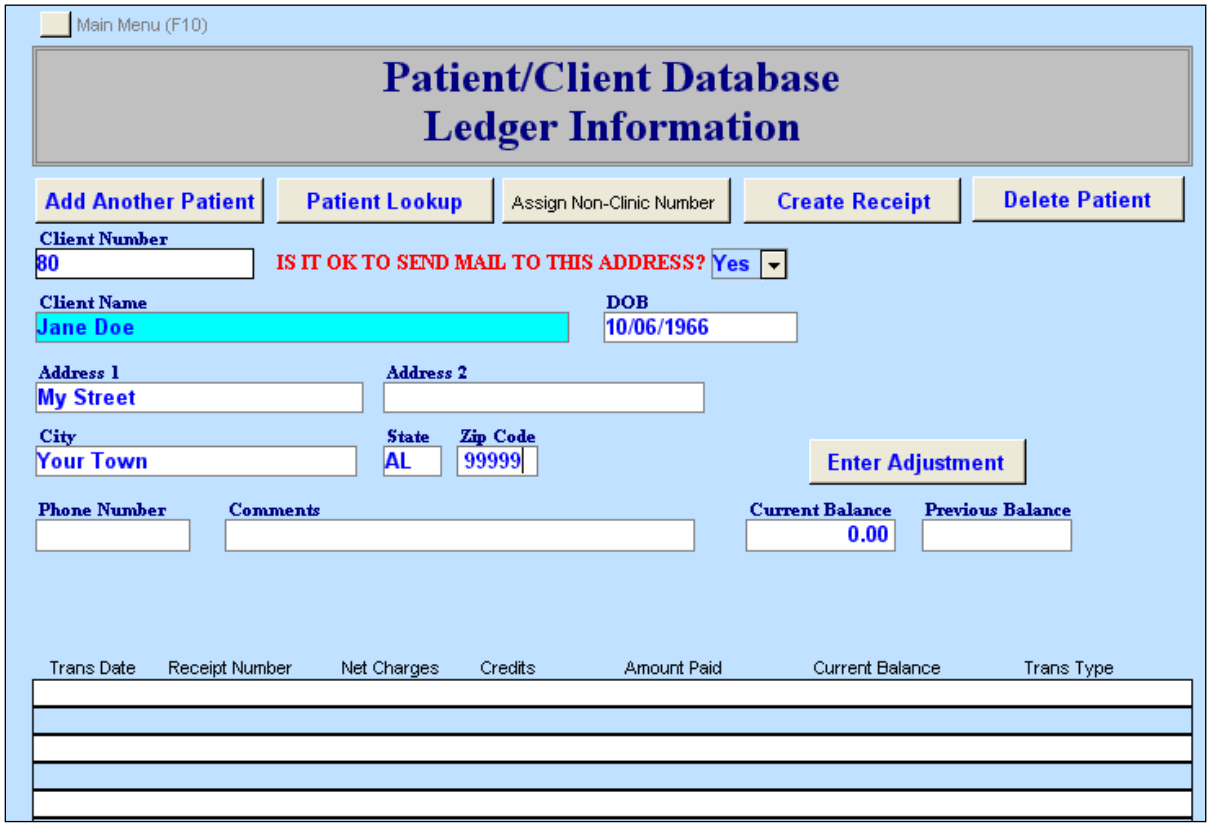


From this screen you may change any of the Patient/Client information except the Client Number and Ledger Card entries. Adjustments to the Current Balance amount will be made by the Office Manager selecting Enter Adjustment. (See Account Adjustments in this manual).

Assign Non-Clinic Number is the way of gathering Patient/Client information on anyone receiving services that would not be assigned a CHR number in the clinic; they would not have a patient chart. Examples: Environment and Vital Statistics.

If the option ASSIGN NON-CLINIC NUMBER is selected the system will assign the next sequential Non-Clinic Client number available and then you will complete the information on the screen. *NOTE: The requirement for entering a zero has been removed. Zero will be automatically put in the Current Balance field for new Clients. It can be changed if a balance is to be entered.*

The "**IS IT OK TO SEND MAIL TO THIS ADDRESS?**" still requires an answer. For Vital Statistics and Environmental the answer should be YES.



Create Receipt this button allows the user to create a receipt for the current client being displayed. For more information on creating a receipt please see the ***CREATE RECEIPT*** section in this manual.

Delete Patient this will allow the user to delete a client record that does **not have any** transactions associated with the Patient.

Enter Adjustment – this will allow the office manager to make adjustments to the client ledger card. See ***Account Adjustments*** section of this document.

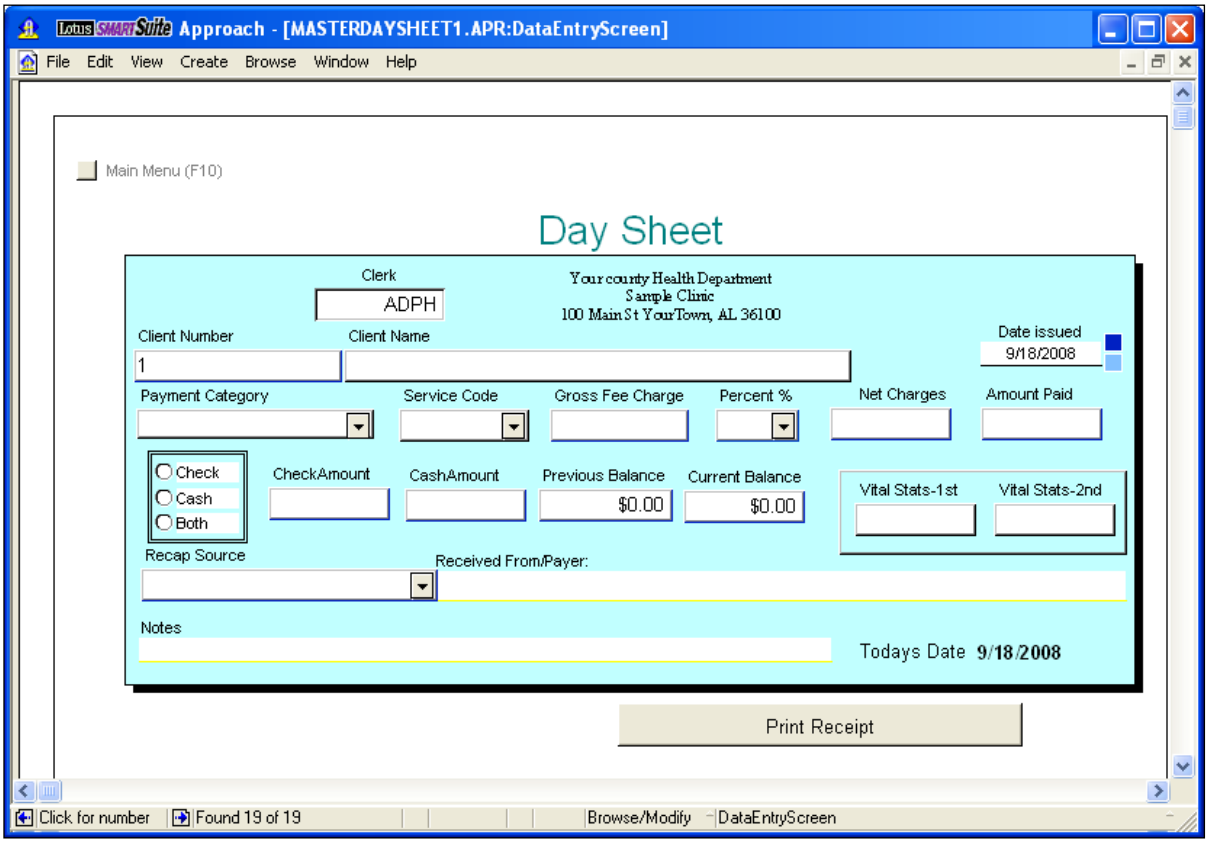
Create Receipt

When the ***Create Receipt*** button is clicked on the Patient/Client Database screen you will receive the day sheet screen to enter a new receipt.

DO NOT LEAVE A PARTIALLY COMPLETED RECEIPT ON YOUR SCREEN FOR A COUPLE OF MINUTES. THIS CAN CAUSE AN ERROR IN CREATING THE RECEIPT. Try to complete the receipt from start to finish without stopping (If Possible).

THE RECEIPT IS NOT COMPLETED UNTIL IT IS PRINTED.

INFORMATION ON THIS SCREEN:



********** **NEVER USE THE ESC OR TAB KEYS** **********

****NEVER BACK UP WHILE ENTERING A RECEIPT-- F10 TO START OVER****

If you make a mistake or just want to cancel out of this screen press the F10 button on your keyboard.

Clerk information is pulled from the sign on information entered when the clerk was added in Team Security. This information will be attached to all entries made from this PC until the current user signs off and someone else signs on.

Client Number is the number assigned to the client when their demographic record was established. For Clinic clients this will be their CHR number. The number cannot be changed on this screen.

Client Name is automatically populated from the Client Record. The name cannot be changed on this screen.

Date Issued is the current date. However, if it is past your Clinic's cut off time for the day the date will roll to the next business day.

Payment Category is a drop down box that allows you to select what service category the client is receiving, you may enter the first letter of the category to make selection faster. Examples of service categories are Family Planning, Immunizations, Environmental, and Vital Statistic etc. You cannot type in this box you must make your selection from the categories provided.

Service Code is a drop down box that allows you to select the Service code associated with the type of service for the previously selected category.

Gross Fee Charge is the MAXIMUM amount that can be charged for the type of service provided.

Percent % is the percent of the Gross Fee Charge that the Client is to pay based on their income assessment. 100%, 75%, 50%, 25%, and 0%

Net Charges is an amount calculated based on the Percent of Gross Fee Charge entered previously. This field can be over written to avoid rounding on County Donations, certain Immunizations and for payment on account.

Amount Paid is the amount you are collecting for this service that will be reflected on this receipt. This field cannot be left blank.

Check, Cash, Both are to be selected depending on the type of payment received.

Check Amount/Cash Amount depending on what block is selected will be populated by the amount in the Paid Amount. If the Both box is selected you will need to enter each amount collected based on the cash and check amount.

Previous Balance is for information purposes only and reflects the Balance the Client had prior to the last receipt issued.

Current Balance is the current outstanding amount the client owes prior to creating this receipt.

Vital Stats-1st is the total amount for original certificates issued at $15 per certificate for this receipt.

Vital Stats-2nd is the total amount for copies of certificates issued at $6 per copy for this receipt.

***NOTE*: Vital Stats-1st and Vital Stats-2nd must equal the amount entered in Amount paid**.

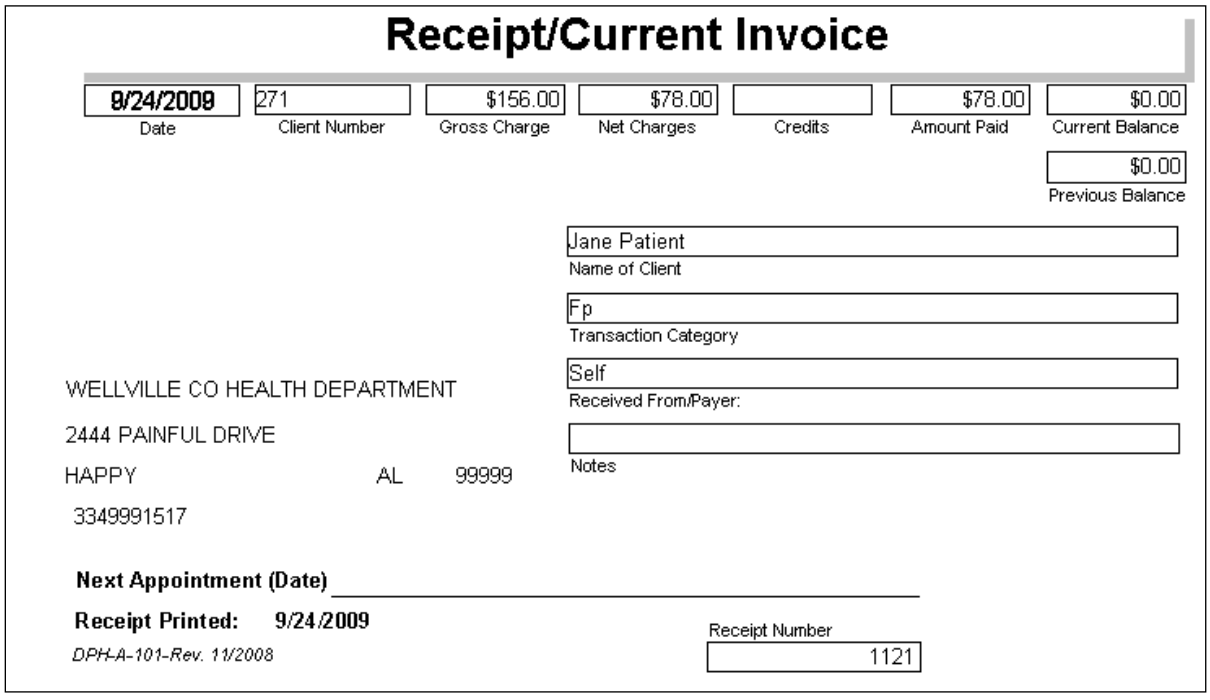
Recap Source is a drop down box that allows you to select where the money collected on this receipt will be captured on the Monthly Recap report. Examples are Family Planning Fees, Environmental Fee, V S 1ST COPY, etc. You cannot type in this box you must make your selection from the Recap Sources provided.

NOTE: When Miscellaneous (05) is selected a description of what the receipt is for must be entered in the NOTES box on the receipt before printing the receipt. *This description is to aid the Financial Services- Budget & Receipts Office in determining why the money was coded to Miscellaneous; it should have enough information so they will understand where the money came from.*

Received From/Payer is an open text field where you record who paid for the services received.

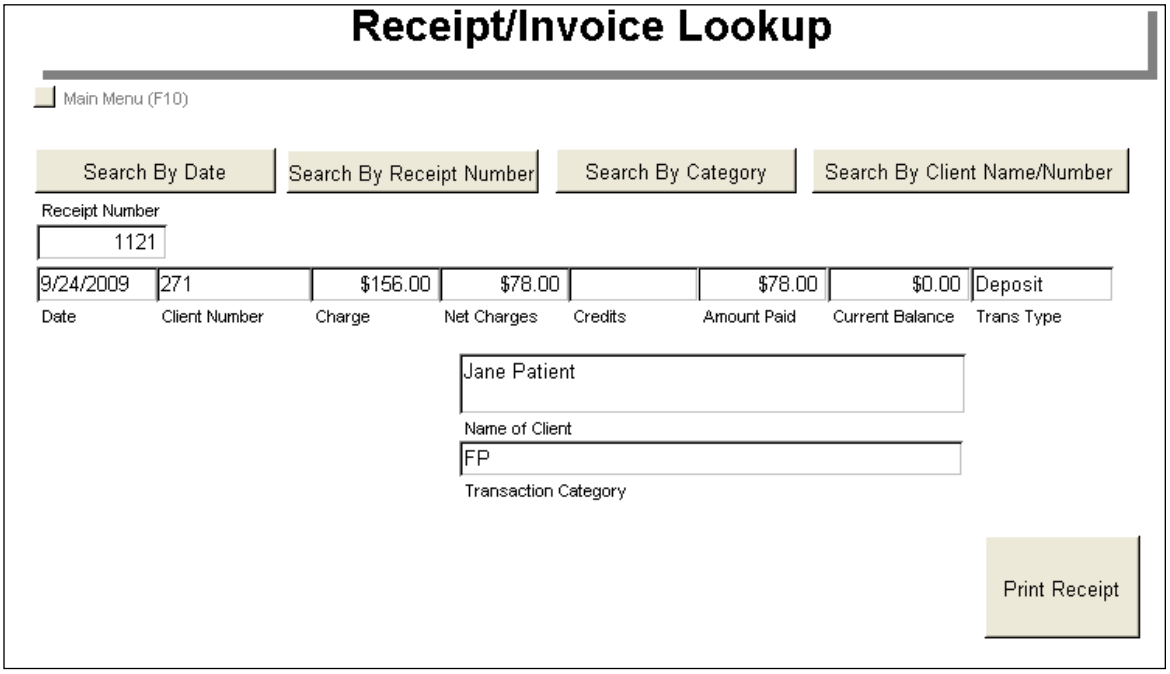
Notes are an open text field that can be used for extra documentation about the receipt and must be used to describe the receipt when the Recap Source of Miscellaneous (05) is used. Entries in this field will print out on the Receipt and the Transactions by Date report (Day Sheet). The Description for Miscellaneous Recap Source will be used on the Electronic Monthly Recap and sent with your Monthly Recap file.

Print Receipt box is for printing this receipt, after reviewing the data entered you must click on Print Receipt in order to create a receipt. When this is done a receipt number will be assigned and the transaction will be recorded to the Clients Ledger as well as printing the receipt to give to the client.

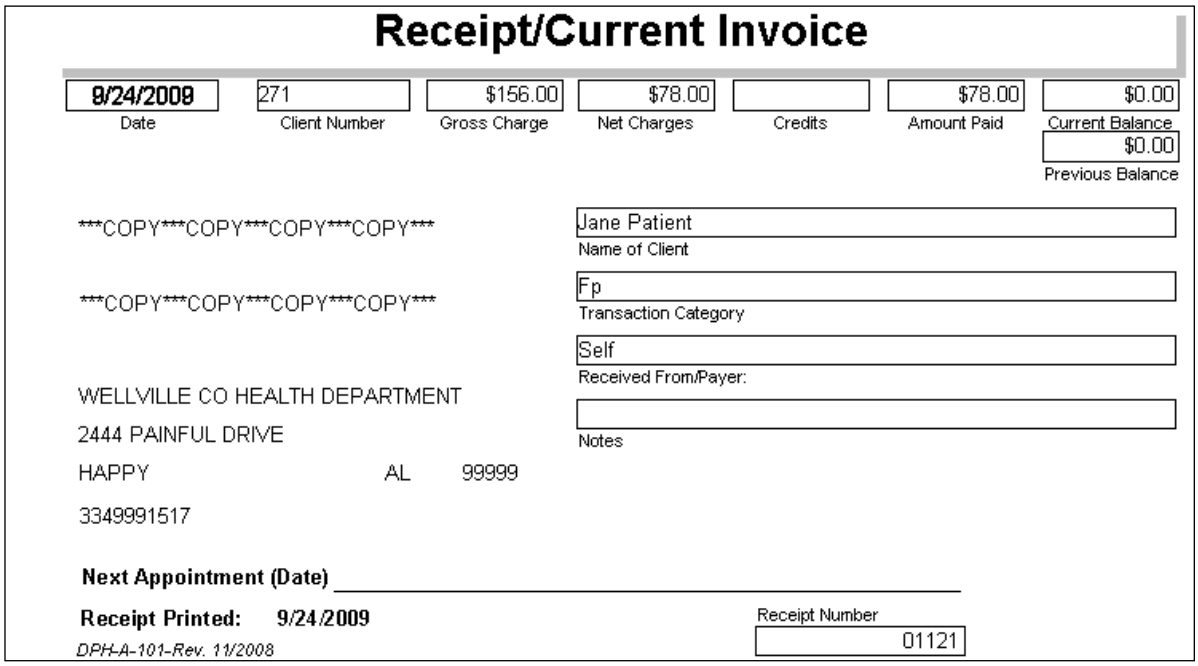


Lookup Receipt

From this sub menu you can look up a previously issued receipt by Date, Receipt Number, Category, or Client Name/Client Number. Below is an example of what the screen looks like when the receipt data is displayed.

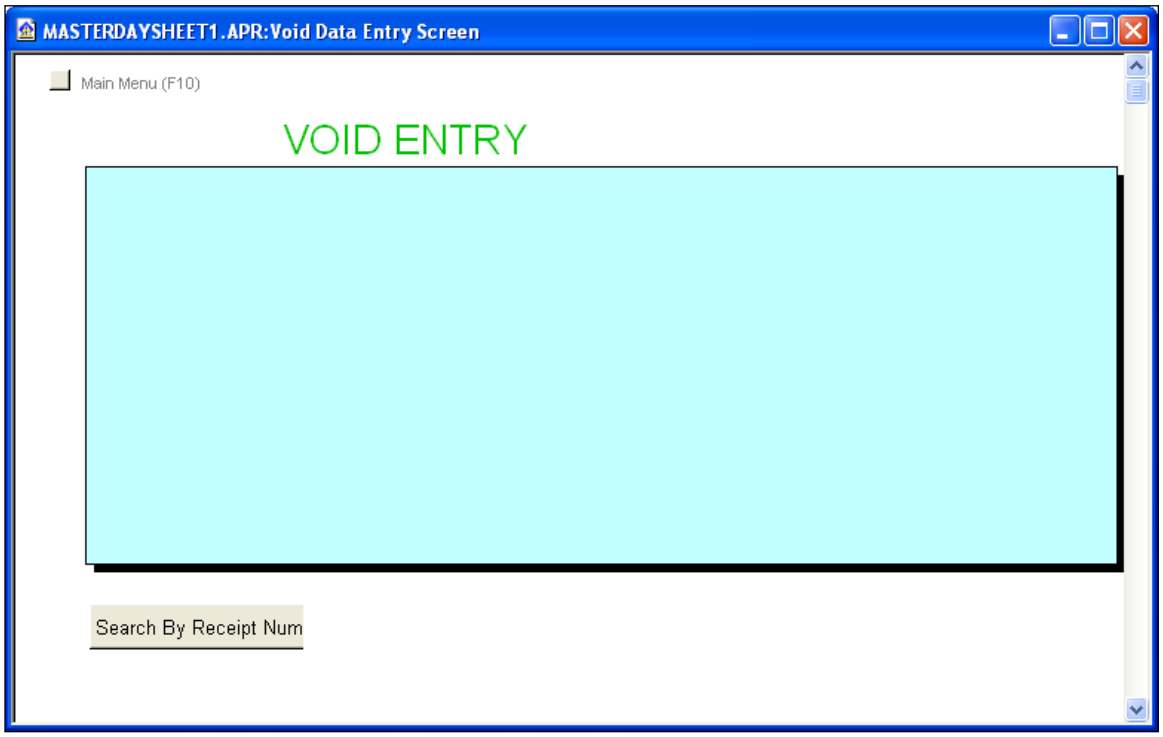


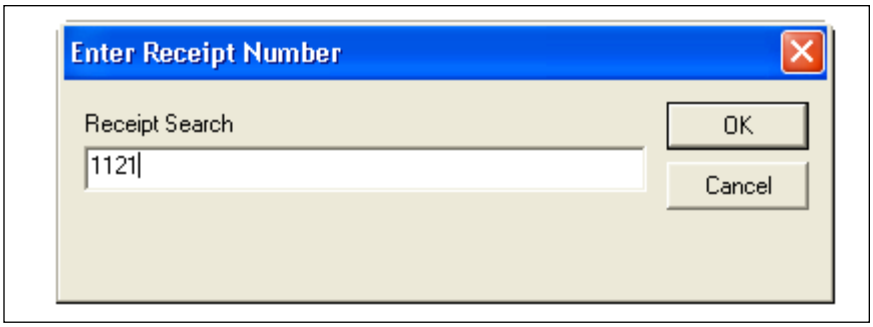
There is a PRINT RECEIPT BOX on the screen that will allow you to print a copy of the selected receipt. The copy will reflect the word COPY printed on the receipt.



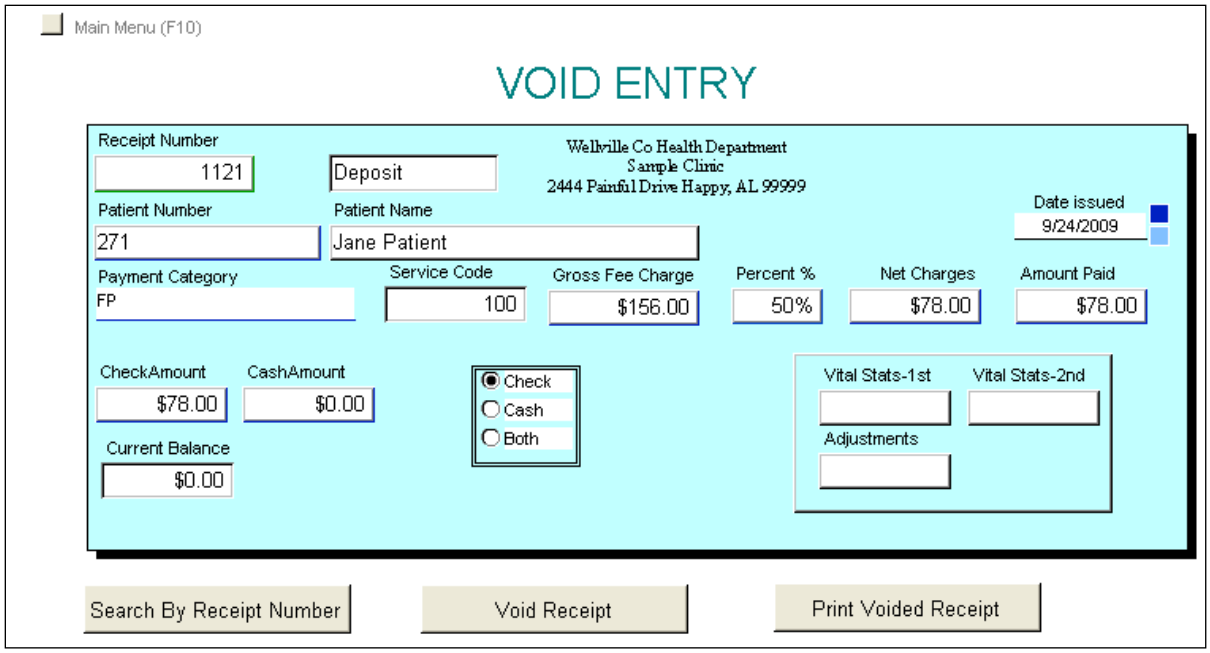
Void Receipt

This sub menu item allows you to VOID an already issued receipt. You must know the receipt number in order to lookup the receipt from this screen. Also you can only VOID a RECEIPT on the SAME DAY THE RECEIPT WAS ISSUED or dated. If the closeout time has been reached, a receipt can still be VOIDED if it has the CURRENT DATE and the Day Sheet has not been closed and the Deposit made has not been made. If the date has rolled to the next business day it will have to be voided on that day if the deposit has not been made.

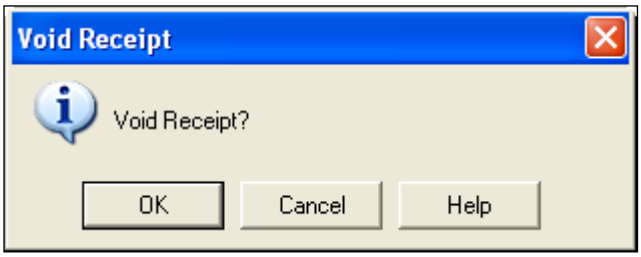




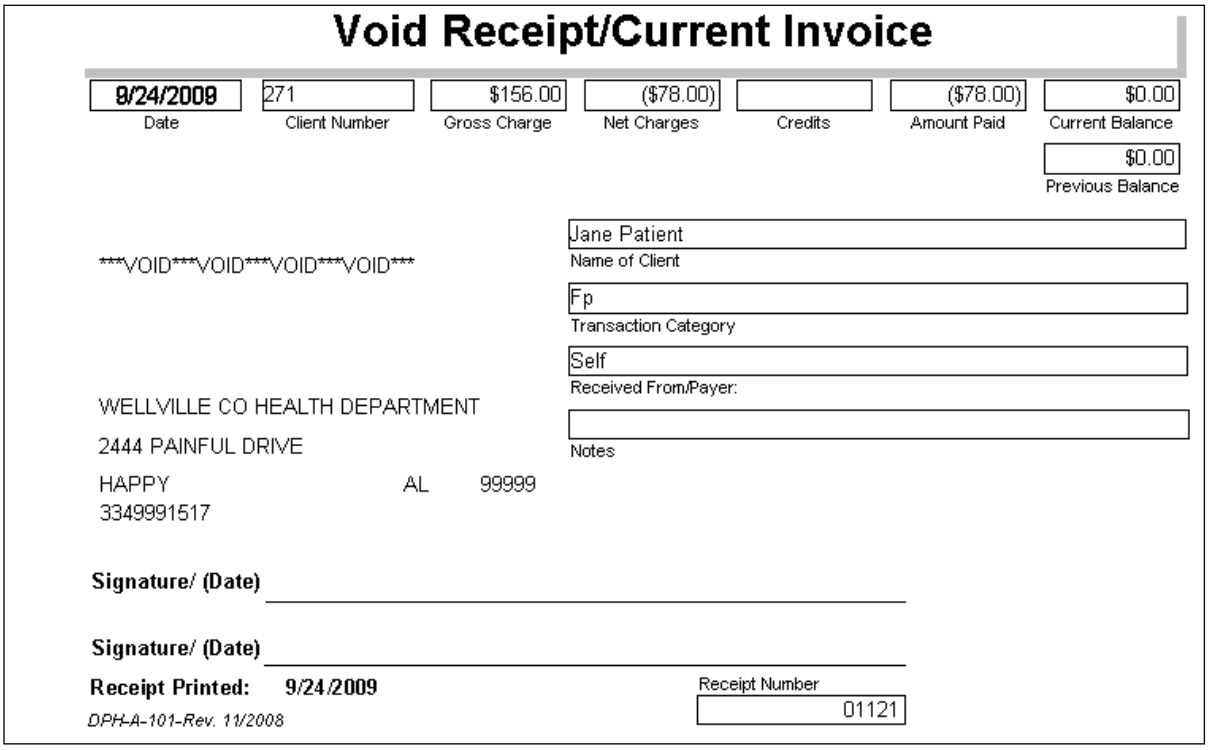
When the receipt to be voided is located you will receive the following screen.



At the bottom of the screen you will need to click on the Void Receipt Button.
Once you click the Void Receipt Button, the following will display. When you click the OK button on both pop-up windows the receipt will be voided and then you will get a confirmation displayed letting you know the receipt has been voided.



Click on the Print Voided Receipt this will print a copy of the voided receipt.
A Voided Receipt must have two signatures or initials and dated in red.
On the next page is an example of a Voided Receipt.



Void Receipt/Current Invoice

Date	Client Number	Gross Charge	Net Charges	Credits	Amount Paid	Current Balance
9/24/2009	271	$156.00	($78.00)		($78.00)	$0.00

Previous Balance: $0.00

VOIDVOID***VOID***VOID***

Name of Client: Jane Patient

Transaction Category: Fp

Received From/Payer: Self

Notes:

WELLVILLE CO HEALTH DEPARTMENT
2444 PAINFUL DRIVE
HAPPY AL 99999
3349991517

Signature/ (Date) _____

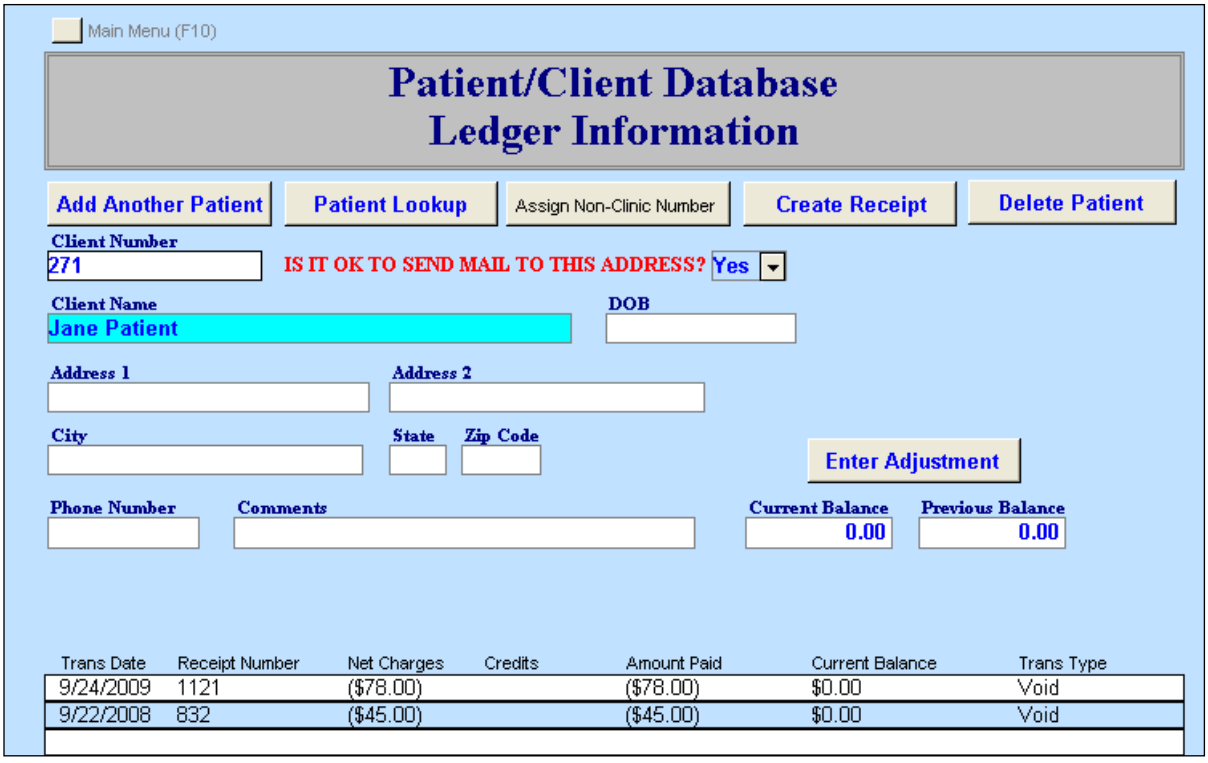
Signature/ (Date) _____

Receipt Printed: 9/24/2009

Receipt Number: 01121

DPH-A-101-Rev. 11/2008

The Client's ledger entry for this receipt will reflect it as voided.



Main Menu (F10)

Patient/Client Database
Ledger Information

Add Another Patient | Patient Lookup | Assign Non-Clinic Number | Create Receipt | Delete Patient

Client Number: 271

IS IT OK TO SEND MAIL TO THIS ADDRESS? Yes

Client Name: Jane Patient

DOB:

Address 1:

Address 2:

City:

State:

Zip Code:

Enter Adjustment

Phone Number:

Comments:

Current Balance: 0.00

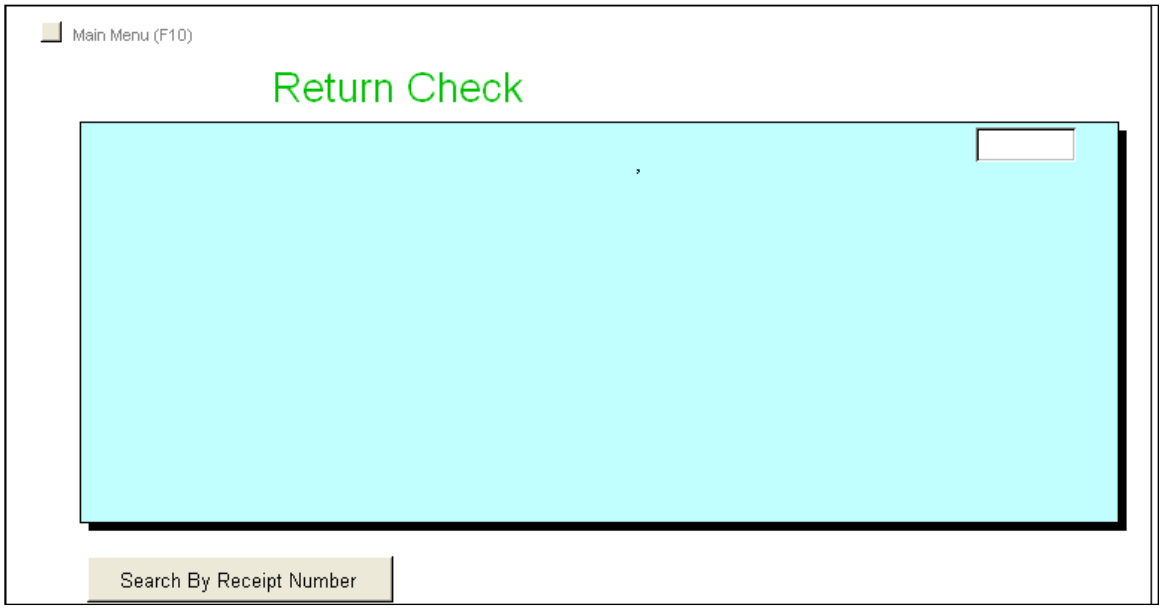
Previous Balance: 0.00

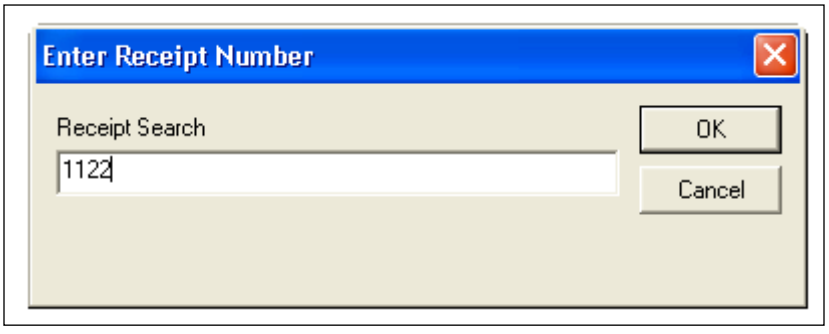
Trans Date	Receipt Number	Net Charges	Credits	Amount Paid	Current Balance	Trans Type
9/24/2009	1121	($78.00)		($78.00)	$0.00	Void
9/22/2008	832	($45.00)		($45.00)	$0.00	Void

Return Check
(See Special instructions at the end of this section for returned check without a Client Ledger Card)

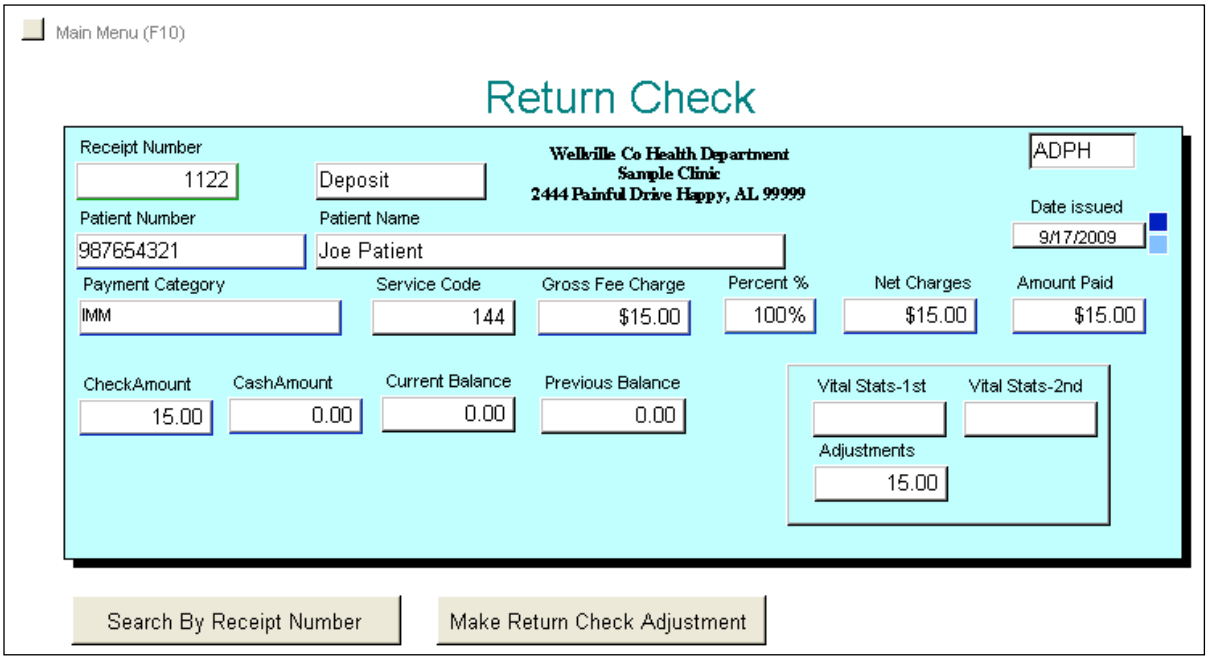
This sub menu is used to capture returned checks. You must know the original receipt number in order to lookup the receipt from this screen. On this screen you click on the Search by Receipt Number button and enter the receipt number on the pop-up window that appears.

If multiple receipts were issued for the Returned Check these instructions must be followed for each receipt.

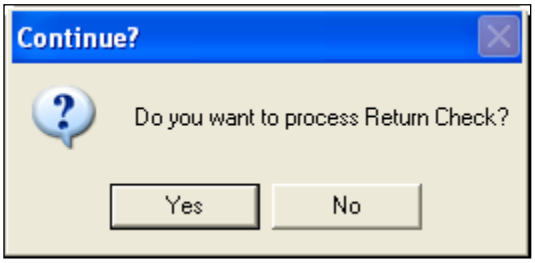




Verify you have the correct Receipt displayed on the screen. The check amount should be displayed in the Adjustment amount, if it is not, enter the Check Amount in that field. **To successfully process a Return Check the Check amount and the Adjustment amount must equal.**

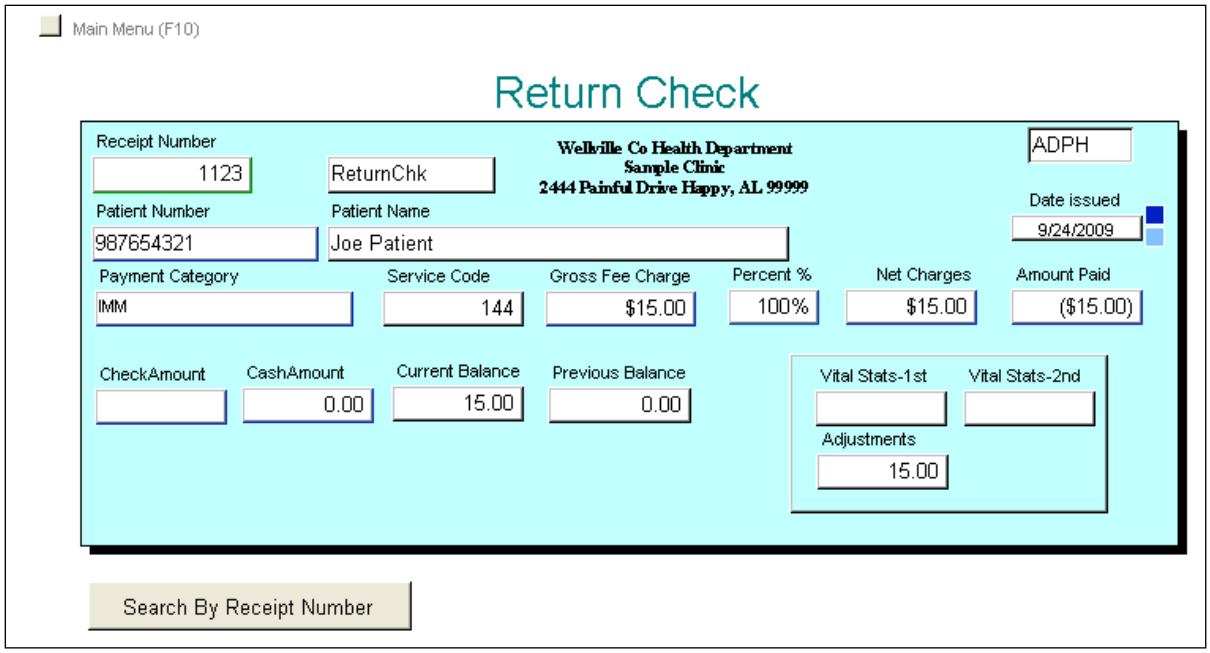


When you have verified these two fields are equal click on Make Return Check Adjustment. You will receive a message "Do you want to process Return Check?" click on Yes or No.

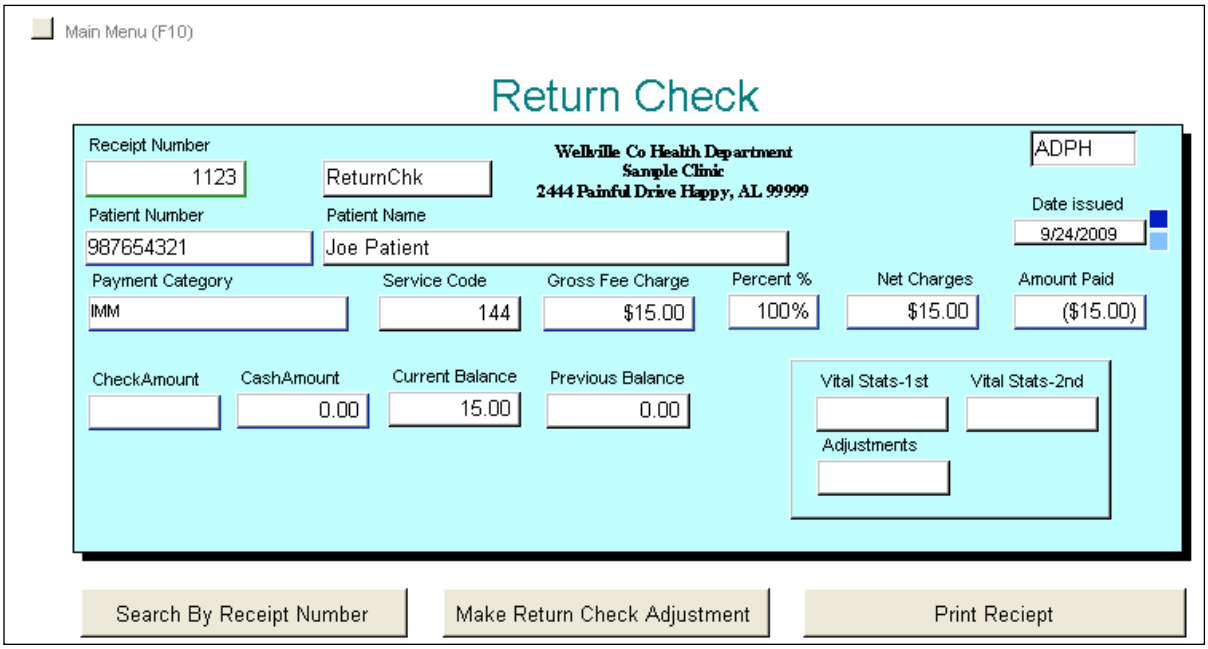


If you click No you will return to the Receipt Screen and you can either Select another receipt number or press F10 to return to the Main Menu.

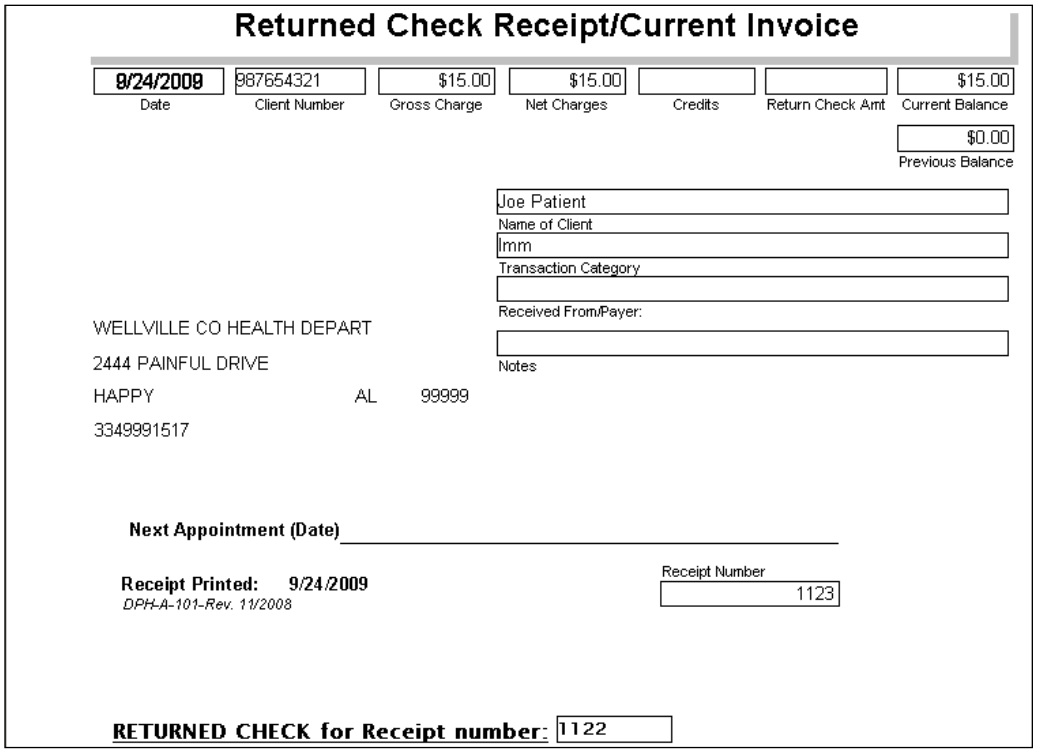
If you click yes a return check receipt is created and displayed. See next page.



Write down the new receipt number being displayed, select F10 to return to the Main Menu and select Return Check option again. Click on Search by Receipt Number and enter the new receipt number assigned to the Return Check. When the Return Check receipt is displayed on the screen, click on the Print Receipt. This will print a Return Check Receipt and on the bottom of the Receipt it will indicate which original receipt had the Return Check.



Refer to the example of a Return Check Receipt on the next page.



Returned Check Receipt/Current Invoice

Date	Client Number	Gross Charge	Net Charges	Credits	Return Check Amt	Current Balance
9/24/2009	987654321	$15.00	$15.00			$15.00

$0.00
Previous Balance

Joe Patient
Name of Client
Imm
Transaction Category
Received From/Payer:
Notes

WELLVILLE CO HEALTH DEPART
2444 PAINFUL DRIVE
HAPPY AL 99999
3349991517

Next Appointment (Date)

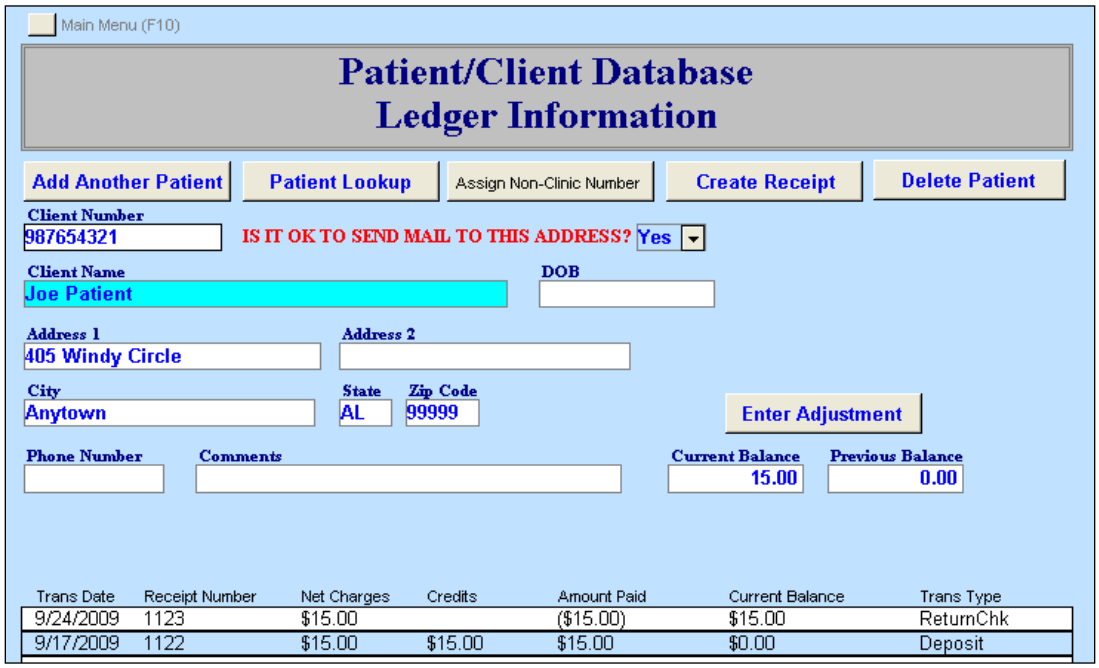
Receipt Printed: 9/24/2009
DPH-A-101-Rev. 11/2008

Receipt Number
1123

RETURNED CHECK for Receipt number: 1122

After printing the Return Check Receipt you are returned to the Main Menu. Attach this receipt to the Transactions by Date report.

Return to the client ledger card and verify that the return check has been posted to the client ledger card. The return check should be listed and the current balance should reflect the check amount being added in to any existing balance.



Main Menu (F10)

Patient/Client Database
Ledger Information

Add Another Patient | Patient Lookup | Assign Non-Clinic Number | Create Receipt | Delete Patient

Client Number: 987654321
IS IT OK TO SEND MAIL TO THIS ADDRESS? Yes
Client Name: Joe Patient
DOB:
Address 1: 405 Windy Circle
Address 2:
City: Anytown
State: AL
Zip Code: 99999
Enter Adjustment
Phone Number:
Comments:
Current Balance: 15.00
Previous Balance: 0.00

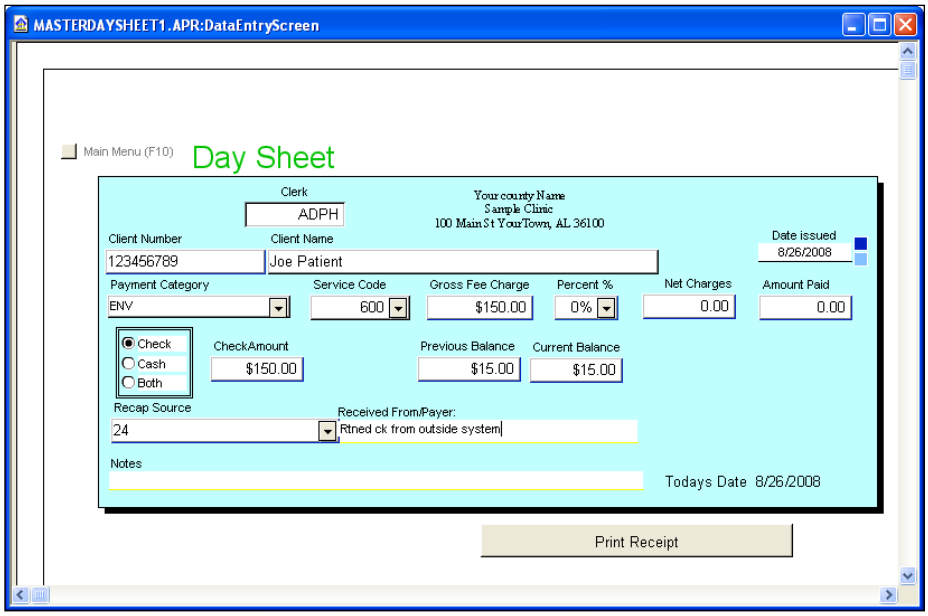
Trans Date	Receipt Number	Net Charges	Credits	Amount Paid	Current Balance	Trans Type
9/24/2009	1123	$15.00		($15.00)	$15.00	ReturnChk
9/17/2009	1122	$15.00	$15.00	$15.00	$0.00	Deposit

Special Instructions for Processing Return Checks from Off-site Flu Clinics and Vital Statistics Cash Register receipts.

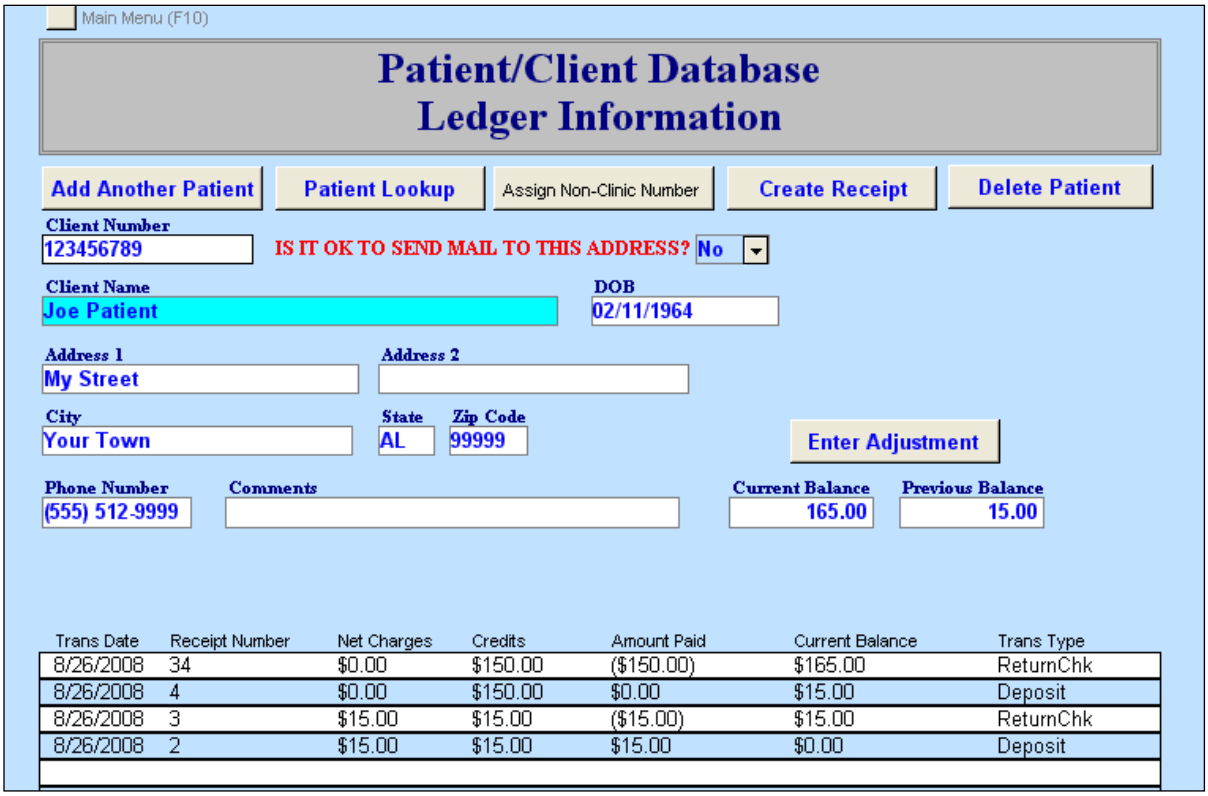
Circumstances that these instructions would be used are:

- You receive a Return Check for a receipt that was issued from the old manual system.
- You receive a Return Check for a check received from a flu clinic and the total collected was entered instead of individual receipts being issued.
- You receive a Return Check for Vital Statistics and you use a Cash Register System.

1. Look Up Patient - If the Patient is not found you will need to add the patient
2. If the Patient is found create a receipt.
3. Use the information from the Original Receipt to create the new receipt EXCEPT:
   - The % must be ZERO
   - Amount Paid must be ZERO
   - Click CHECK
   - The Check Amount must equal the Original Receipt and/or the Return Check amount
   - Received From/Payer: **RTR CHK FROM**



4. Print the Receipt
5. F10
6. Select Return Check option
   - Search with the new zero receipt number
   - Verify the correct Receipt is displayed on the screen
   - Click on Make Return Check Adjustment
   - Answers Y to do you want to Process Return Check?
   - Write down new receipt number in the upper left corner of the screen
   - F10
   - Select Return Check again
   - Search using the Receipt number for the Return Check just processed
   - Verify you have the correct receipt on the screen
   - Click on the Print Receipt



Attach both the ZERO Receipt and the Return Check Receipt to the Transactions by Date report.

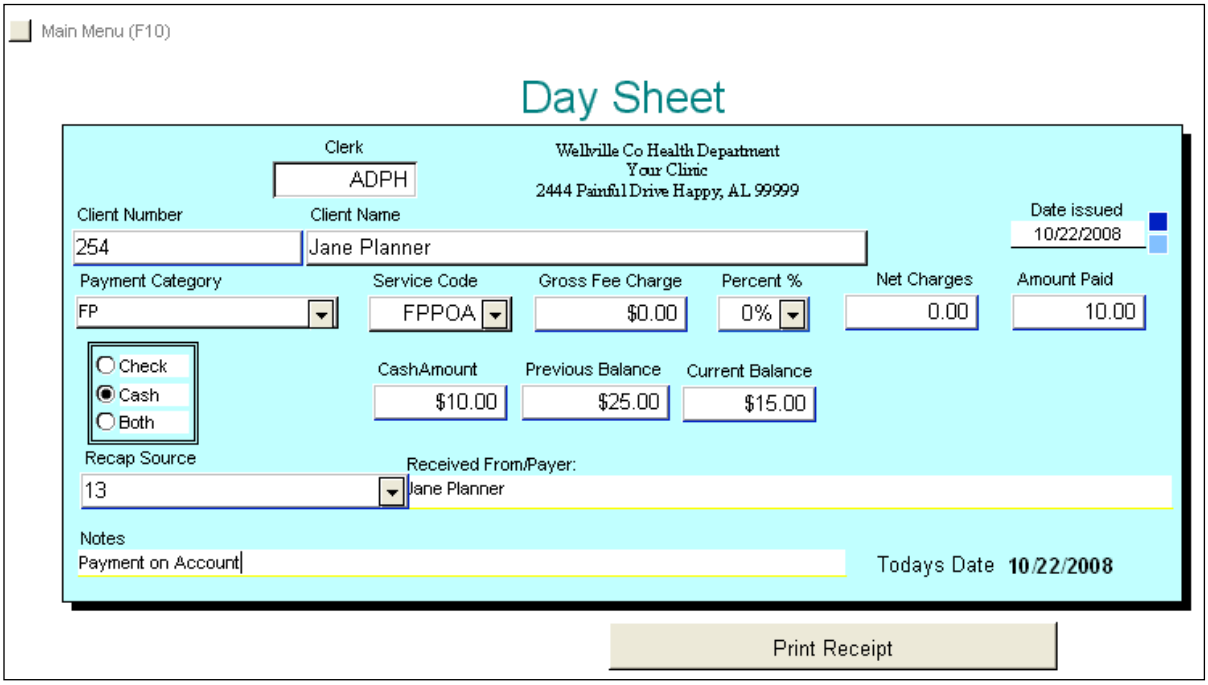
The Check Amount on the Transactions by Date report will contain the amount entered on the Zero Receipt, but it will not be reflected in the Amount Paid column.

Documentation will be needed because the Check and Cash amounts will not total the Amount Deposited.

Payment on Account or Redeposit of a Return Check

To process a payment on account or redeposit of a returned check, pull up the Patient/Client Ledger Information.

Click on the Create Receipt button.

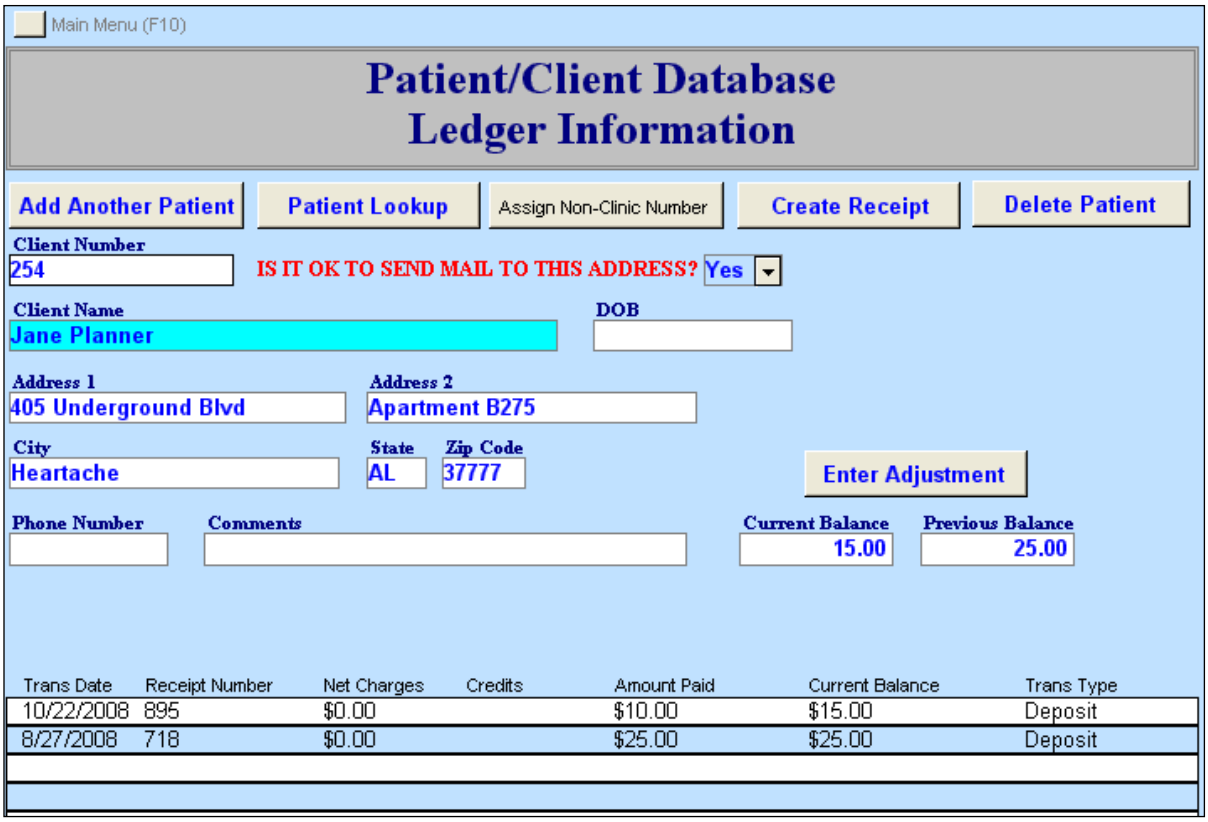


Create a receipt for the Payment Category (do a receipt lookup if you need this information).

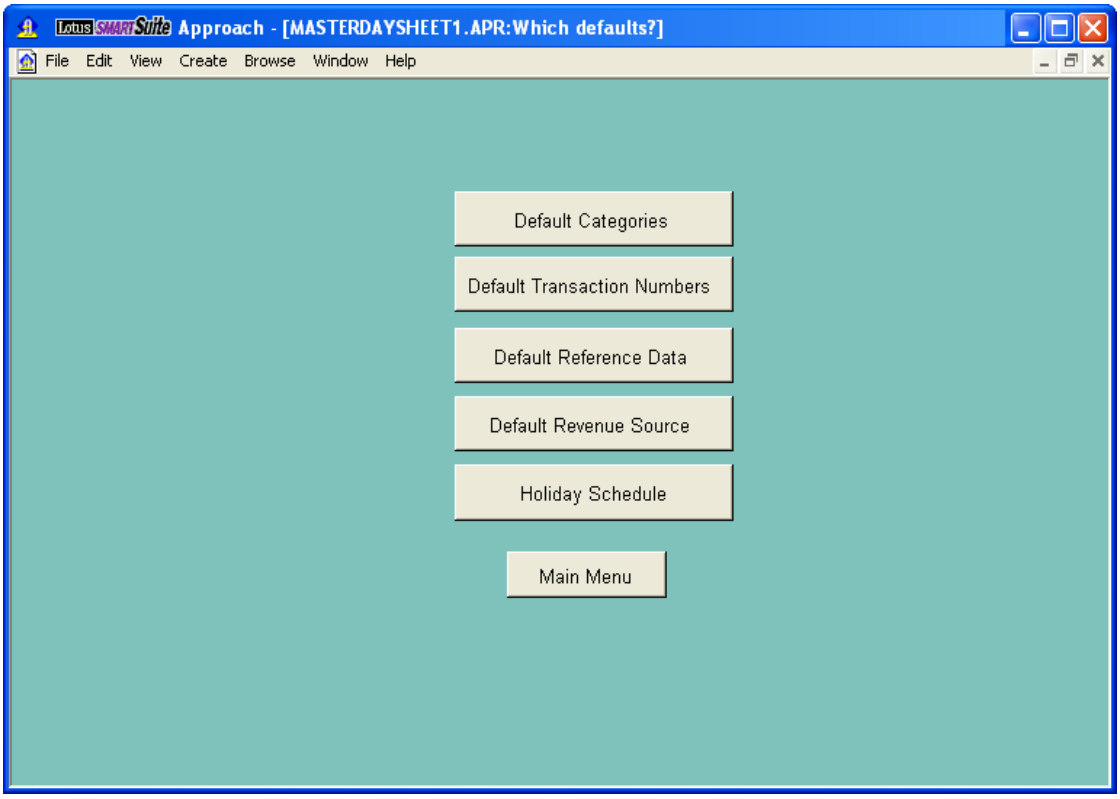
Use the POA (Payment On Account) service codes for Family Planning, Other Clinic, Immunization, and Environmental. Gross fee, Percent, and Net Charges will be zero. Enter the amount of payment in the Amount Paid field. Refer to the example above.

NOTE: Vital Statistics processing of Return Check is handled the same way except there is not a Service Code for Payment on Account. Use the Service Code 802 and follow the example above plus enter the Vital Stats-1st and Vital Stats-2nd amounts. Make sure you select the 71 Vital Statistics Recap Source.

Then after printing the receipt the client ledger card will show the payment and reflect the new current balance for the client.



Defaults Menu (F2) Office Mangers/System Administrators



This Sub Menu is only to be updated by the designated Administrator. The items on this menu control the Day Sheet Types of service, Rates charged, County information, Recap sources and Receipt numbering, Patient numbering, Invoice/Letter, and the Holiday Schedule.

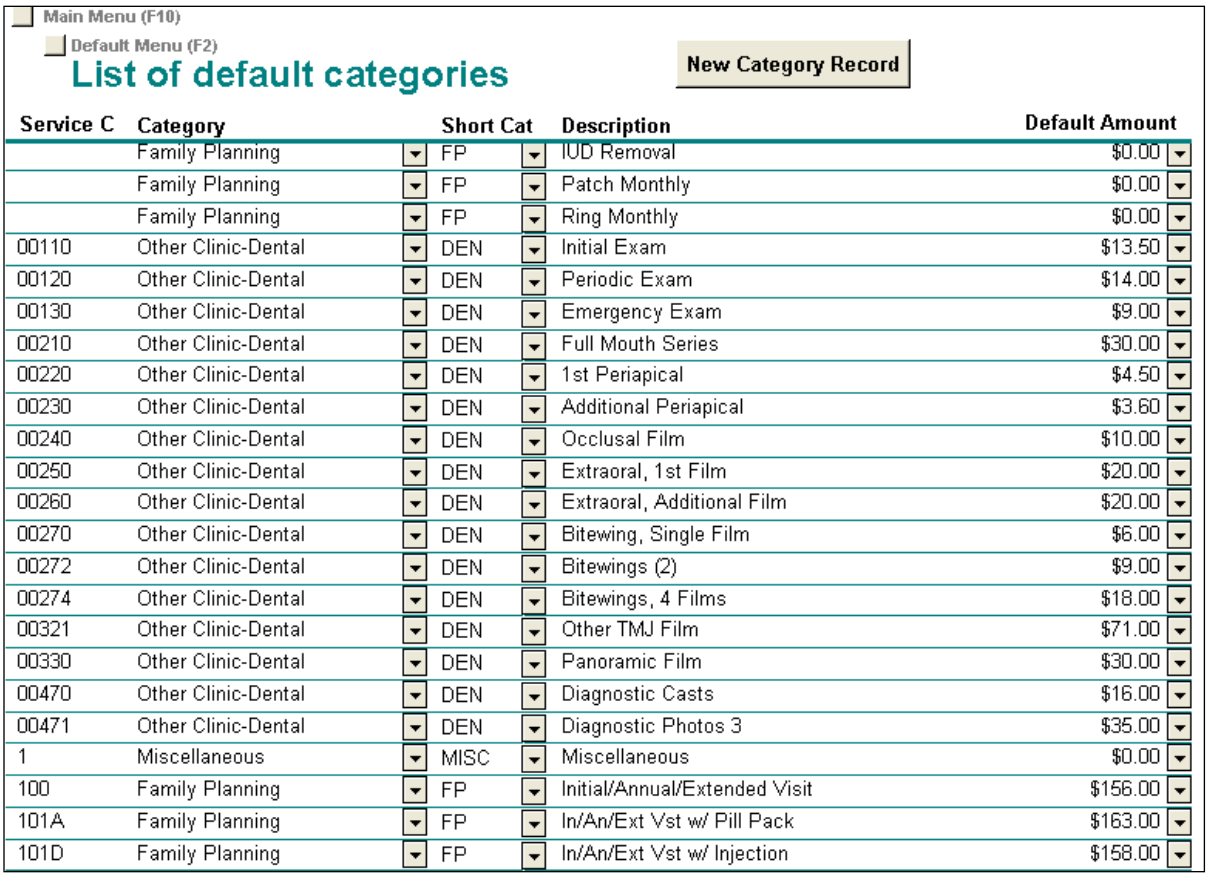
Default Category

This screen includes all your service codes, categories, descriptions, and the default amounts for each service codes. These amounts have been downloaded for you from the tables in the Fee Manual. You will need to double check them to make sure that they are in accordance with the Fee Schedule that you have approved for your county.

To Add a New Category Click on the NEW CATEGORY BUTTON and enter the new Service Code, use the drop down boxes for Category, Short Cat, and Default amounts. Enter the Description.

To update the category table click on **Default Categories** button and you will receive a listing of categories. To update a category place your cursor on that line, use the drop down boxes to update or change Category, Short Cat, and Default Amount columns. In the Amount Column you may type the correct amount once the drop down box has been selected. To Change the Description you must highlight the entire description and type the change.

To print the listing Click on File in the upper left corner and then click on print. This will give you a listing of all the categories. You can follow these instructions to print any of the Default Menu options.


Main Menu (F10)

Default Menu (F2)

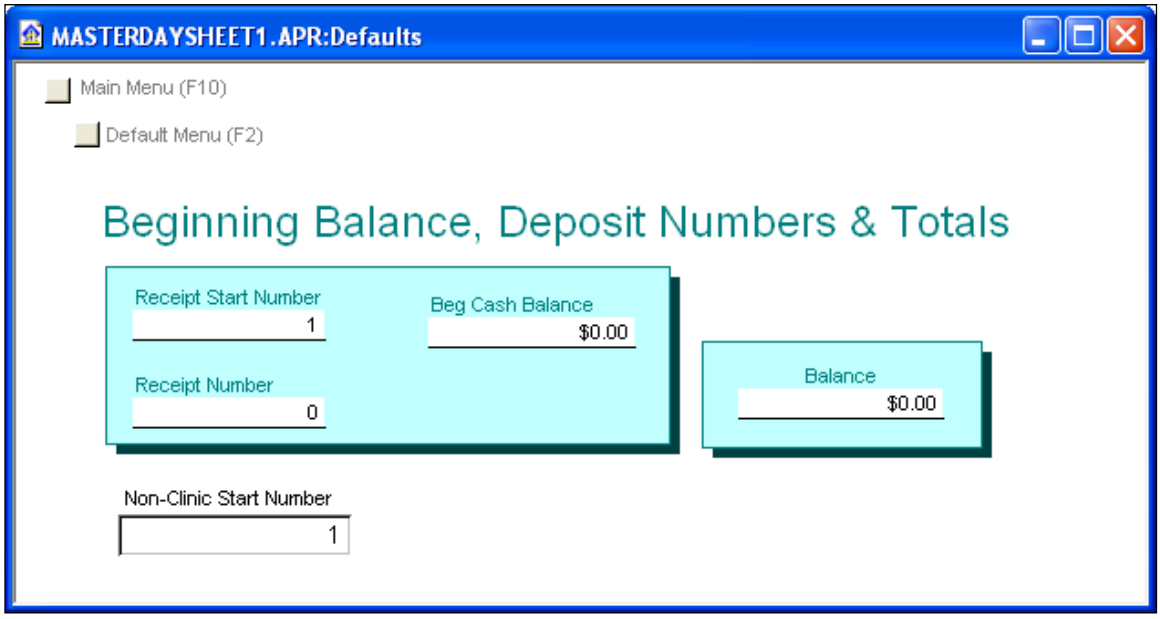
List of default categories

New Category Record

Service C	Category	Short Cat	Description	Default Amount
	Family Planning	FP	IUD Removal	$0.00
	Family Planning	FP	Patch Monthly	$0.00
	Family Planning	FP	Ring Monthly	$0.00
00110	Other Clinic-Dental	DEN	Initial Exam	$13.50
00120	Other Clinic-Dental	DEN	Periodic Exam	$14.00
00130	Other Clinic-Dental	DEN	Emergency Exam	$9.00
00210	Other Clinic-Dental	DEN	Full Mouth Series	$30.00
00220	Other Clinic-Dental	DEN	1st Periapical	$4.50
00230	Other Clinic-Dental	DEN	Additional Periapical	$3.60
00240	Other Clinic-Dental	DEN	Occlusal Film	$10.00
00250	Other Clinic-Dental	DEN	Extraoral, 1st Film	$20.00
00260	Other Clinic-Dental	DEN	Extraoral, Additional Film	$20.00
00270	Other Clinic-Dental	DEN	Bitewing, Single Film	$6.00
00272	Other Clinic-Dental	DEN	Bitewings (2)	$9.00
00274	Other Clinic-Dental	DEN	Bitewings, 4 Films	$18.00
00321	Other Clinic-Dental	DEN	Other TMJ Film	$71.00
00330	Other Clinic-Dental	DEN	Panoramic Film	$30.00
00470	Other Clinic-Dental	DEN	Diagnostic Casts	$16.00
00471	Other Clinic-Dental	DEN	Diagnostic Photos 3	$35.00
1	Miscellaneous	MISC	Miscellaneous	$0.00
100	Family Planning	FP	Initial/Annual/Extended Visit	$156.00
101A	Family Planning	FP	In/An/Ext Vst w/ Pill Pack	$163.00
101D	Family Planning	FP	In/An/Ext Vst w/ Injection	$158.00

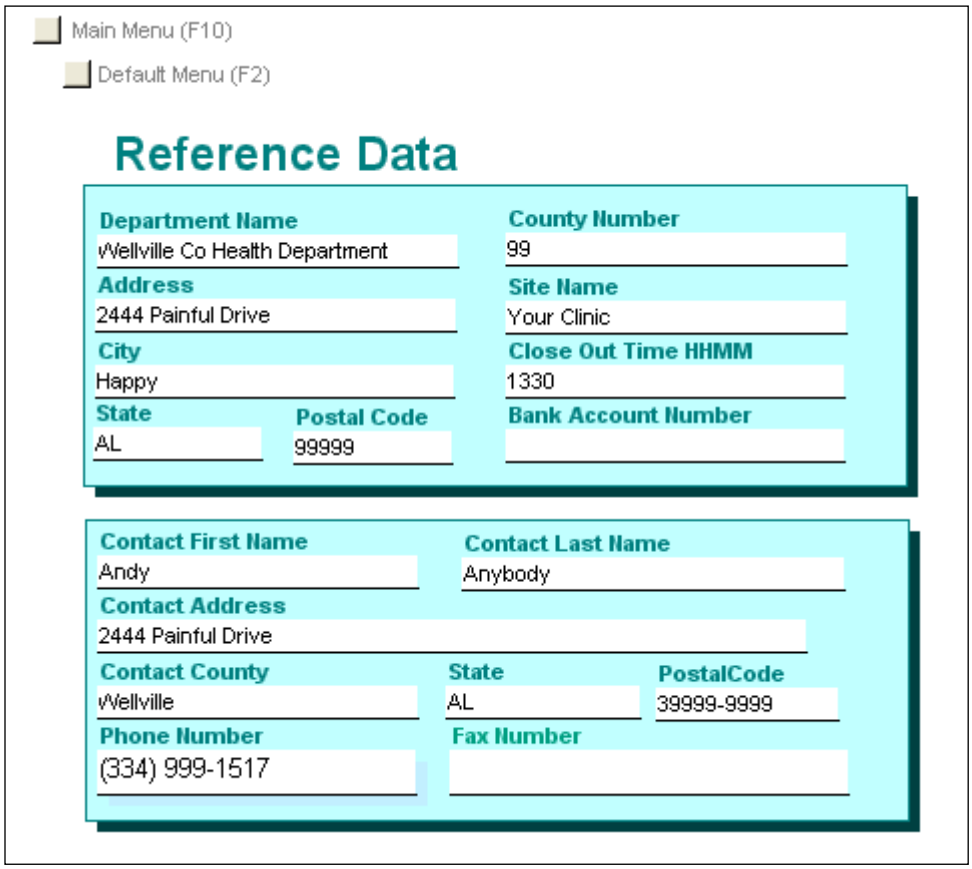
Default Transaction Numbers (THIS IS FOR FIRST TIME SETUP ONLY)

This screen allows you to record your Beginning Receipt Number, Beginning Cash Balance (approved change funds), and your Non-Clinic Beginning Number. The receipt numbers will automatically advance to the next number. Your non-clinic number will be assigned for any clients/patients who do not require a medical record, (Environmental, Vital States, etc.). Suggest leaving these as they are except for Beg Cash Balance.



Default Reference Data

This screen allows you to record your contact information for your Health Department. This information will print out on the receipts and invoice/letters you issue to your clients. The county information will be used to produce the Monthly Recap. The Close Out Time is the time that the office manager sets to have the system automatically roll the current date to the next business day. The close out time must be done using a 24 hour clock. So for the hours you must add 12 to the time to get the correct time. For example if your close out time is 3:30pm then you would enter 1530 as your close out time. If your close out time is in the morning you would just enter the time like 0800 for 8:00am.



The Department Name, Address, City, State, Postal Code are used in the Mail Payments to section of the Invoice/Letter.

The Contact First Name and Contact Last Name are used for the person signing the Invoice/Letter.

The Contact County is used on the Invoice/Letter to put next to County Health Department.

Default Revenue Source Codes

This screen includes all the revenue source codes that are reported on the monthly recap for Finance. These have already been populated for you. You cannot add or delete a code but you can change the description. Local Codes must be updated to have the approved descriptions. If you do not know what Local Codes your county/site have been assigned, a list can be provided to the Office Managers and Area Clerical Directors by the Budget Office.

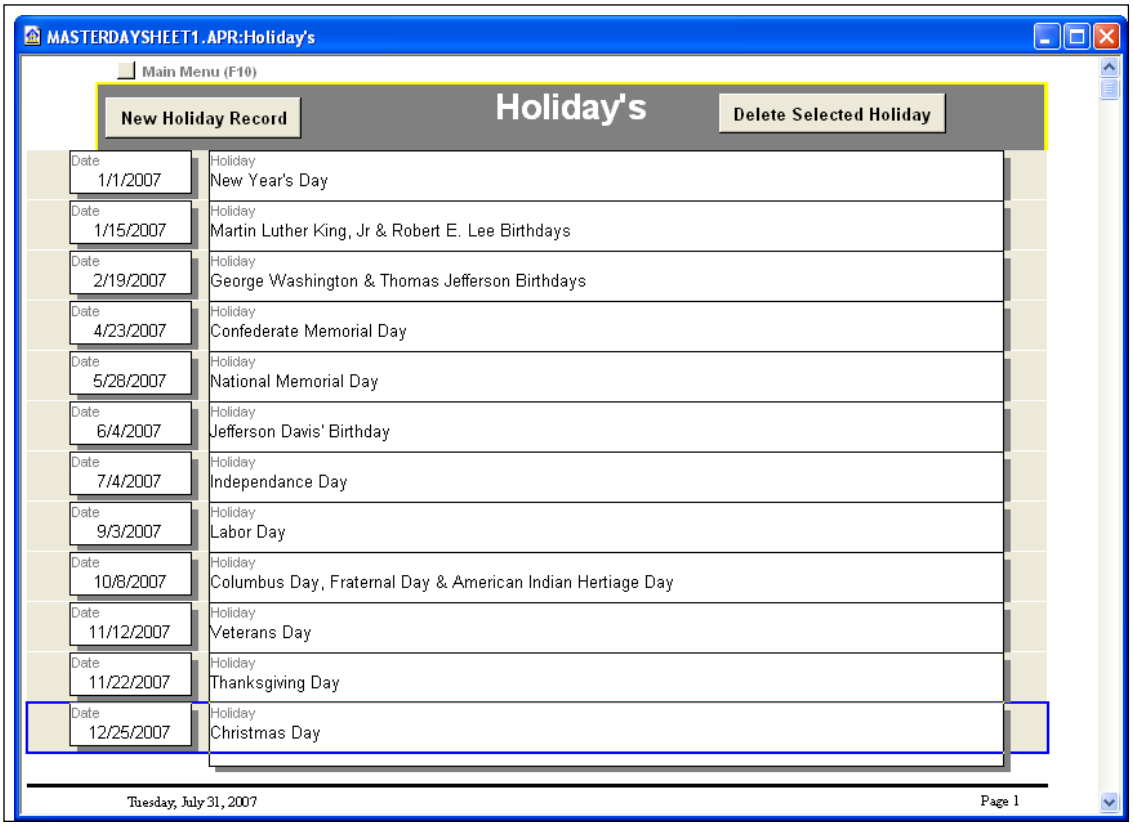

Default Menu (F2)

Revenue Source For Monthly Recap

RevenueSource	RevenueDescription	Valid
01	COUNTY FUNDS	
05	MISCELLANEOUS	
08	MATERNITY CARE COORDINATION	
09	GIFT OF LIFE	
10	HOME HLTH OTH FEES	
11	FAMILY PLANNING CONTRACEPTIV	
13	FAM PLAN PT FEES	
14	MEDICAID MATERNITY - FEE SERVI	
15	MATERNITY PT FEE	
16	MEDICAID WAIVER-COA	
18	DONATIONS	
20	PATIENT FEES DENTAL	
22	PATIENT FEES CLINIC	
23	IMMUNIZATIONS	
24	ENVIRONMENT FEE	
27	MATERNITY OTHER	
28	MEDICAID DENTAL	
30	LOCAL SUPPORT	
31	LOCAL SUPPORT	
32	LOCAL SUPPORT	
33	LOCAL SUPPORT	
34	LOCAL SUPPORT	
35	LOCAL SUPPORT	
37	HIV/AIDS WAIVER	
40	LOCAL SUPPORT	
41	CASE MANAGEMENT	
44	OPTIONS II	
45	OFFICE VISITS - MEDICAID	
47	LOCAL SUPPORT	
4A	OPTIONS I	
50	LOCAL SUPPORT	
51	LOCAL SUPPORT	

Office Holiday Schedule

This screen shows the scheduled office holidays. The state holidays have been pre-loaded. The office manager will have to update the dates every year to ensure that the receipt dates roll forward correctly when a new receipt is being created



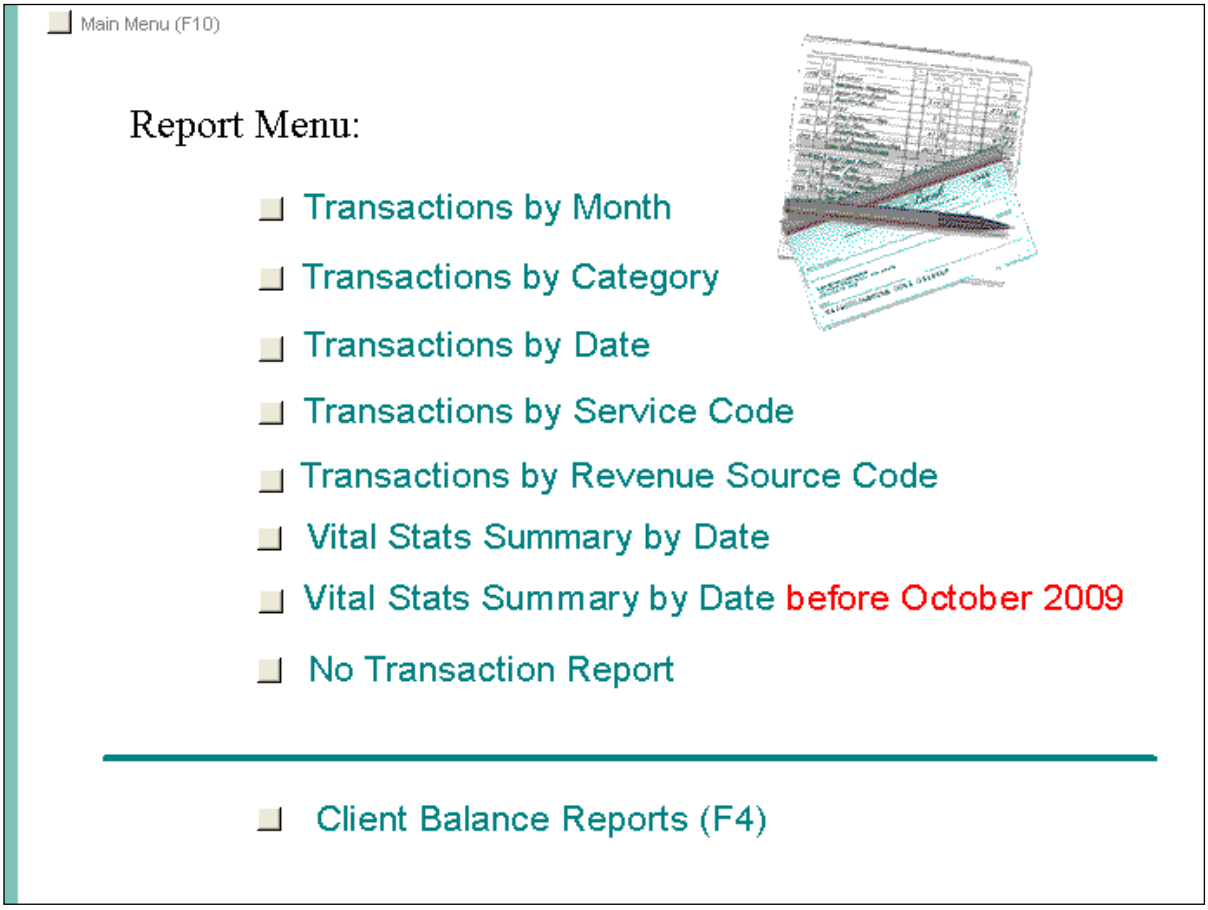
If your county has a different holiday or a Clinic closed date other than those listed, click on the New Holiday Record to add that date to the schedule. Also, if we are granted additional Holiday Time by the Governor this will need to be added as well.

To Add a Holiday click on New Holiday Record button, enter the date and the description of the Holiday. Press enter then F10 to return to the Main Menu or F2 to return to the Defaults Menu. New Holiday records added will be found at the end of the list.

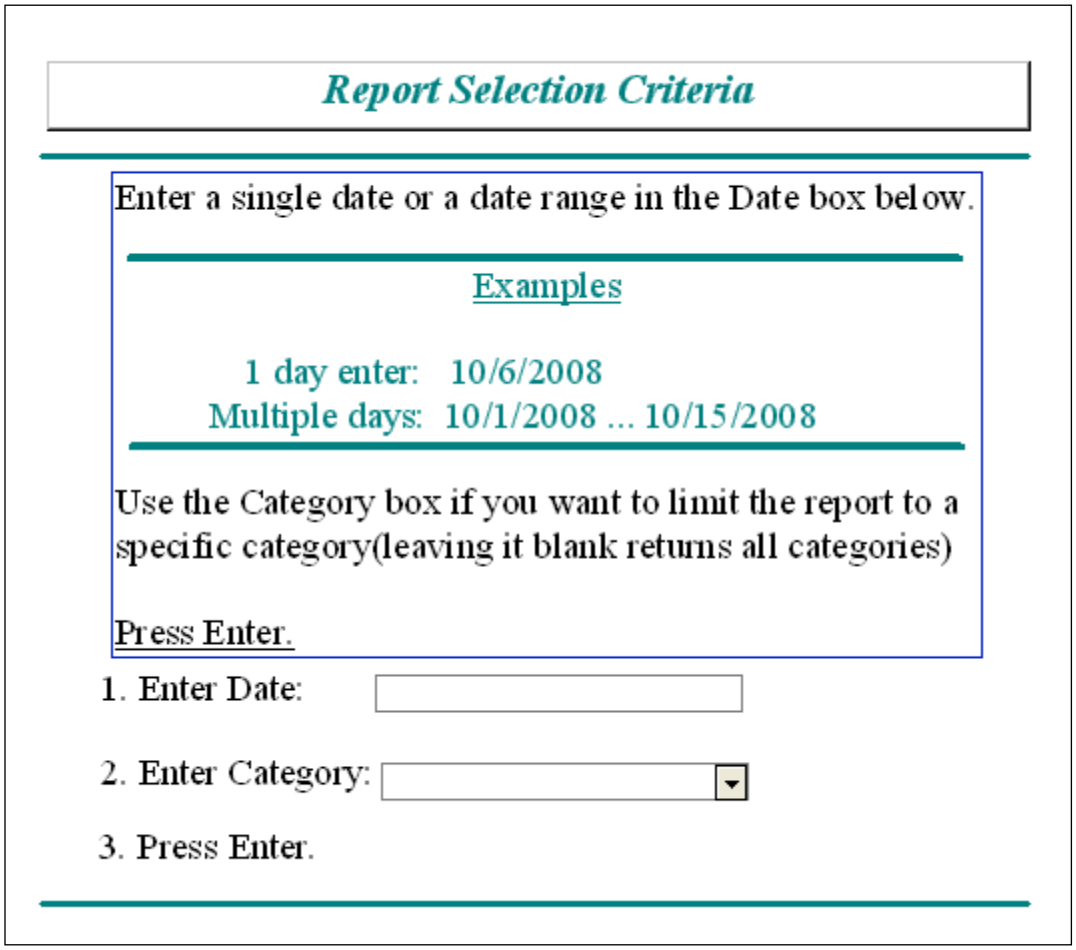
To Delete a Holiday: Click on the date of the Holiday you wish to Delete, and then click on the Delete Selected Holiday button. Press enter then F10 to return to the Main Menu or F2 to return to the Defaults Menu.

Reports Menu (F5)

This sub menu contains reports available for reviewing transactions. Running of the reports above the dividing line is the same for each report. The Client Adjustment Reports brings up another menu of reports (F4).



When you click on one of the report types you will receive a screen with the following prompts



If you clicked on the wrong report selection and this screen is displayed, and F10 does not work. DO NOT click on the red X in the top right corner of the screen Just press enter and after the report displays then you can press F10 to go back to the Main Menu.

ENTER DATE: For one day MM/DD/YY or for a range such as a week or month you will enter the appropriate range MM/DD/YY ... MM/DD/YY, notice the example there is a space and 3 periods and another space between the two date ranges. **IF THE DATE BOX IS LEFT BLANK THE REPORT WILL CONTAIN ALL TRANSACTIONS THAT ARE IN THE SYSTEM.**

ENTER CATEGORY: Use the drop down box and select a category or leave the box blank and you will receive all categories for the date selection.

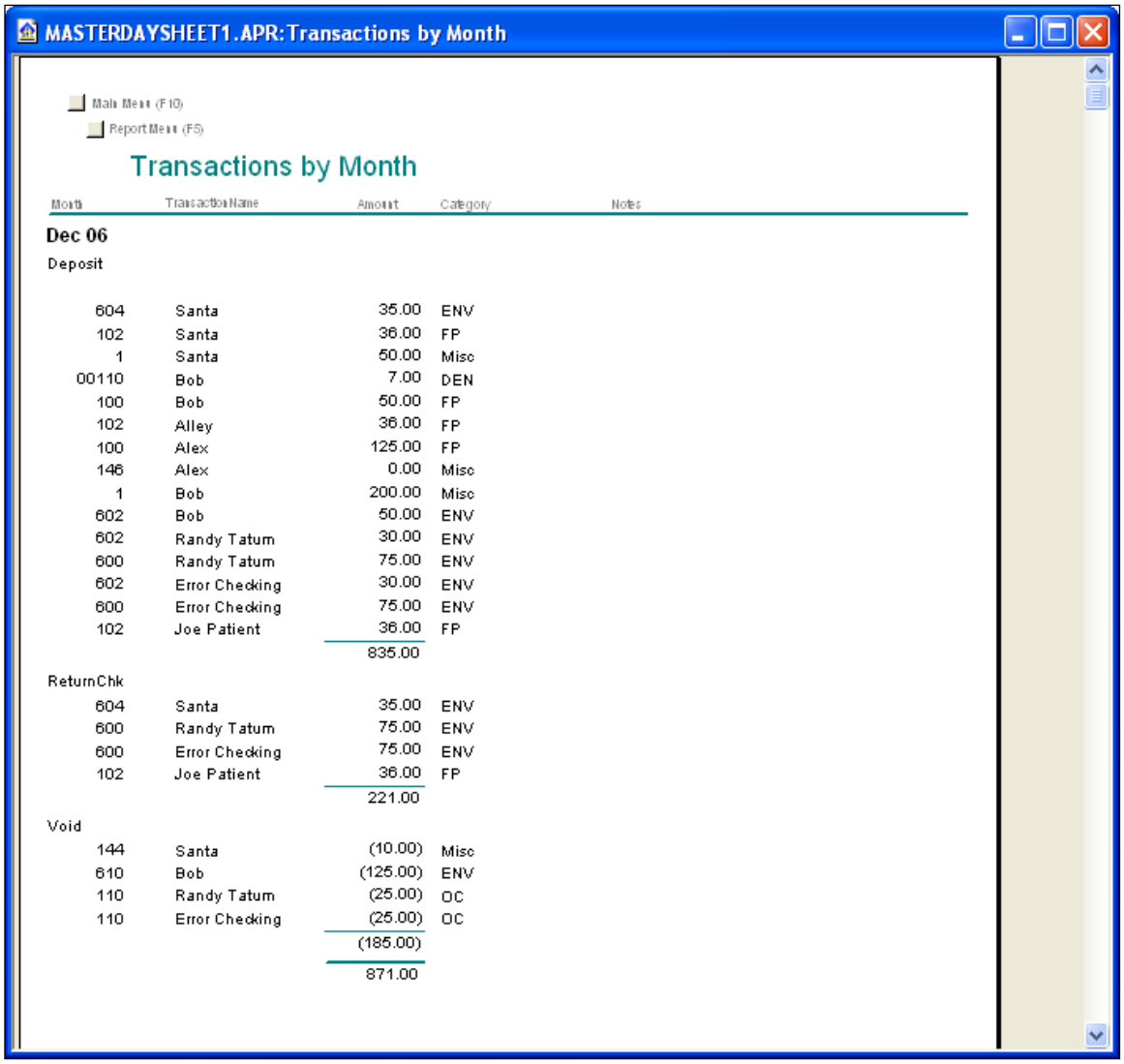
PRESS RETURN: This is also your ENTER key.

The report will display on your screen and after reviewing it, you may print the report by clicking on FILE in the upper left corner of the screen, and clicking on print.

To return to the Reports Menu press F5, to return to the Main Menu press F10.

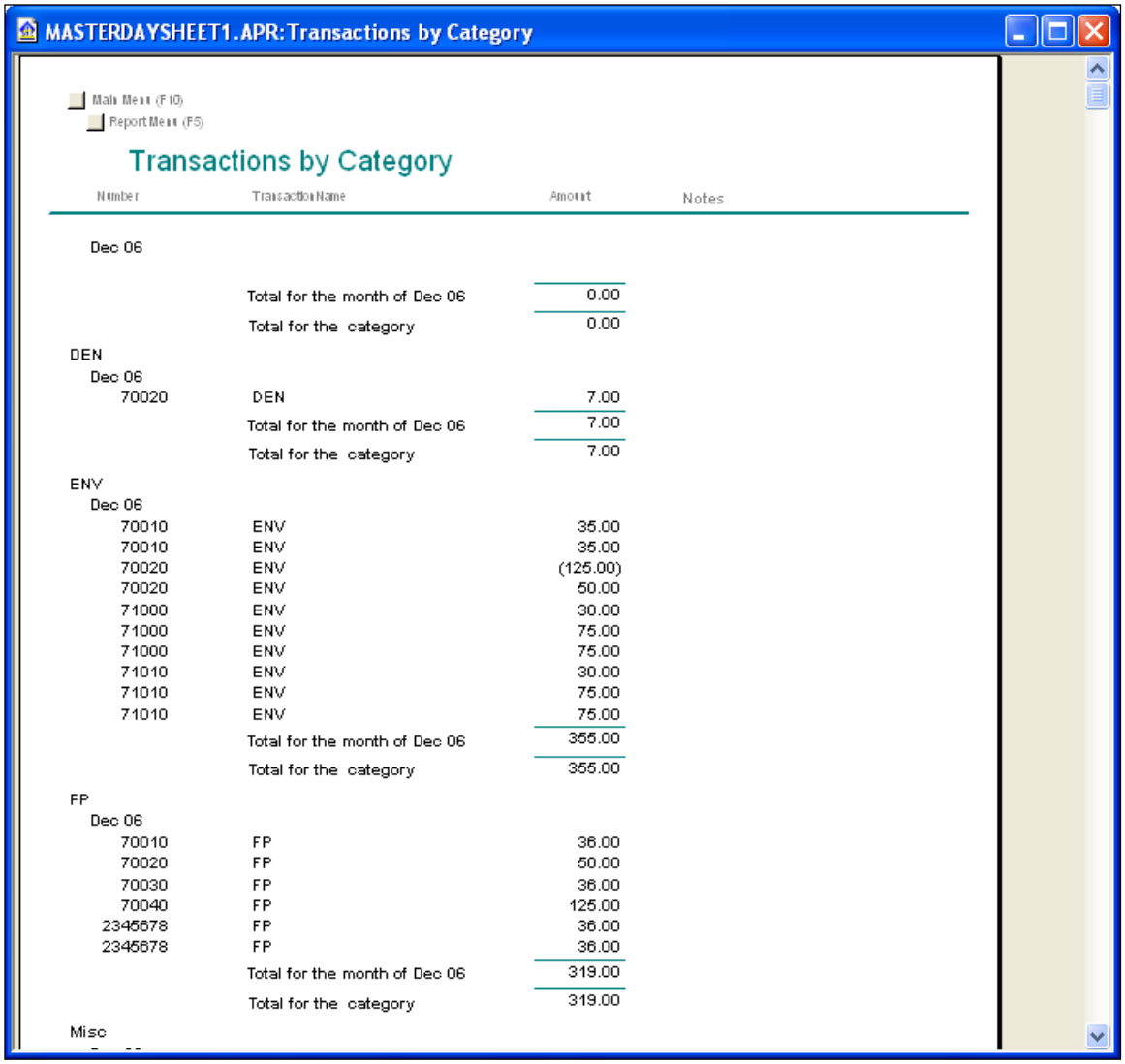
Transactions by Month

This report will show all transactions that have been recorded for the selected date range and selected category. The report will display the Month and Year selected, the transactions will be grouped and totaled by type (Deposit, Return Check, Voids). Each detail line will show the service category, Client Name, Amount, and the category name (ENV, VS, FP, etc).



Transactions by Category

This report is grouped by Category Type (Env, FP, VS, and Misc) for the date selected. The Month and Year are displayed under the category type. The detail lines include the Client Number and Category Name and Amount of the transaction. THIS REPORT DOES NOT INCLUDE THE CLIENT NAME NOR DOES IT SEPARATE TRANSACTIONS BY TYPE (Deposit, Return Check, Void).



Number	Transaction Name	Amount	Notes
Dec 06			
	Total for the month of Dec 06	0.00	
	Total for the category	0.00	
DEN			
Dec 06			
70020	DEN	7.00	
	Total for the month of Dec 06	7.00	
	Total for the category	7.00	
ENV			
Dec 06			
70010	ENV	35.00	
70010	ENV	35.00	
70020	ENV	(125.00)	
70020	ENV	50.00	
71000	ENV	30.00	
71000	ENV	75.00	
71000	ENV	75.00	
71010	ENV	30.00	
71010	ENV	75.00	
71010	ENV	75.00	
	Total for the month of Dec 06	355.00	
	Total for the category	355.00	
FP			
Dec 06			
70010	FP	36.00	
70020	FP	50.00	
70030	FP	36.00	
70040	FP	125.00	
2345678	FP	36.00	
2345678	FP	36.00	
	Total for the month of Dec 06	319.00	
	Total for the category	319.00	
Misc			

Transactions by Date

This is the report you will use the most. It MUST be run every day when you close out your drawer for close out purposes. The final report should be run for the current date only, no date range and do not select a category, run all categories. This report will be used to balance the drawer at the end of each day. You will also attach any Adjustments, Voids, and Return Check Receipts to this report and keep it on file.

This report contains all the Transactions for the selected date and they are grouped and totaled by type (Adjustment, Deposit, Return Check, and Void). For each transaction detail the following information is shown:
Client Name, Receipt Number, Client Number, Amount Paid, Cash Amount, Check Amount, Category/Recap Code, Service Code, the ID of the person that entered the transaction and the information keyed in the Received From: and Notes fields on the Receipt.

For DEPOSITS the Amount Paid Total will equal the Cash and Check amount totals. This should help in balancing at the end of the day.

Main Menu (F10)
Report Menu (F5)

SiteName: Sample Clinic

Transactions by Date

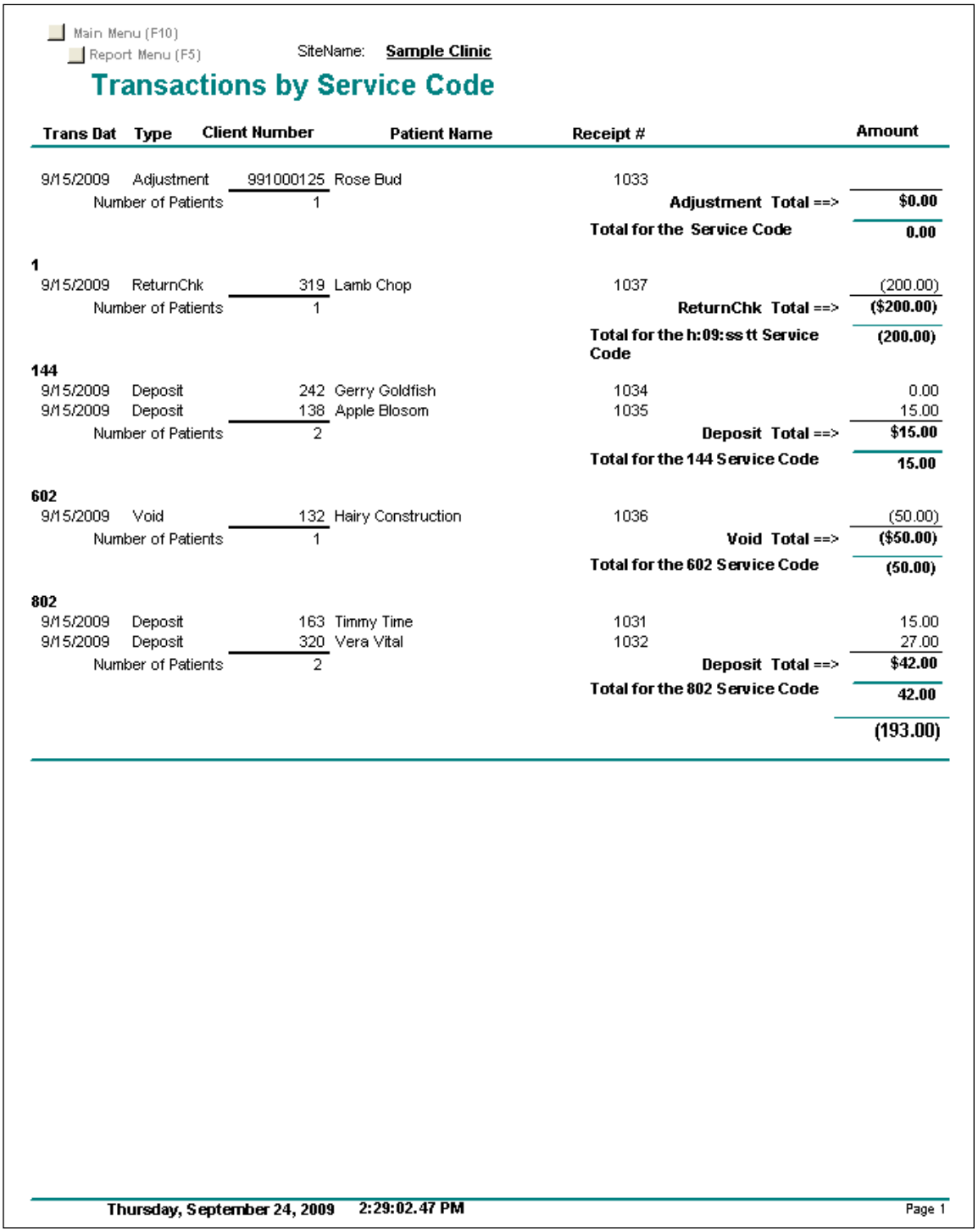
Date	Receipt	Patient Number	Adjustment	Amount Paid	Cash Amt	Check Amt	Cat / RevSrc	Svc Code	Clerk
9/15/2009									
Patient :Rose Bud Received From : Notes : Write off 90 day old balance	1033	991000125	$91.00				Adju /		ADPH
Adjustment Totals ===>			**$91.00**	**$0.00**	**$0.00**	**$0.00**			
Patient :Timmy Time Received From : Self Notes : 1 bc	1031	163		$15.00	$15.00	$0.00	VS / 71	802	ADPH
Patient :Vera Vital Received From : Mark Vital Notes : 1 dc 2 copies dc	1032	320	$27.00	$27.00	$0.00	$27.00	VS / 71	802	ADPH
Patient :Gerry Goldfish Received From : Gerry Goldsmith Notes :	1034	242		$0.00	$0.00	$0.00	IMM / 23	144	ADPH
Patient :Apple Blosom Received From : Cherry Blosom Notes : Check # 2251	1035	138		$15.00	$0.00	$15.00	IMM / 23	144	ADPH
Deposit Totals ===>			**$27.00**	**$57.00**	**$15.00**	**$42.00**			
Patient :Lamb Chop Received From : Chop Bldg Notes : January Rent	1037	319	$200.00	($200.00)	$0.00		MISC / 05	1	ADPH
ReturnChk Totals ===>			**$200.00**	**($200.00)**	**$0.00**	**$0.00**			
Patient :Hairy Construction Received From : John Hairy Notes :	1036	132		($50.00)	$50.00	$0.00	ENV / 24	602	ADPH
Void Totals ===>			**$0.00**	**($50.00)**	**$50.00**	**$0.00**			

Thursday, September 24, 2009 1:39:15.96 PM Page 1

All receipt numbers should be accounted for each day. If a number is missing, the reason for the missing number must be documented. Call for help when this happens.

Transactions by Service Code

This report is grouped by Category Type (ENV, FP, VS, and Misc) for the date selected. The Month and Year are displayed under the Service Code. The detail lines include the Service Date, Transaction Type, Client Number, Client Name, Receipt Number, and Amount of the transaction. The Data is totaled by Transaction type, and then by Service Code.



Main Menu (F10)
Report Menu (F5)
SiteName: **Sample Clinic**

Transactions by Service Code

Trans Dat	Type	Client Number	Patient Name	Receipt #		Amount
9/15/2009	Adjustment	991000125	Rose Bud	1033		
	Number of Patients	1			**Adjustment Total ==>**	**$0.00**
				Total for the Service Code		**0.00**
1						
9/15/2009	ReturnChk	319	Lamb Chop	1037		(200.00)
	Number of Patients	1			**ReturnChk Total ==>**	**($200.00)**
				Total for the h:09:ss tt Service Code		**(200.00)**
144						
9/15/2009	Deposit	242	Gerry Goldfish	1034		0.00
9/15/2009	Deposit	138	Apple Blosom	1035		15.00
	Number of Patients	2			**Deposit Total ==>**	**$15.00**
				Total for the 144 Service Code		**15.00**
602						
9/15/2009	Void	132	Hairy Construction	1036		(50.00)
	Number of Patients	1			**Void Total ==>**	**($50.00)**
				Total for the 602 Service Code		**(50.00)**
802						
9/15/2009	Deposit	163	Timmy Time	1031		15.00
9/15/2009	Deposit	320	Vera Vital	1032		27.00
	Number of Patients	2			**Deposit Total ==>**	**$42.00**
				Total for the 802 Service Code		**42.00**
						(193.00)

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Vital Stats Summary by Date

This report should be run for Certificates issued after September 2009, reflecting the new rates.

Do not run with a date ranges spanning September 2009 and October 2009.

This report displays the summary by date(s) for each of the transaction types for Vital Stats that were used when issuing a receipt. Totals include Voids and Return Checks. The number of 1st and 2nd copies of certificates issued is calculated based on the dollar amounts entered in each field.

SiteName: **Sample Clinic**

Vital Stats Summary

after September 2009

	Total of Vital Stats-1st	Number 1st Copy	Total of Vital Stats-2nd	Number 2nd Copy
10/2/2009				
Deposit	*135.00*	*9*	*84.00*	*14*
Void	*15.00*	*1*	*0.00*	*0*
	$150.00	10	$84.00	14

Special Note: **If receipts were issued on or after October 1, 2009 using the old rates you WILL NOT BE ABLE to use the Number 1st and 2nd copy figures.**

In the example below there was a Return Check processed at the old rate and the check was re-deposited. Notice the Number 1st and 2nd copy figures cannot be used.

SiteName: **Sample Clinic**

Vital Stats Summary

after September 2009

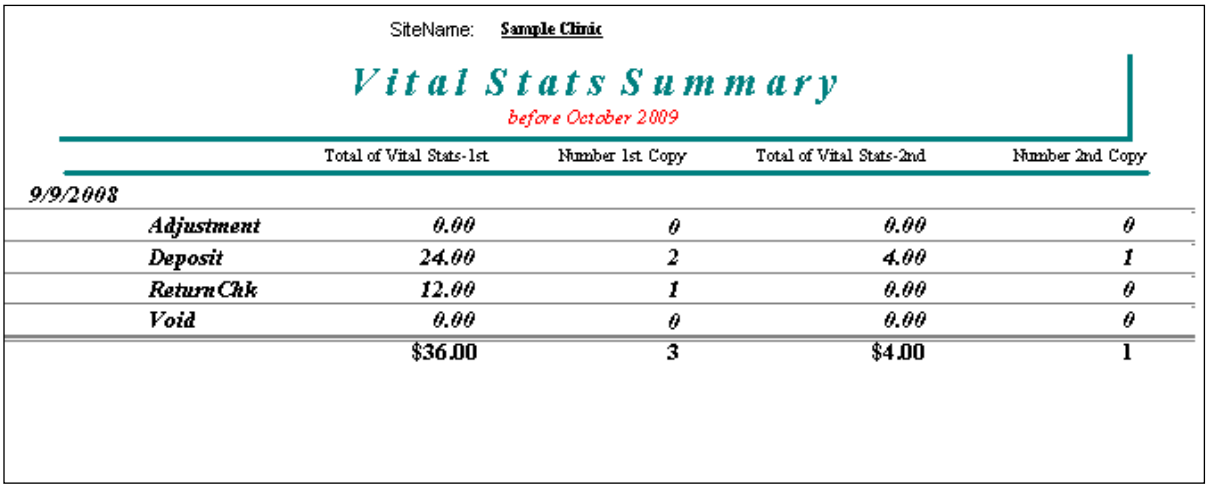
	Total of Vital Stats-1st	Number 1st Copy	Total of Vital Stats-2nd	Number 2nd Copy
10/2/2009				
Deposit	*147.00*	*9.8*	*88.00*	*14.6666666*
ReturnChk	*12.00*	*0.8*	*4.00*	*0.66666666*
Void	*15.00*	*1*	*0.00*	*0*
	$174.00	11.6	$92.00	15.3333333

Vital Stats Summary by Date before October 2009

This report should be run for Certificates issued before October 2009, reflecting the old rates.

Do not run with a date ranges spanning September 2009 and October 2009.

This report displays the summary by date(s) for each of the transaction types for Vital Stats that were used when issuing a receipt. Totals include Voids and Return Checks. The number of 1st and 2nd copies of certificates issued is calculated based on the dollar amounts entered in each field.



SiteName: **Sample Clinic**

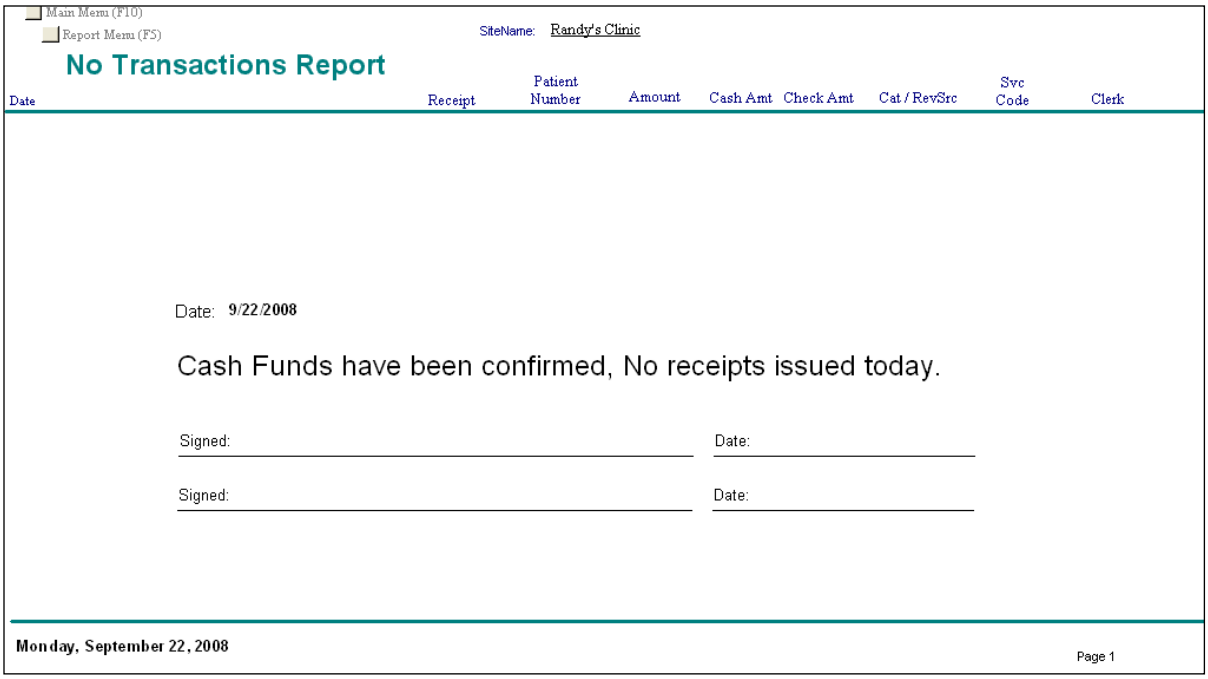
Vital Stats Summary

before October 2009

	Total of Vital Stats-1st	Number 1st Copy	Total of Vital Stats-2nd	Number 2nd Copy
9/9/2008				
Adjustment	***0.00***	***0***	***0.00***	***0***
Deposit	***24.00***	***2***	***4.00***	***1***
ReturnChk	***12.00***	***1***	***0.00***	***0***
Void	***0.00***	***0***	***0.00***	***0***
	$36.00	**3**	**$4.00**	**1**

No Transactions Report

This report is used on days when no receipts are issued. This report should be placed where the Day Sheet would go for that day.


Main Menu (F10)
Report Menu (F5)

SiteName: Randy's Clinic

No Transactions Report

Date	Receipt	Patient Number	Amount	Cash Amt	Check Amt	Cat / RevSrc	Svc Code	Clerk

Date: 9/22/2008

Cash Funds have been confirmed, No receipts issued today.

Signed: _____ Date: _____

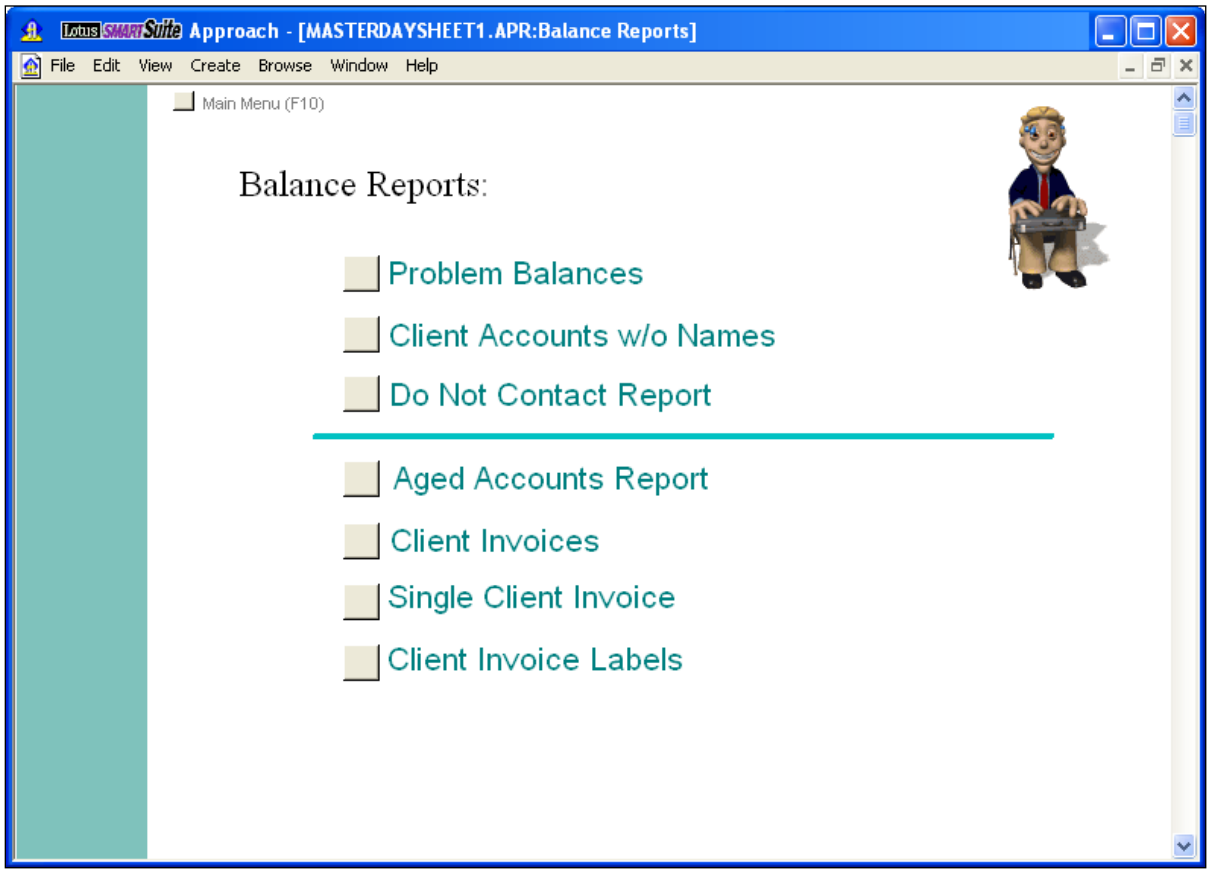
Signed: _____ Date: _____

Monday, September 22, 2008

Page 1

Client Balance Reports (F4)

This report option displays a set of reports for client accounting. Please see Account Aging for more information.



Examples of the Problem Balances, Client Accounts w/o Names, and Do Not Contact reports are on the following pages.

Refer to the section in this guide **Aging Accounts, Invoicing, and Write Off** Instructions for detail information on the Aged Accounts Report, Client Invoices, Single Client Invoice, and Client Invoice Labels.

From the Client Balance Report Menu click on the Problem Balances Report and press enter. A report will be created that will show any balances that are Negative or Blank. Follow the instructions in the Aging Accounts section of this manual for this report.

Problem Balances

Randy's Clinic

Patient Number	Patient Name	Current Balance
222	Jamie Bullock	($3.00)
143	Johnson Funeral Home	($20.00)
510000	Monty Gomery	
243	Tessy Pest	
133	Victor Victoria	($12.00)
		($35.00)

From the Client Balance Report Menu click on the Client Accounts w/o Names and press enter. A report will be created that will give a listing of Account numbers without Names. The Non Clinic numbers without names can be used by entering the number in the Patient Lookup screen and entering a name (this is an option). CHR numbers cannot be reused. There should not be any balances associated with these records, if there are balances call for help.

Client Numbers W/O Names

Patient Number	Patient Name	Current Balance
2		
46		
49		
73		
78		
116		
120		
183		
189		
201		
206		
213		
2345		
994444		
990200064		$0.00

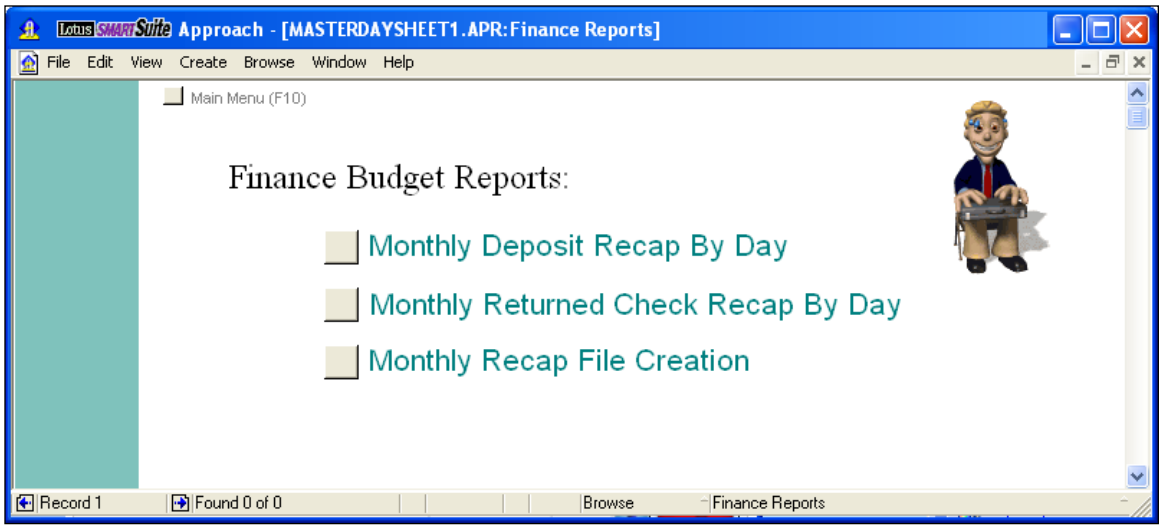
From the Client Balance Report Menu click on Do Not Contact Report and press enter. A report will be created that will provide an alphabetical listing of all clients that have NO for the Mailing question on the Patient/Client ledger card screen. This should be reviewed to avoid MAILING invoices to any client regardless of the service.

No Contact Report

Patient Number	Patient Name	Current Balance	Contact	Last Visit
23	Adam Carter	$0.00	No	9/2/2008
5	Adam Viatal	$312.00	No	9/12/2008
456465	Alice Tooth	$0.00	No	9/17/2008
112	Amanda Jones	$8.00	No	5/23/2007
165	Annie O Money	$12.00	No	7/24/2007
138	Apple Blosom	$0.00	No	9/5/2008
1	Bobby Smith	$200.00	No	8/25/2008
250	Clair Balance	$0.00	No	9/17/2008
40	David Jones	$0.00	No	9/19/2008
265	Jennie June	$83.26	No	8/21/2008

Finance Reports

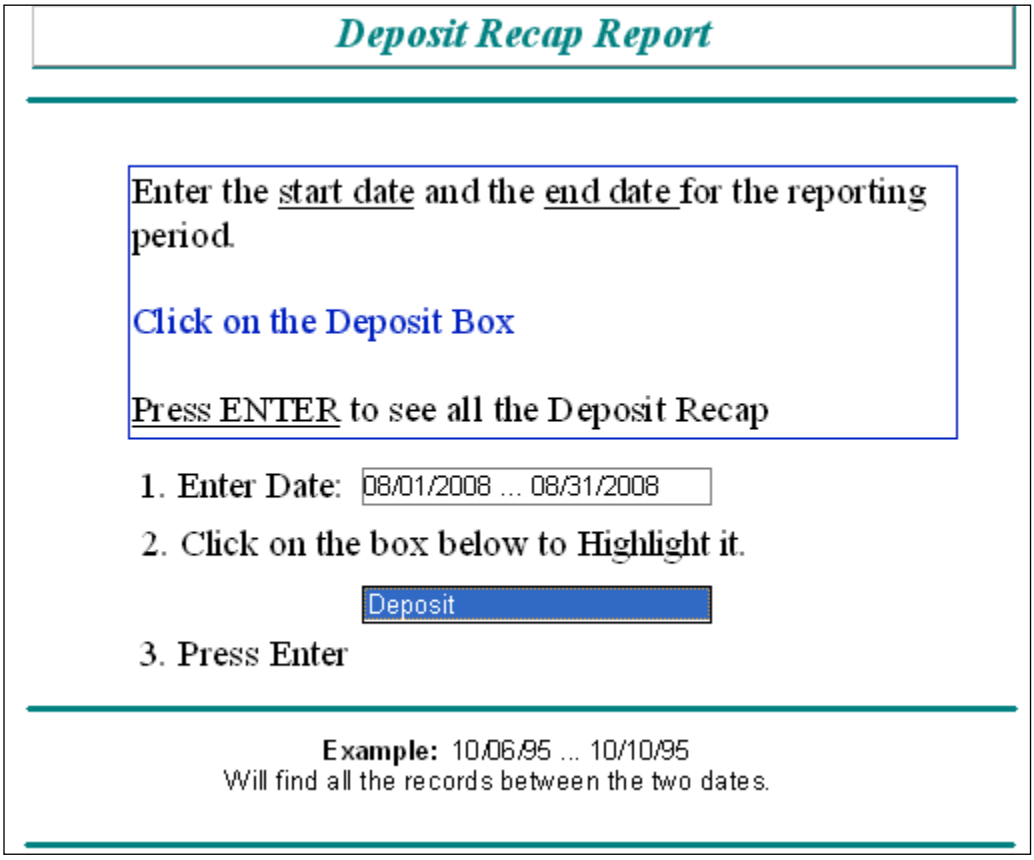
The reports generated on this menu can only be run by the Office Manager and are run to generate the Monthly Recap data for reporting to the Budget Office.



Monthly Deposit RECAP by Day

This sub menu option will create the Monthly Deposit Recap spreadsheet. The data is also to be printed and stored. This report prints on regular letter size paper.

To run this Recap, enter a date range, click on the box with Deposit to highlight it, and press enter as shown below.

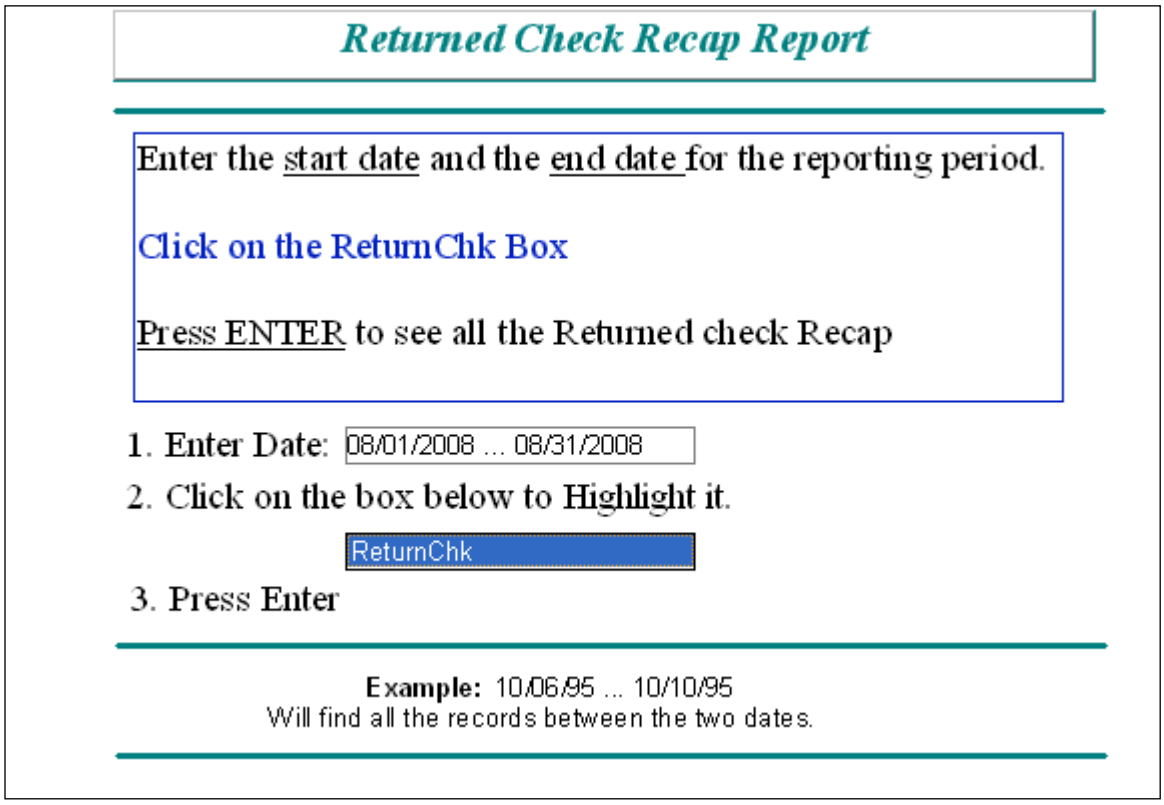


This report should be reconciled with each Day Sheet and Deposit for every day of the Month, before creating the Monthly Recap File.

Monthly Returned Check RECAP by Day

This sub menu option will create the Monthly Returned Check Recap report. If you had a returned check during a reporting month you run this report. A copy of this data is to be printed and attached to the Monthly Deposit Recap print out and stored.

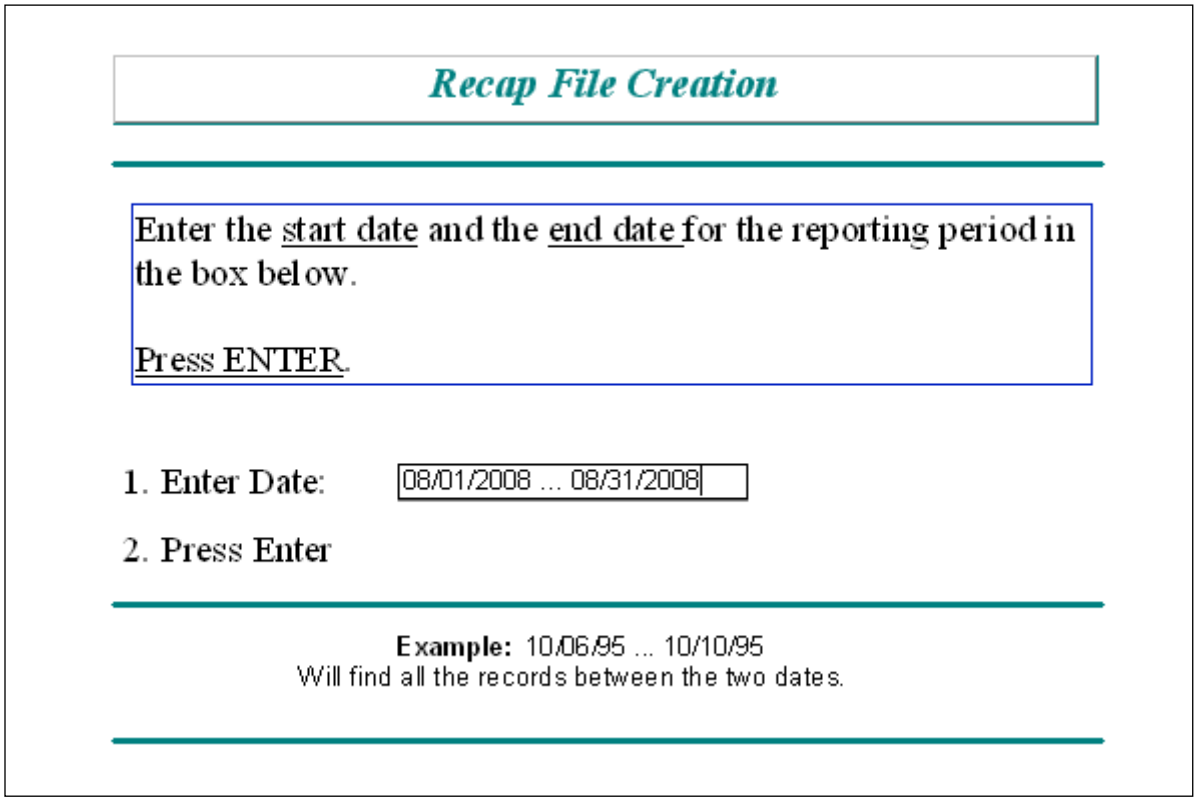
To run this Recap, enter a date range and click on the box with Return Check to highlight it and press enter.



This report should also be reconciled with the Day Sheets for each day of the Month, before creating the Monthly Recap File.

Monthly RECAP File Creation

This sub menu option will create Monthly Recap file. Enter the date range for the month and press enter.



Once the Recap file has been created the following will display and you will click OK.

Once you receive the notice that the recap file has been created you MUST click on the desktop icon to transmit the file to be processed. You will receive a confirmation email when the recap file has been received and is ready for processing.

Exit - F11

Clicking on this or pressing F11 is the only correct way to close the E-Day Sheet.
This MUST be done each day before leaving for the day.

Instructions for Entering/Updating Day Sheet User Information
These instructions will be used to ADD new employees or to change existing passwords.

The only person allowed to enter the User Information is a designated Administrator for the Electronic Day Sheet system. Please follow the steps below for creating User Information for each person in your County that will be entering data into the Day sheet system.

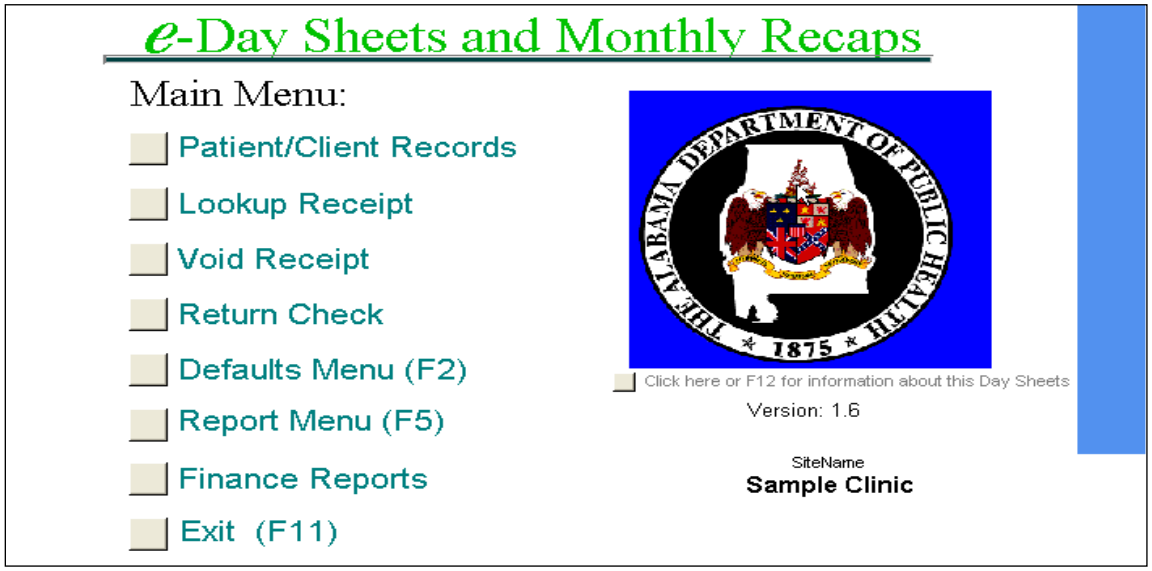
1. Click on the Electronic Day sheet Icon on your PC.

2. You will be prompted for the Approach File Password

3. ENTER: ***the office manager's password***

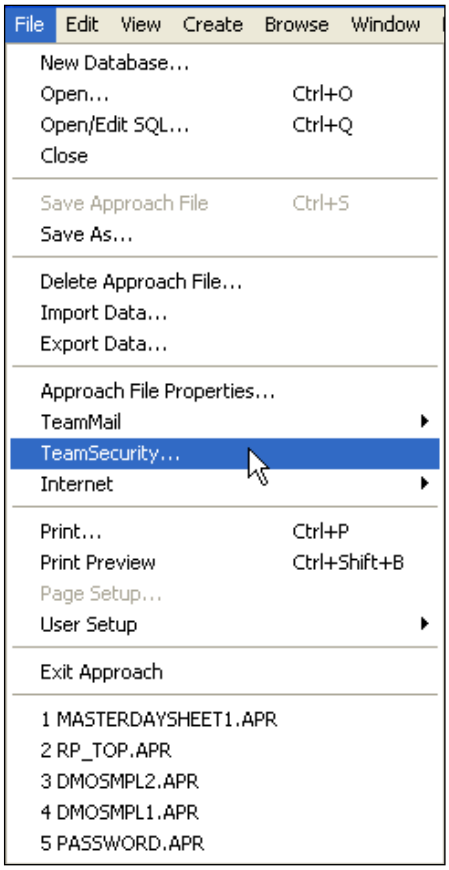
4. Click: OK

5. You will receive the *E-Day* Sheets and Monthly Recaps Main Menu

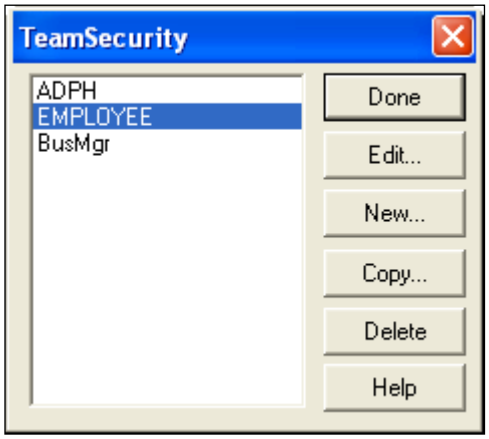


6. Move your cursor to the word **File** in the upper left corner of your screen, and Click.

7. Move your cursor down to **TEAM SECURITY**.... and click.

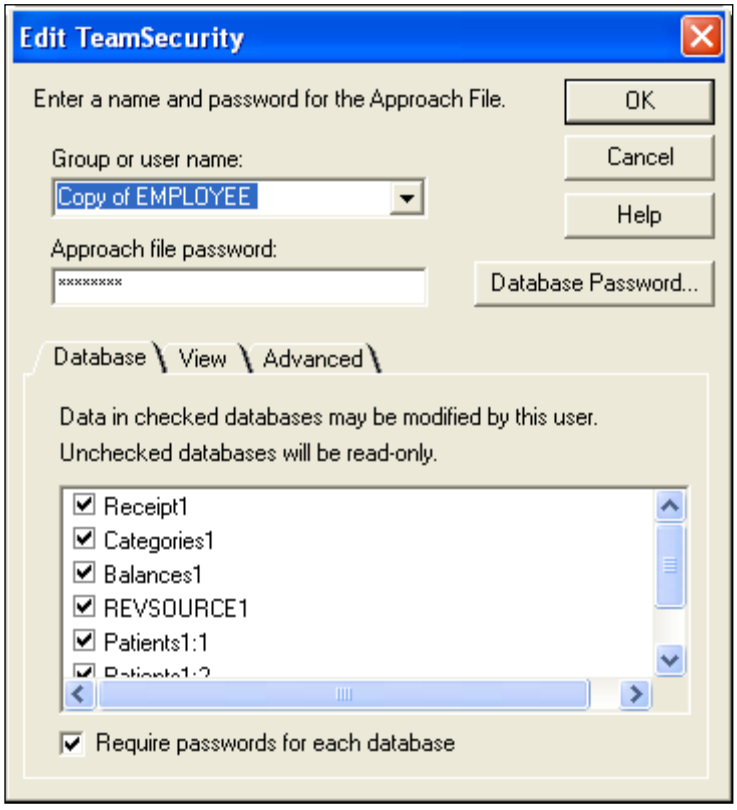


8. You will receive the Team Security Box, Click on **EMPLOYEE** and it will be **HIGHLIGHTED**.



9. Click on **COPY**

10. You will receive Edit Team Security Group or User Name (**COPY OF EMPLOYEE**) will be **highlighted.**



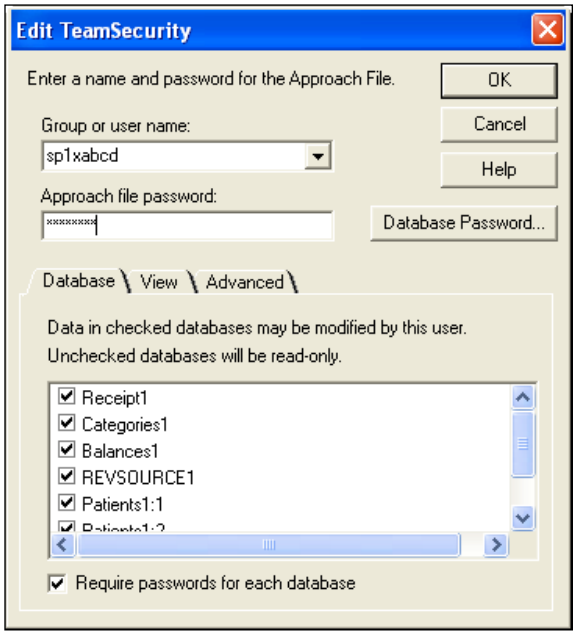
11. Enter the Employees Sign on information in this box. Do not enter the employees' entire name. THIS INFORMATION WILL BE USED TO RECORD THE EMPLOYEES ACTIVITY IN THE SYSTEM AND WILL PRINT ON THE TRANSACTIONS BY DATE REPORT.

User names should be the same as the employee's computer sign on ID and are limited to 10 characters in length. Example: h99rtatu

If a user name is created that is longer than 10 characters the users will receive the following pop up message on various screens. Call for HELP!

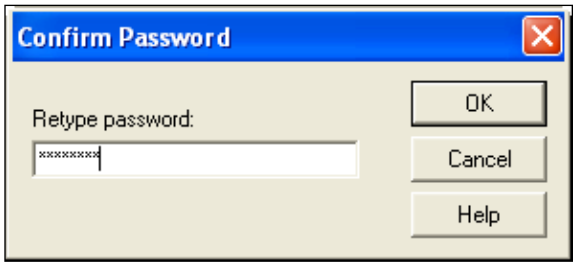
TAB down and enter a password for that employee, THIS WILL BE WHAT THE EMPLOYEE ENTERS WHEN SIGNING ON TO THE DAY SHEET SYSTEM

The word **PASSWORD *CANNOT*** is used as a password.



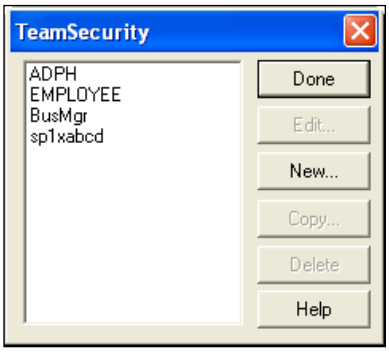
12. CLICK OK

You will be prompted to re-enter the password,



13. Re-enter the password and CLICK on OK

You will be returned to the TEAM SECURITY BOX and you should see the employees Sign on information you just entered in the box.



14. CLICK ON EMPLOYEE again and repeat steps 9 through 14 for each employee that needs to be entered. When finished perform steps 16 and 17.

    When you have entered all your employees, you have the TEAM SECURITY BOX displayed on your screen showing all employees user ids information.

15. **CLICK on DONE and you will return to the *E-Day* Sheets and Monthly Recaps Main Menu**

16. **Hold down the CTRL Key and press S at the same time, this will save all of your user information.**

*****************************Warning*****************************

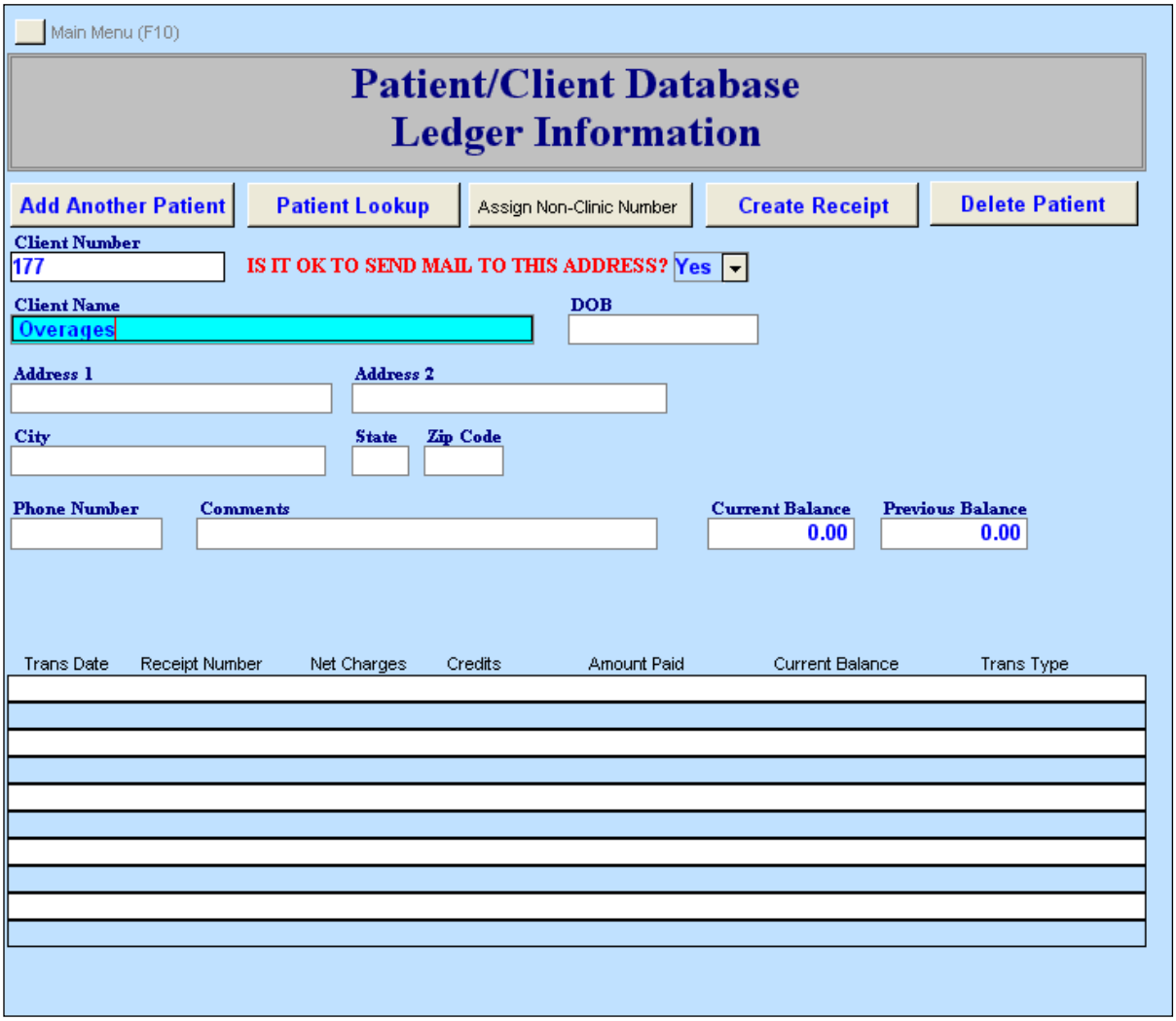
If you do not do steps 16 and 17 all work done entering user ids will be lost when the database closes.

KEEP A CURRENT LISTING OF ALL USER ID'S THAT HAVE BEEN ENTERED IN A SAFE AND SECURE PLACE.

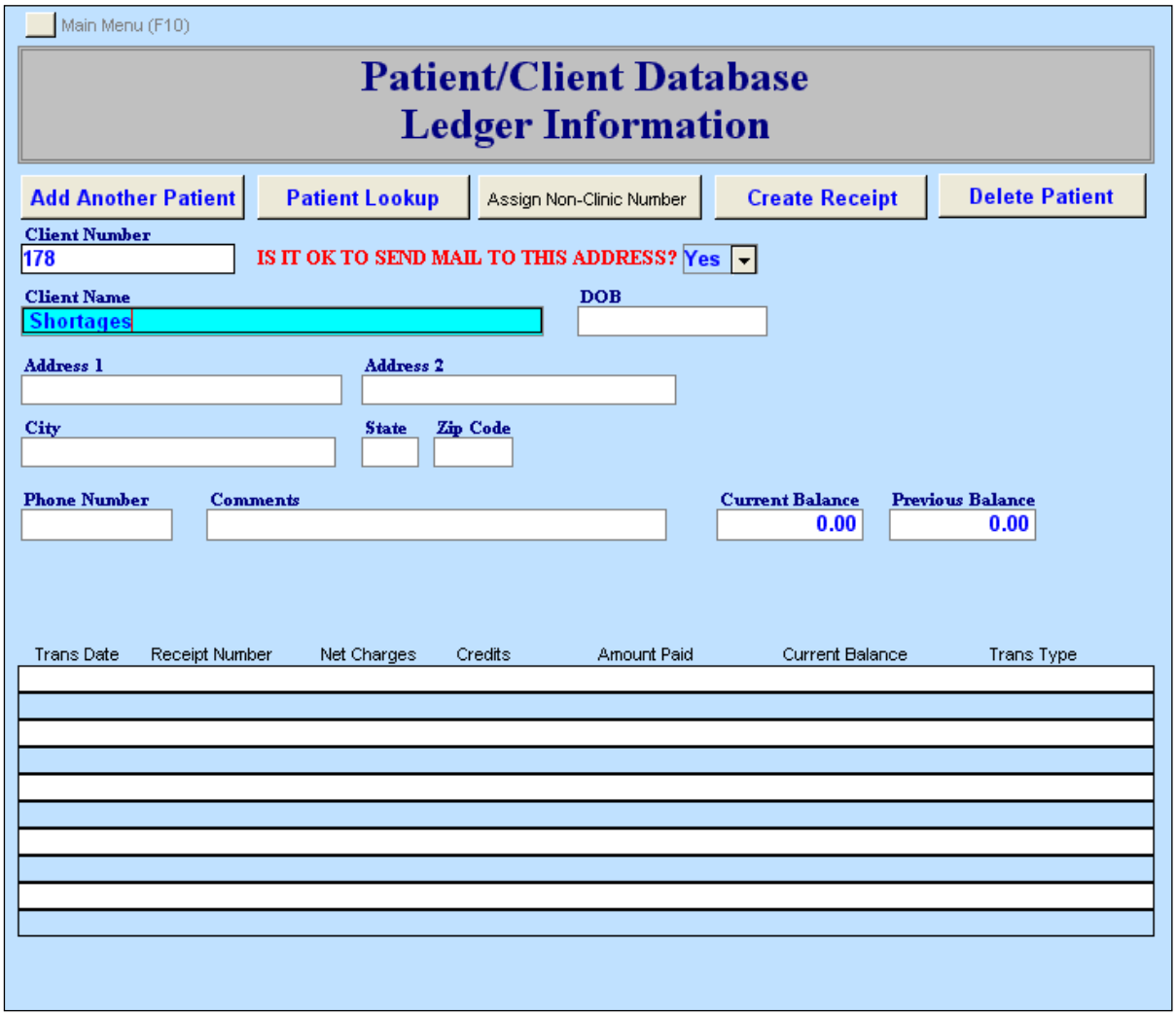
Shortages and Overages

Create a non-clinic number ledger card, one for Overage and one for Shortage **(This is only done once) or** Look up the ledger card for the overages or shortages.

Overage ledger card

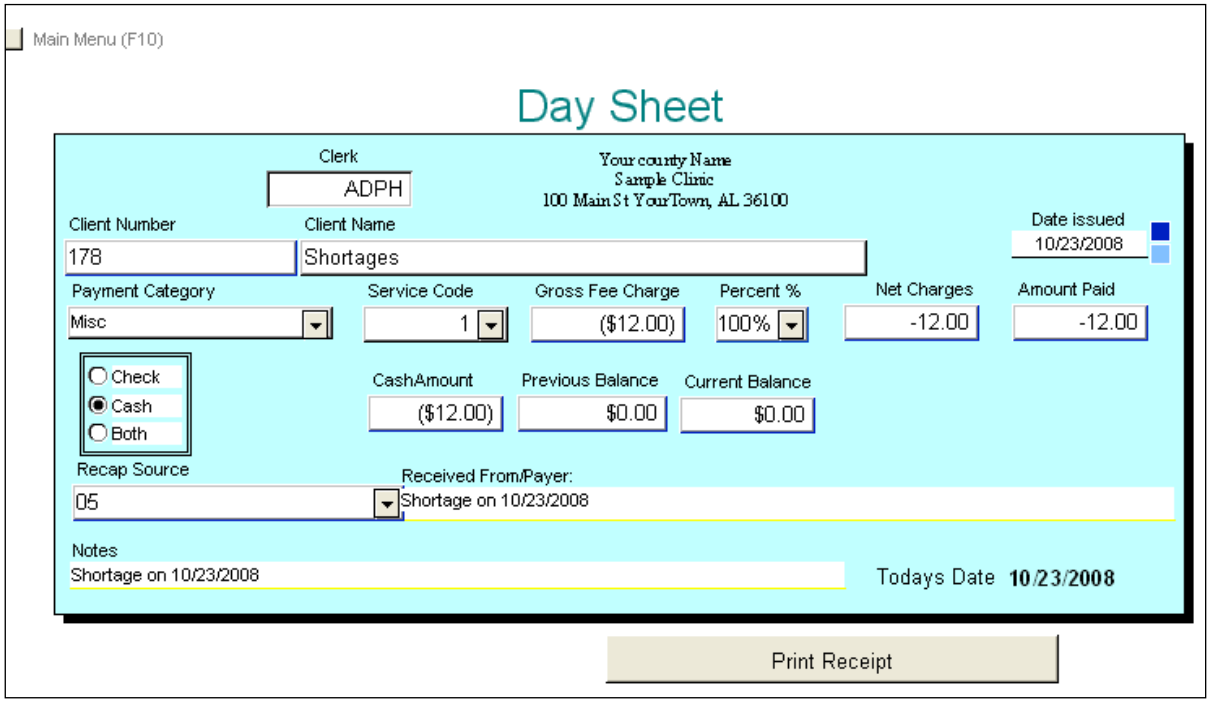


Shortage ledger card



Shortages

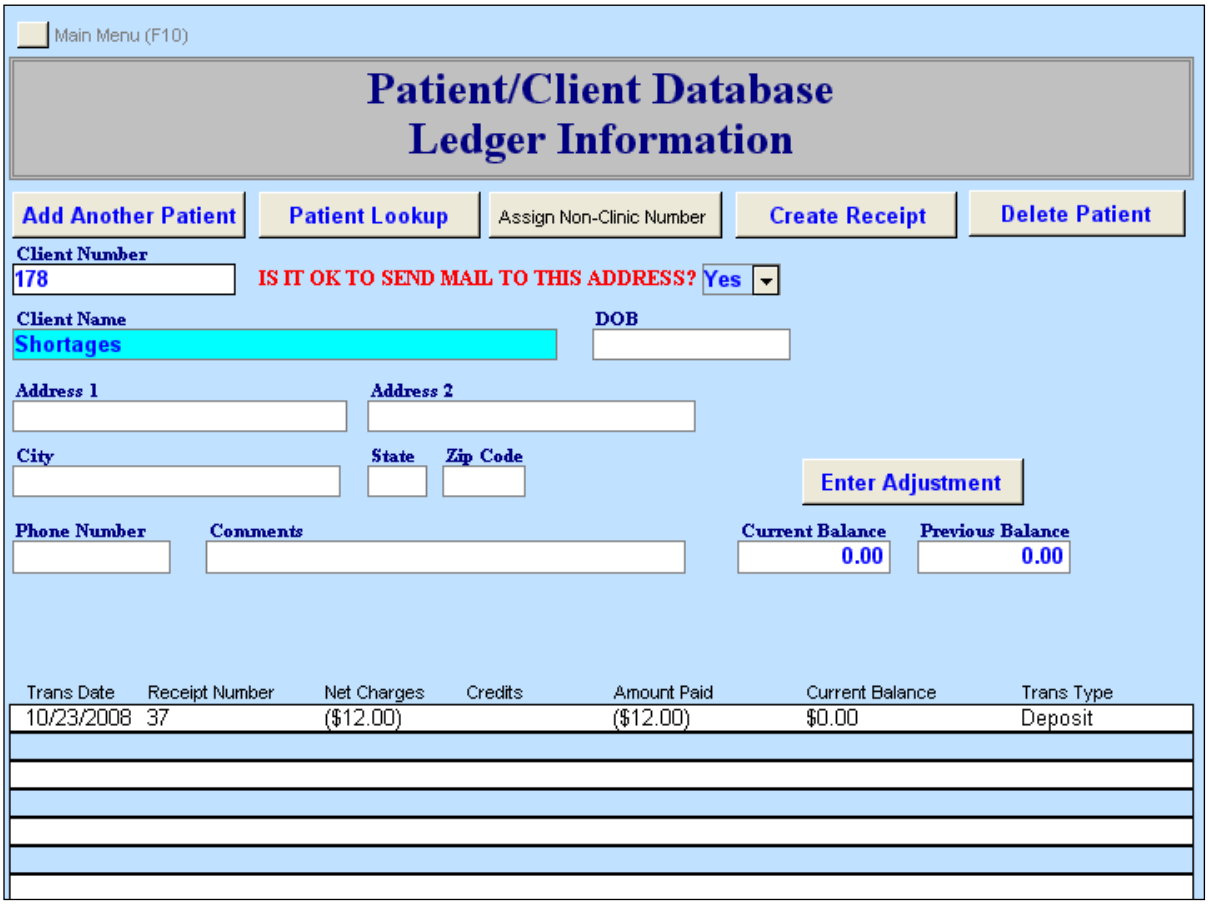
If your **MONEY** is short at the end of the day, go to patient look-up and select your shortage ledger card. Select create a receipt ***CHANGE THE DATE*** if it is after Close Out.



Payment category should be Misc., Service Code is 1, gross charge is the shortage amount as a **NEGATIVE**, net charge is a **NEGATIVE**, payment is a **NEGATIVE**, recap source should be misc. Notes should be used to document the shortage. Print the receipt and re-run your daily transaction report. Attach the shortage receipt to the daily transaction report.

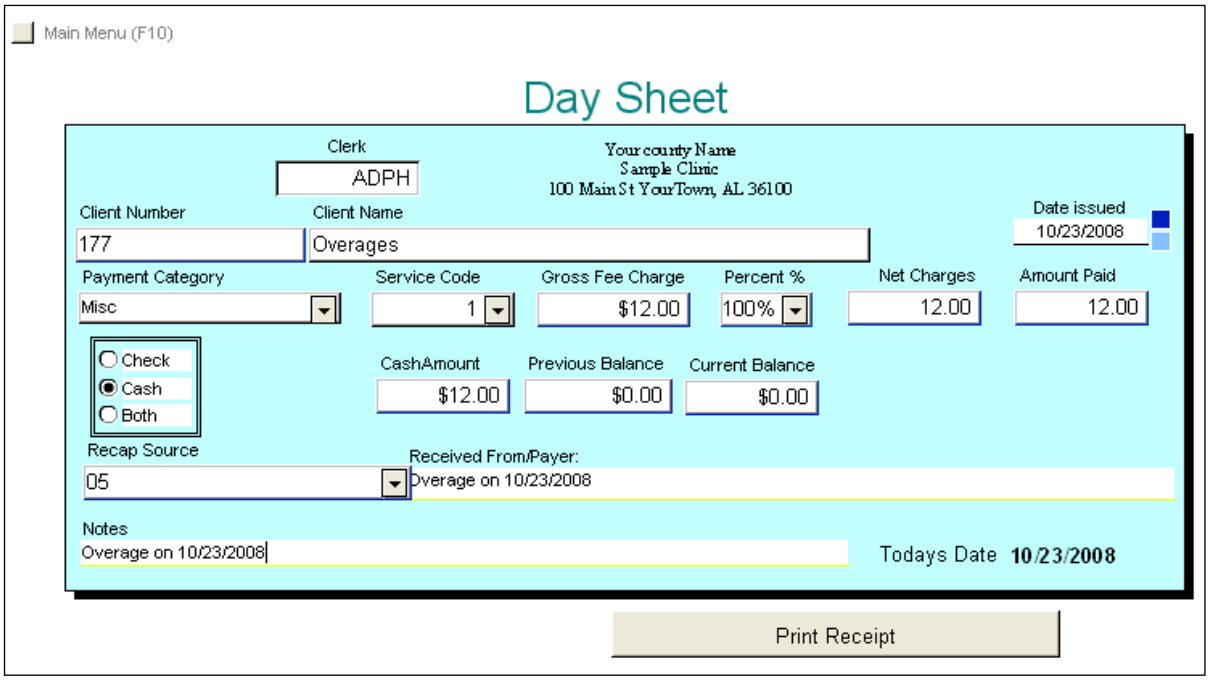
Keep both the original and the new daily transaction reports for your records.

The shortage account will now contain a record for the shortage for the day.



Overages

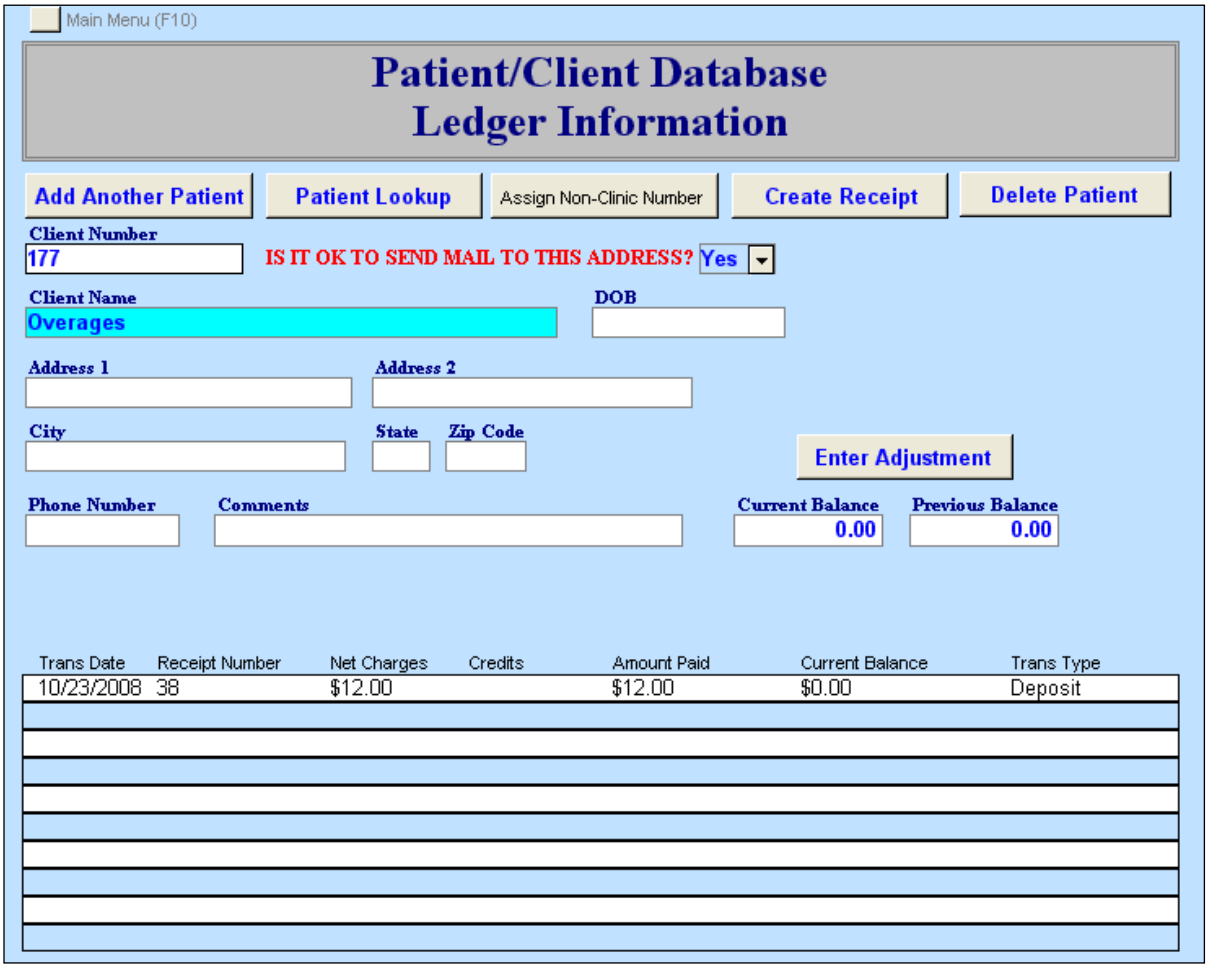
If your **MONEY** is over at the end of the day, go to patient look-up and select your overage ledger card. Select create a receipt ***CHANGE THE DATE*** if it is after Close Out.



Payment category should be Misc., Service Code is 1, gross charge is the overage amount as a **POSITIVE**, net charge is a **POSITIVE**, payment is a **POSITIVE**, recap source should be misc. Notes should be used to document the overage. Print the receipt and re-run your daily transaction report. Attach the overage receipt to the daily transaction report.

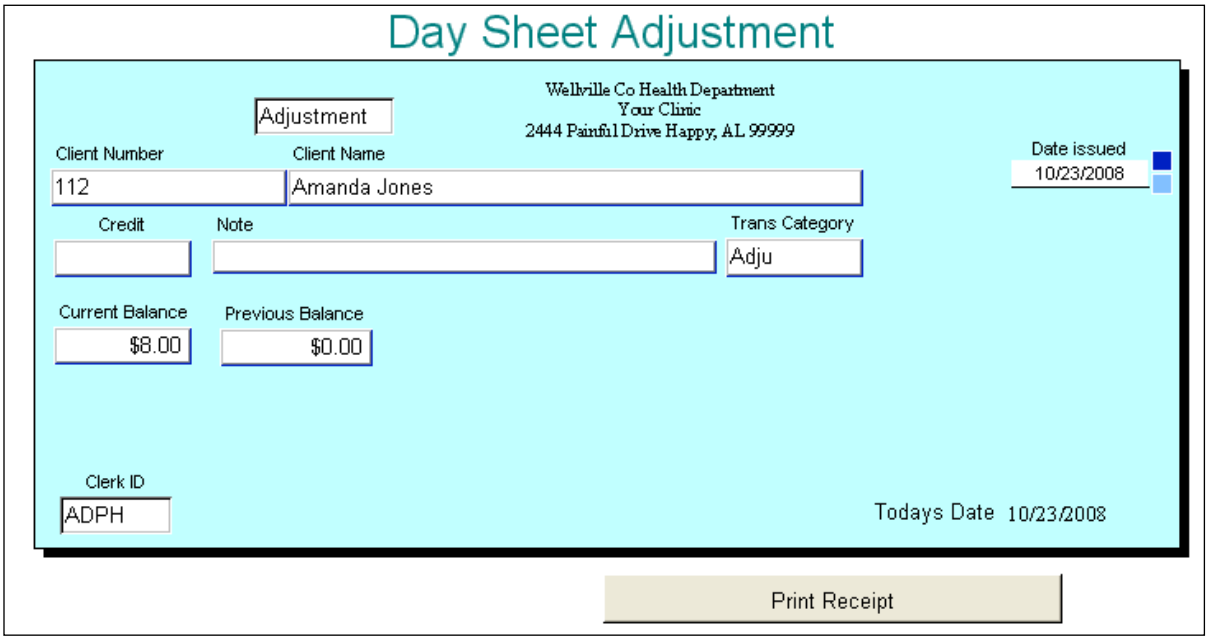
Keep both the original and the new daily transaction reports for your records

The Overage account will now contain a record for the overage for the day.

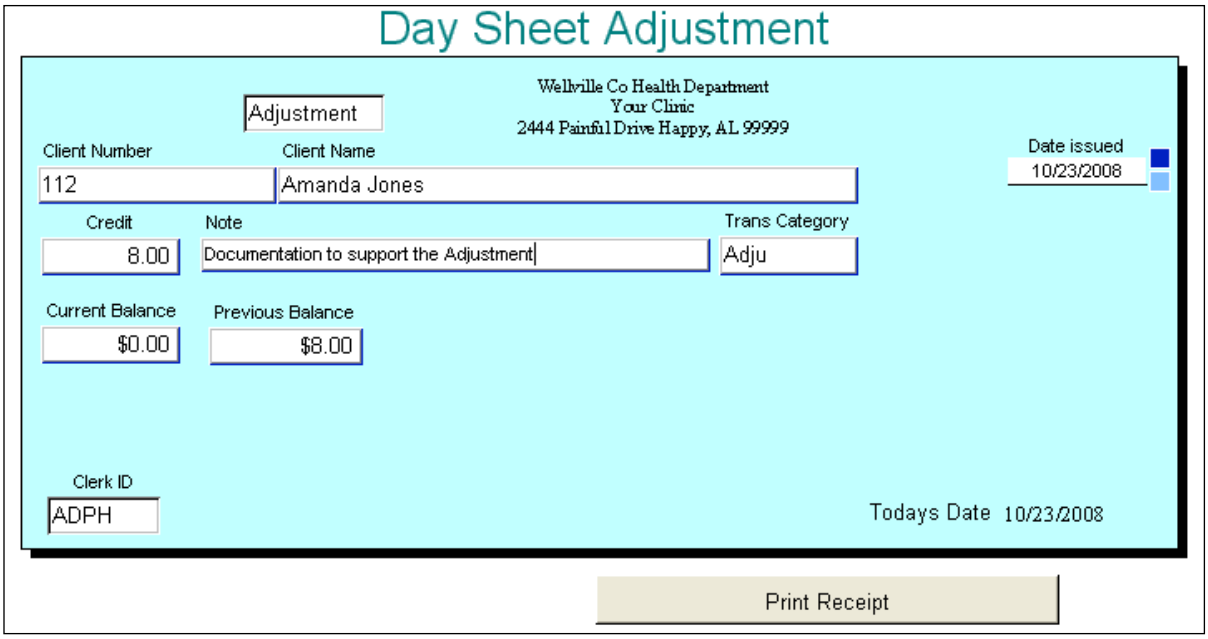


Account Adjustments

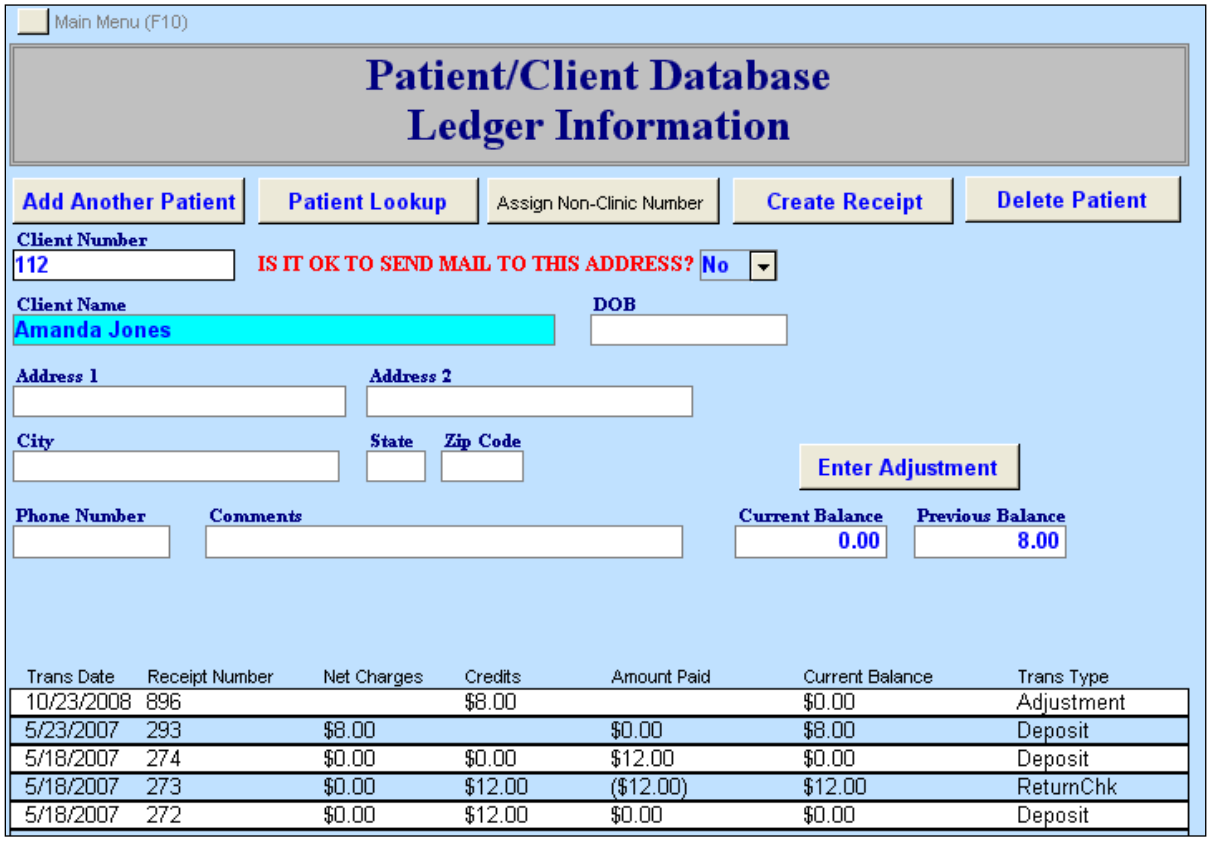
From time to time it is necessary to make adjustments to a clients account for many reasons. Reasons include but are not limited to: errors when entering data and account balance write-offs. Adjustments are performed by the Office Manager. The "Enter Adjustment" button on the client ledger card is used to make these adjustments. Once the button is pressed the following screen is displayed.



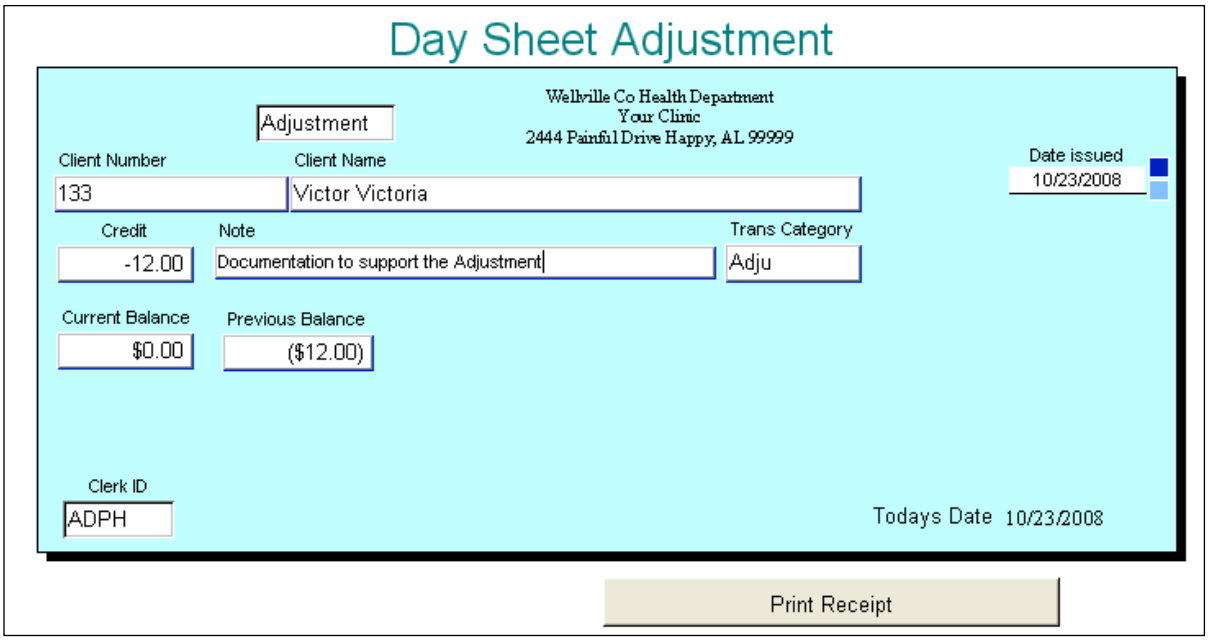
To decrease the client's current balance you enter a positive number in the Credit box and enter the reason for the Adjustment in the Note box.



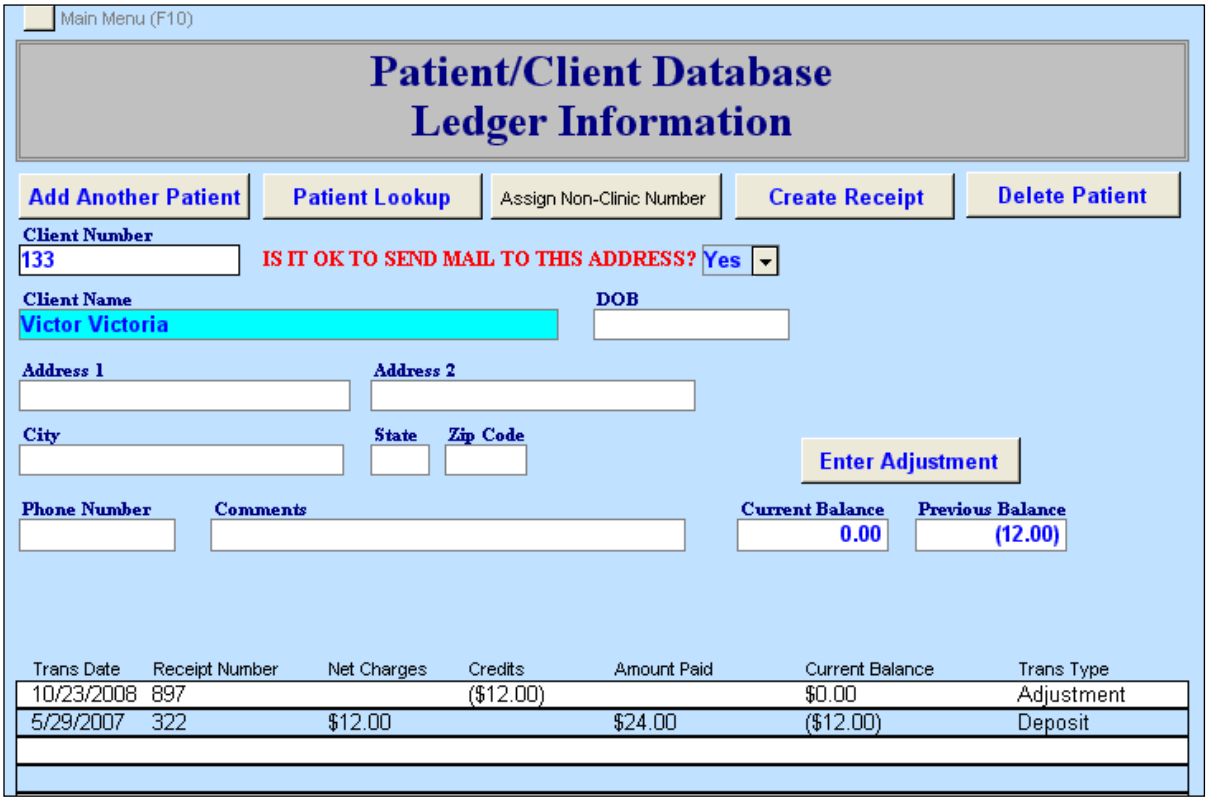
Once you click print receipt the client ledger card will reflect the adjustment. Attach the printed receipt to the Day Sheet for that day and document the reason for the adjustment on the receipt and sign it.



To increase the client's current balance you enter a negative number in the Credit box and enter the reason for the Adjustment in the Note box.



Once you click print receipt the client ledger card will reflect the adjustment. Attach the printed receipt to the Day Sheet for that day and document the reason for the adjustment on the receipt and sign it.

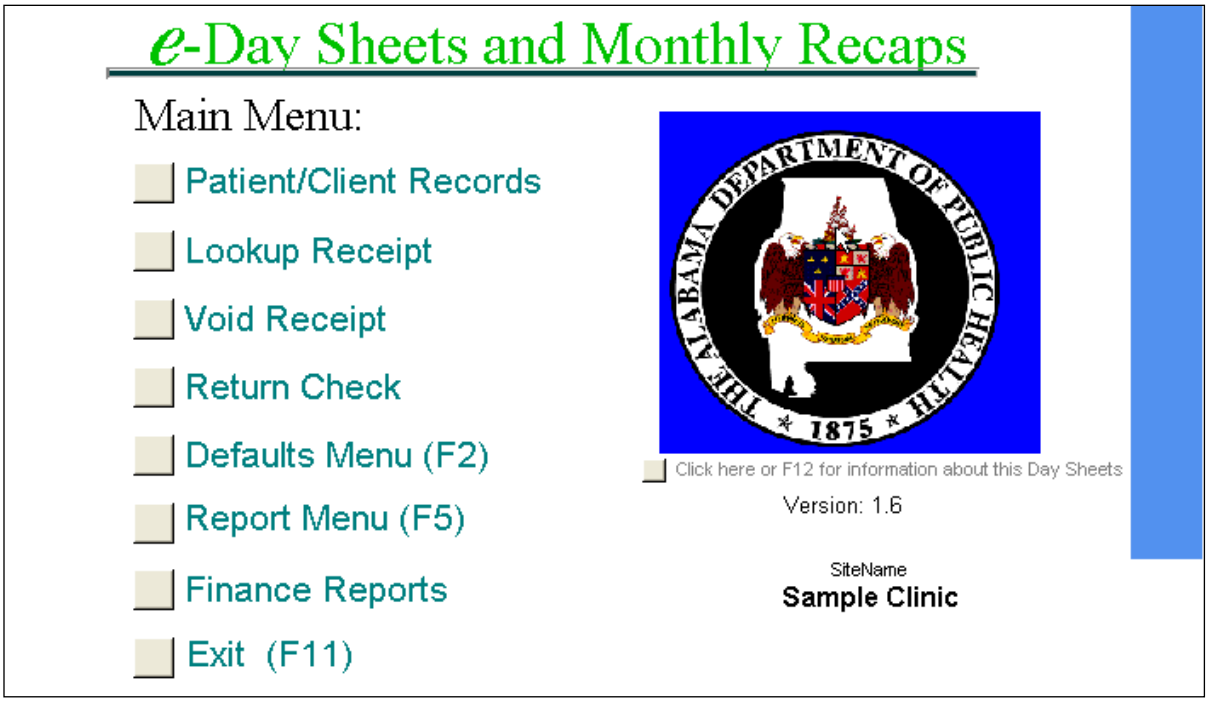


AGING OF ACCOUNTS, INVOICING, AND WRITE OFF INSTRUCTIONS

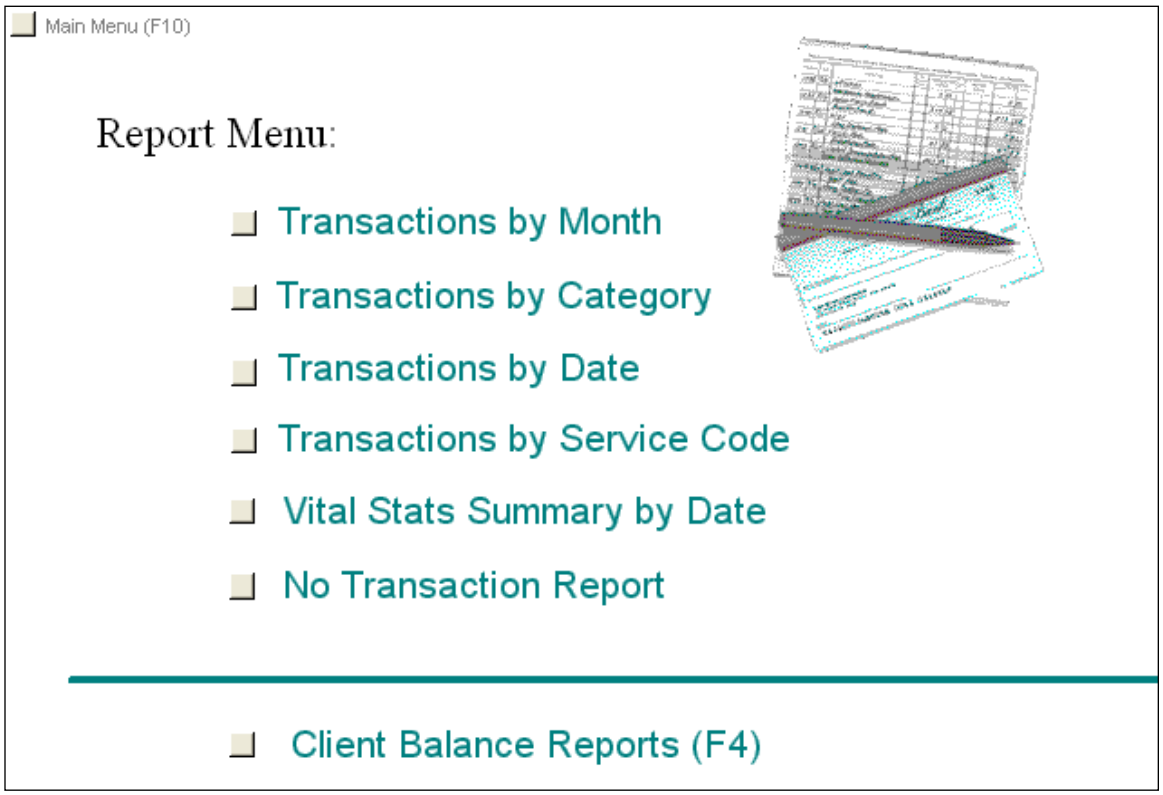
Aging of Accounts:

Aging reports are to be run every quarter beginning October 5, 2008

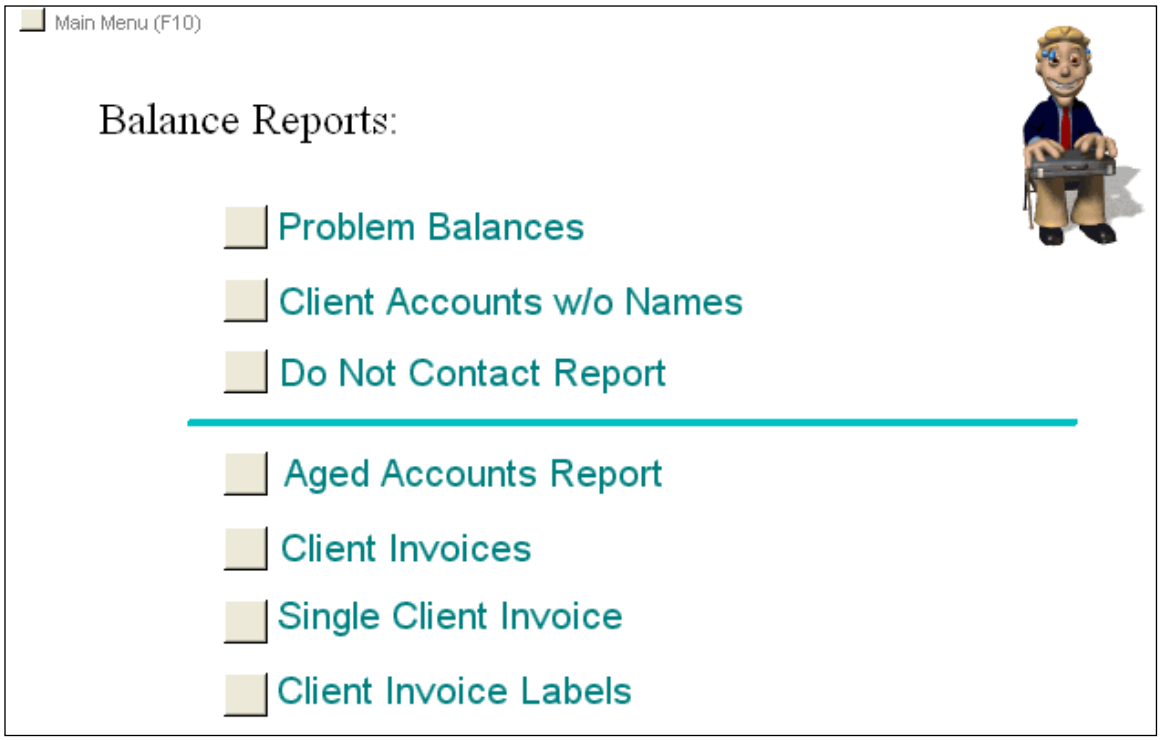
From the E-Day Sheet Main Menu select Report Menu (F5).



From the Report Menu (F5) select Client Balance Reports (F4).



From the Client Balance Reports (F4) menu select Aged Accounts Report.



FY12 Date Range Table for Aging Accounts Receivable Reports

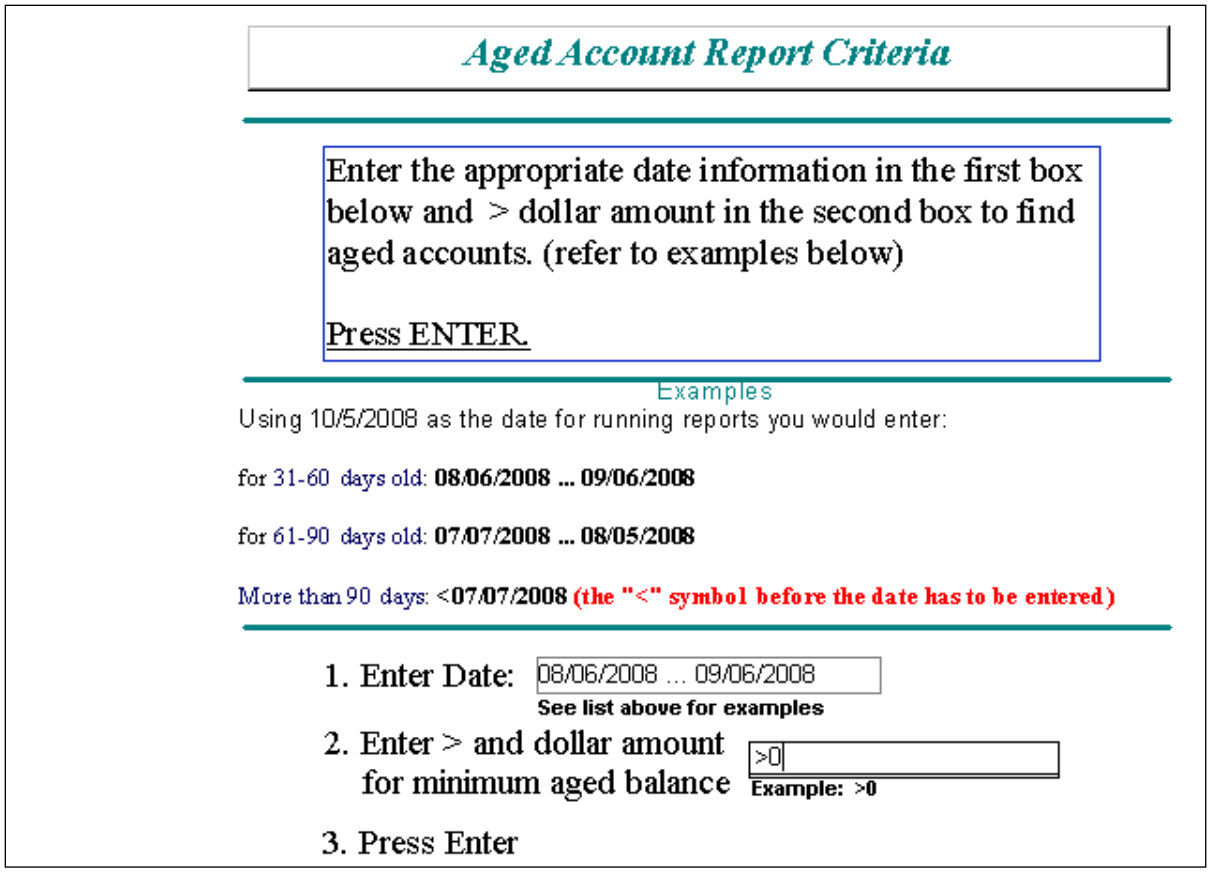
The date range table below gives the date the aged reports should be printed and the date information that should be entered to properly age the reports.

Select the **date range or <date** from the table below for the desired aging. Refer to the next page for sample screen.

The Run Date is the date the aged reports should be printed. If the Run Date falls on a weekend wait until the next business day and print the reports with the date range listed in the table.

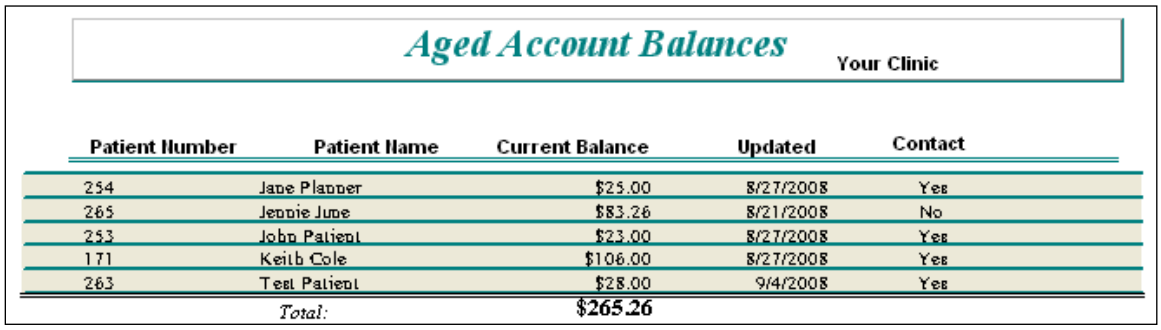
The Date Information contains the date ranges for the 31 – 60, 61 – 90, and 91 - 120 day reports and the <date for the 121 and more days report. Enter the Date Information exactly as it is shown below.

Run Date	Aging	Date Information to Enter	Action
10/05/2011	0 – 30 Days		None – Account balances are considered current
10/05/2011	31 – 60 Days	08/06/2011 … 09/04/2011	Mail invoice to clients
10/05/2011	61 – 90 Days	07/07/2011 … 08/05/2011	Mail invoice to clients
10/05/2011	91 – 120 Days	06/07/2011 … 07/06/2011	Mail invoice to clients
	121 –more days	<06/07/2011	Write-off old Accounts Receivable Balance to Zero
01/05/2012	0 – 30 Days		None – Account balances are considered current
01/05/2012	31 – 60 Days	11/06/2011 … 12/05/2011	Mail invoice to clients
01/05/2012	61 – 90 Days	10/07/2011 … 11/05/2011	Mail invoice to clients
01/05/2012	91 – 120 Days	09/07/2011 … 10/06/2011	Mail invoice to clients
	121 -more days	<09/07/2011	Write-off old Accounts Receivable Balance to Zero
04/05/2012	0 – 30 Days		None – Account balances are considered current
04/05/2012	31 – 60 Days	02/05/2012 … 03/05/2012	Mail invoice to clients
04/05/2012	61 – 90 Days	01/06/2012 … 02/04/2012	Mail invoice to clients
04/05/2012	91 – 120 Days	12/07/2011 … 01/05/2012	Mail invoice to clients
	121 –more days	<12/07/2011	Write-off old Accounts Receivable Balance to Zero
07/05/2012	0 – 30 Days		None – Account balances are considered current
07/05/2012	31 – 60 Days	05/06/2012 … 06/04/2012	Mail invoice to clients
07/05/2012	61 – 90 Days	04/06/2012 … 05/05/2012	Mail invoice to clients
07/05/2012	91 – 120 Days	03/07/2012 … 04/05/2012	Mail invoice to clients
	121 –more days	<03/07/2012	Write-off old Accounts Receivable Balance to Zero



The example above will produce an Aged Accounts Balance Report for 31 – 60 days.

Refer to the report example below.



Aged Account Balances Your Clinic

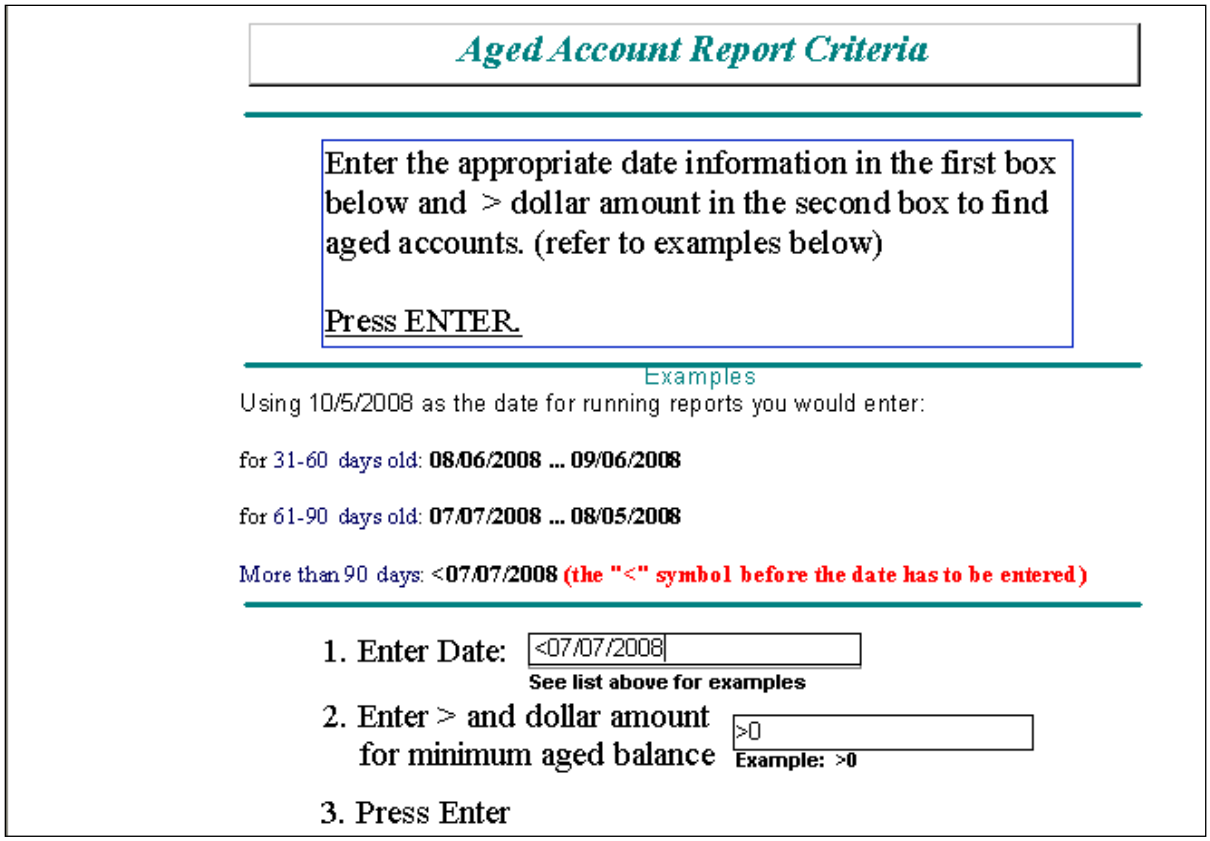
Patient Number	Patient Name	Current Balance	Updated	Contact
254	Jane Planner	$25.00	8/27/2008	Yes
265	Jennie June	$83.26	8/21/2008	No
253	John Patient	$23.00	8/27/2008	Yes
171	Keith Cole	$106.00	8/27/2008	Yes
263	Test Patient	$28.00	9/4/2008	Yes
	Total:	**$265.26**		

The Updated field will be the last Receipt date which is used for aging and the Contact field is used to determine whether an Invoice should be mailed. NO means DO NOT Mail an Invoice.

To run the Aged Account Balances Report for the 61 – 90 days follow the same instructions as above except enter the date range from the table for the 61 – 90 date range.

When working the reports 31 – 60, 61 – 90, and 91 - 120 days use tick marks to indicate the actions taken for each client. Place an **X** by the name of those clients that were DO NOT MAIL, at the bottom of the report write "X we did not mail invoices due to confidentiality reasons". For the remaining clients use a **check mark** by the dollar amount to indicate verified and an **M** to indicate invoice was mailed. Tick marks will be listed at the bottom of the reports to show the actions taken, and the reports filed.

For the 121 day and greater report enter the < and the date from the table for More than 120 days. Refer to the example below.

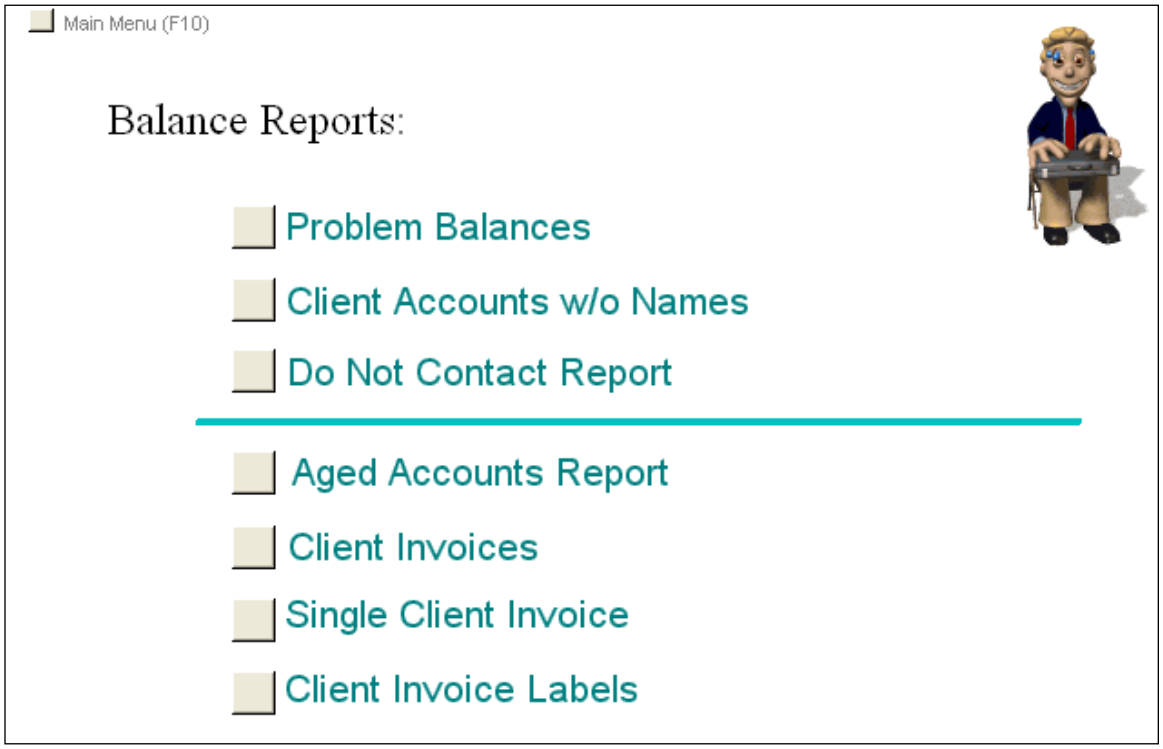


This report will be used to Write Off old balances. (Refer to Write Off section in this document) All adjustment receipts for Write Off balances will be attached to this report and filed for audit purposes. Also, use tick marks to indicate any other actions taken and explain the tick mark and action at the bottom of the report.

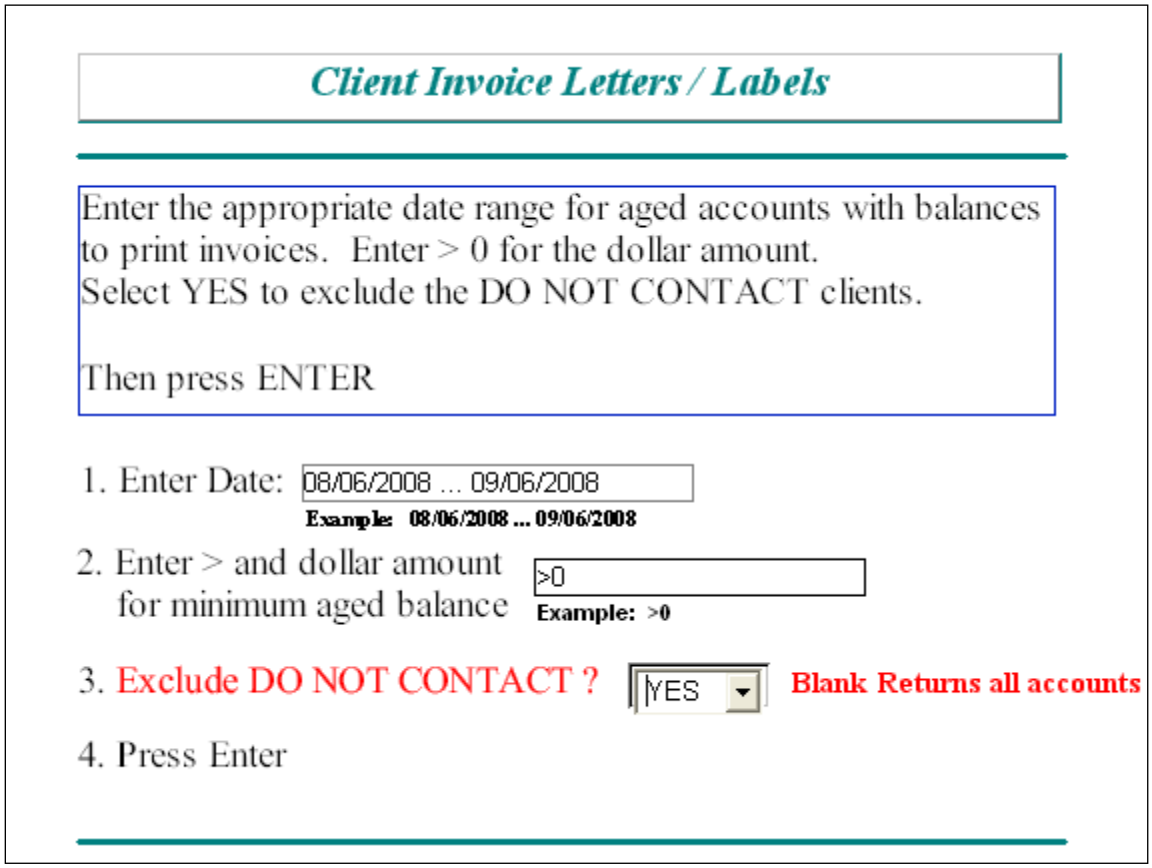
Invoicing:

Before mailing invoices each account on the Aged Balances report must be verified. There are instances where the balance is incorrect. These invoices should be held and worked after the correct balance invoices are mailed.

From the Balance Reports Menu, you can get there by pressing F4 from any screen in the E-Day Sheet, select Client Invoices. Refer to the example below.



Enter the same date range that was entered for the Aged Accounts Report, >0 for balance selection, and select YES from the Exclude DO NOT CONTACT box. Refer to the example below of the Client Invoice Letter screen.



This will produce the Invoice Letters for all Clients within the specified aging date range.

DO NOT CONTACT Clients will not print an invoice. Double check the Aged Accounts Report to make sure there is not any DO NOT CONTACT invoices printed. If there are some DO NOT CONTACT invoices pull them, do not mail them.

The Invoice/Letter is formatted to print on County Health Department letter head.

Follow the same instructions for Invoices for the 61 – 90 and 91 - 120 day aging except enter the date range from the table for that aging.

Refer to the next page for a sample Invoice/Letter.

October 16, 2008

Dear Jane Planner:

SUBJECT: Outstanding Balance of **$25.00**
Patient: Jane Planner
CHR No. 254

The Alabama Department of Public Health is proud to offer certain clinical services to our customers on a sliding scale with discounts based on family size and income. As you were informed at your last Health Department clinic visit on **August 27, 2008** , the balance due on your account is **$25.00**

Payment is due on your account by **November 16, 2008**

Please send your payment to: **Wellville Co Health Department**
2444 Painful Drive
Happy , AL 99999

Clinic services will not be denied due to inability to pay.

If you have any questions or if there have been any changes in your financial situation which might affect your account, please contact the Health Department at (334) 999-1517.

Sincerely,

Andy Anybody
Wellville County Health Department

Information about Invoice/Letters:

The date is the current date they are printed, close out time and date roll over DOES NOT effect this date.

Client Name: Prints just as it is entered on the ledger card. Some will be first and last name and some will be last name and first name.

Outstanding Balance comes from the CURRENT BALANCE box on the Patient/Client Database Ledger Information screen. It does not come from the balance on the individual ledger entries in the ledger card.

Clinic Visit date is the date of the last receipt issued.

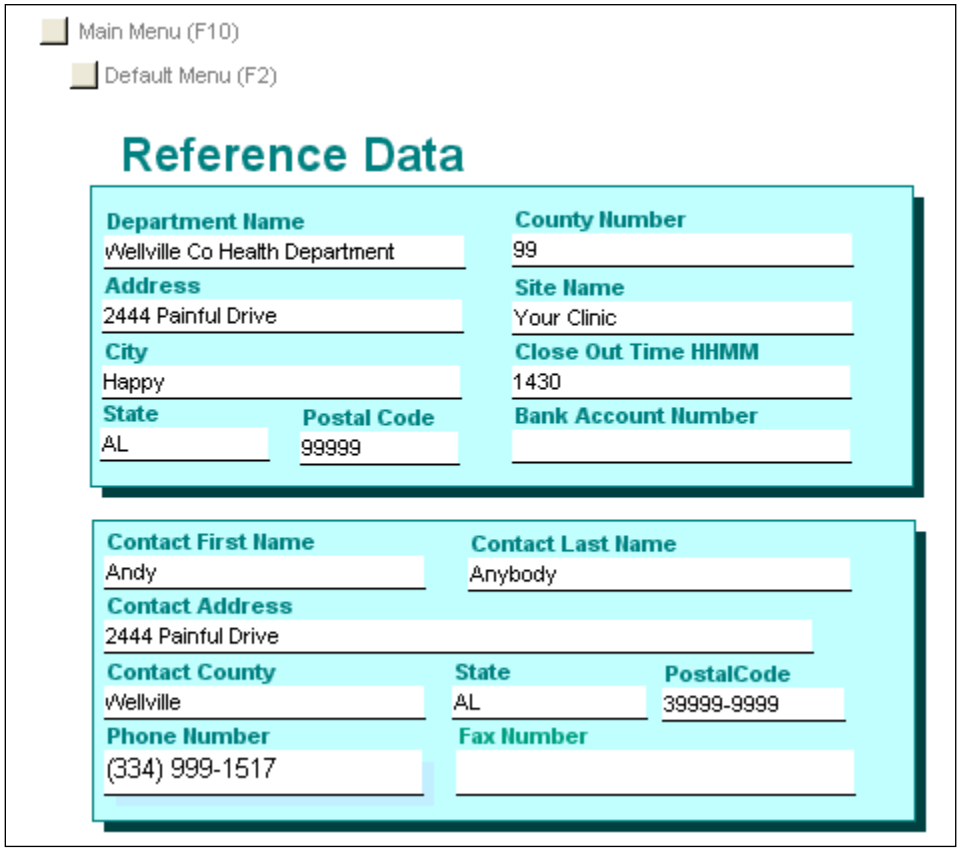
Due date is calculated 30 days from the date the invoices were run. Run them after verifying the Aged Accounts Report.

Send payment to name and address comes from what is entered in the Defaults Reference data for Department name and address, upper right portion, as well as the telephone number.

County contact name comes from what is entered in the Defaults Reference data for Contact First and Last name. (Bottom box)

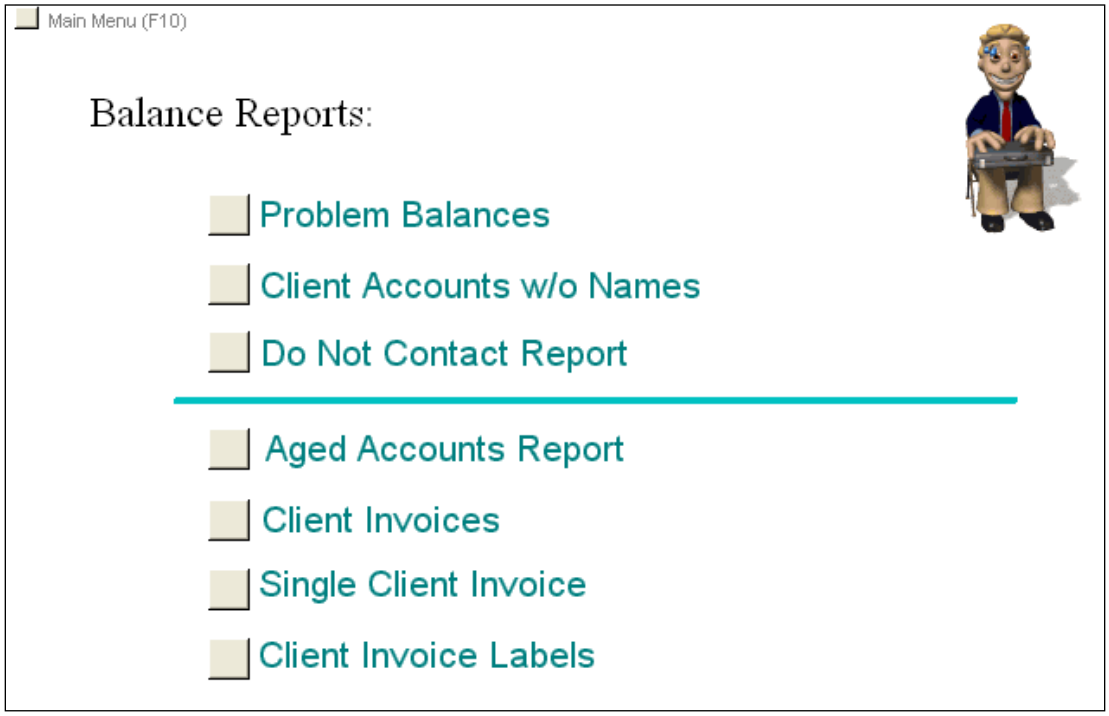
County Name after the Signature comes from what is entering in the Contact County. (Bottom Box)

Refer to the example of the Default Reference Data screen below.

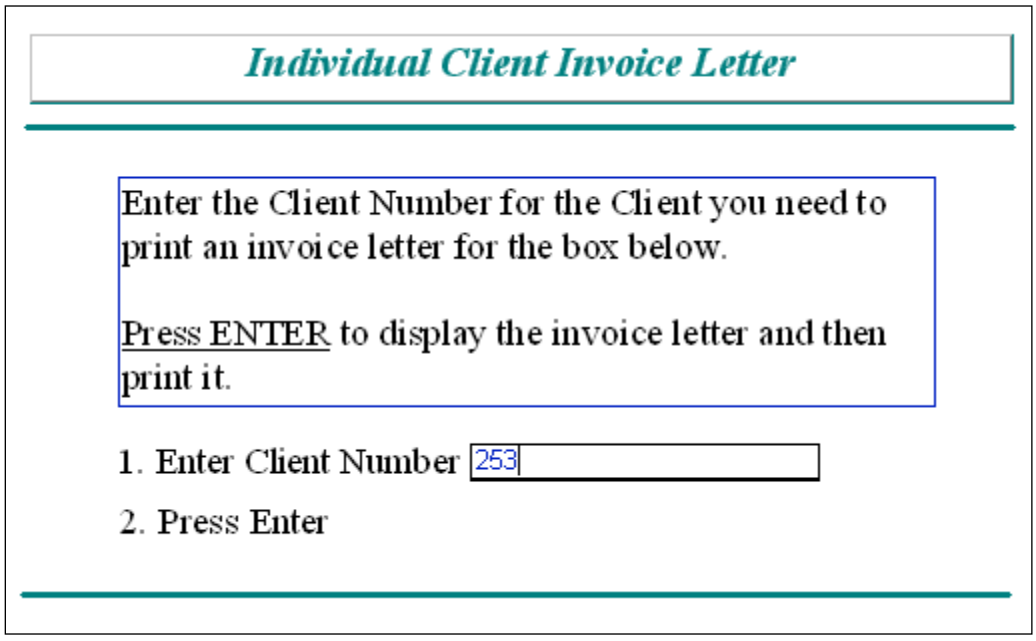


Single Client Invoices:

If you only want to print one invoice for a certain client selects Single Client Invoice from the Client Balance Reports (F4) menu. See example below:



Enter the client number in the box and press enter. See example below:



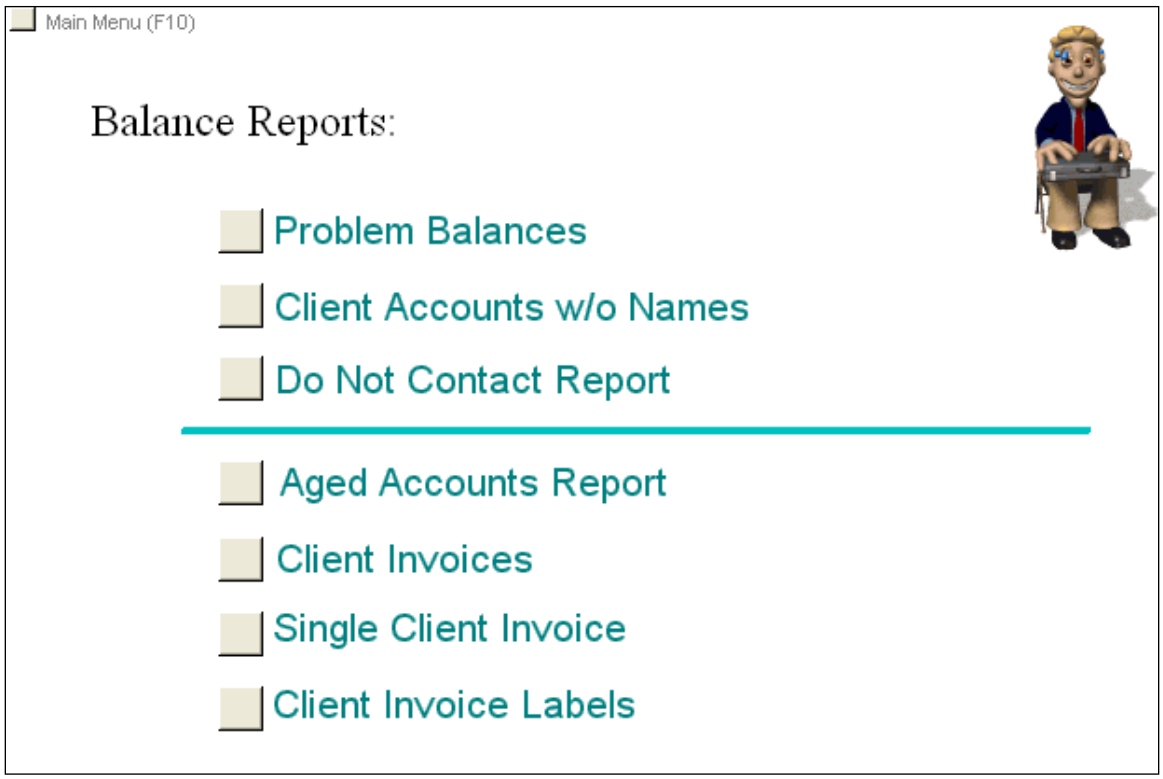
Only one invoice for the selected client will print.

Mailing Invoices:

If the Client's address is not entered in the E-Day Sheet Patient/Client Database Ledger Information screen, the CHR number can be used to print a PHALCON address label for mailing the invoice.

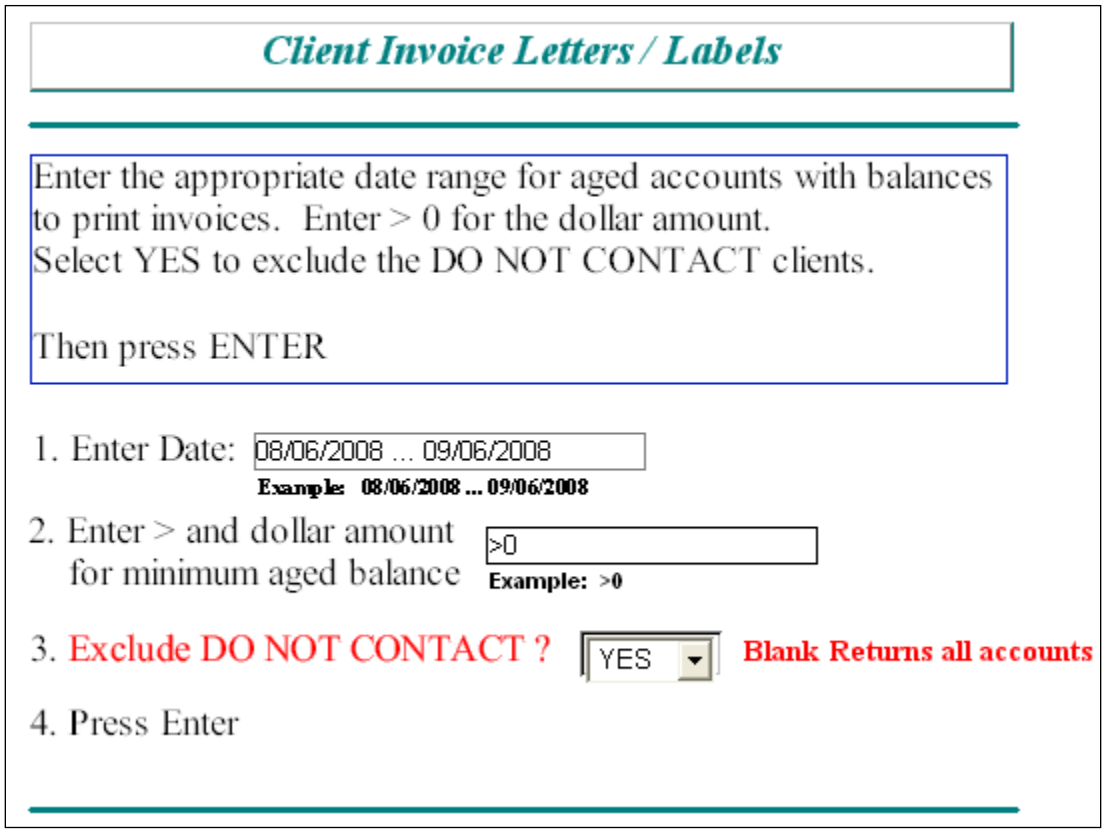
The client address information can be entered at anytime by selecting Patient/Client Records from the Main Menu. Click on Patient Lookup and search by either the name or client number. Enter the address information.

If the Client's address information is entered in the E-Day Sheet there is an option to print invoice mailing labels. Select Client Invoice Labels from the Client Balance Reports (F4) menu. See example below.

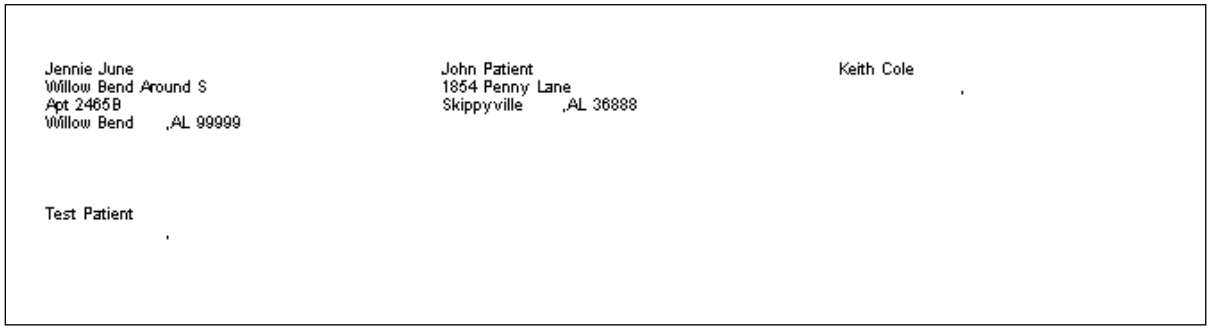


Please include a self addressed return envelope when the invoice is mailed.

Enter the same date range that was entered for the Aged Accounts Report, >0 for balance selection, and select YES from the Exclude DO NOT CONTACT box. Refer to the example below.



The labels are formatted to print on the equivalent of Avery sheet labels 5260. Three across and ten down. See example below:



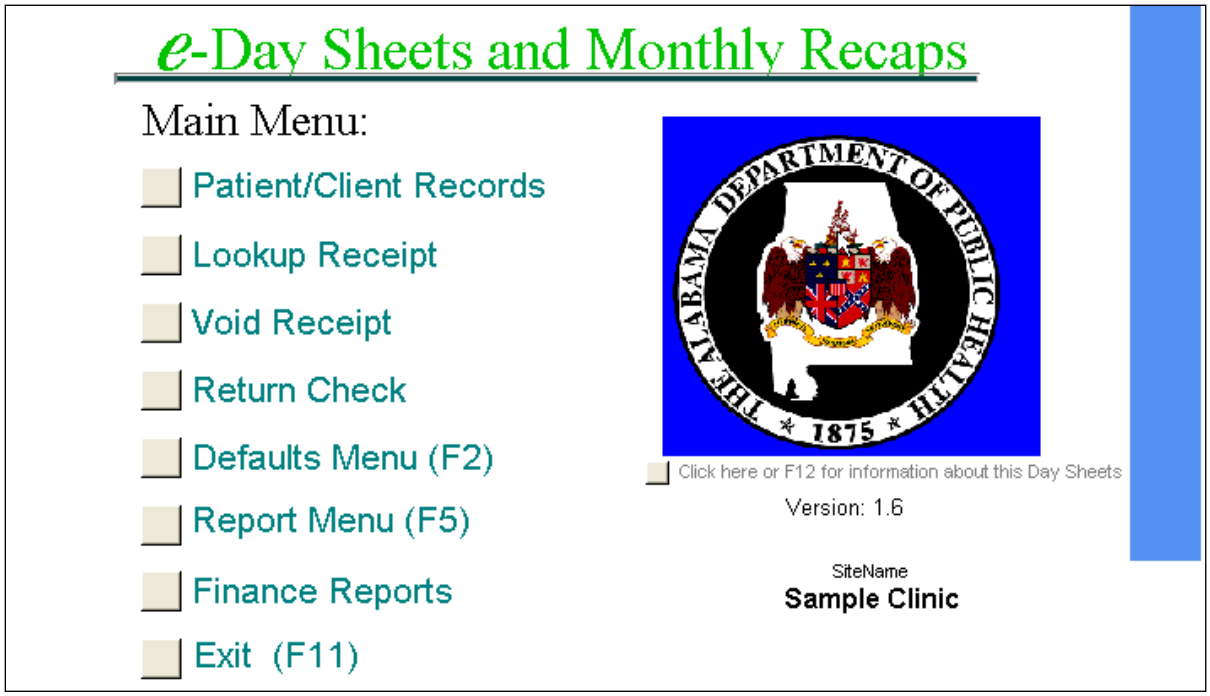
Notice the last two did not have an address entered and only the name and a comma printed.
By entering the same aging date range and >0 amount the invoice/letters and address labels should be for the same clients and all in alphabetical order. Where the Exclude DO NOT CONTACTS: YES was selected those clients will not print an invoice or label.

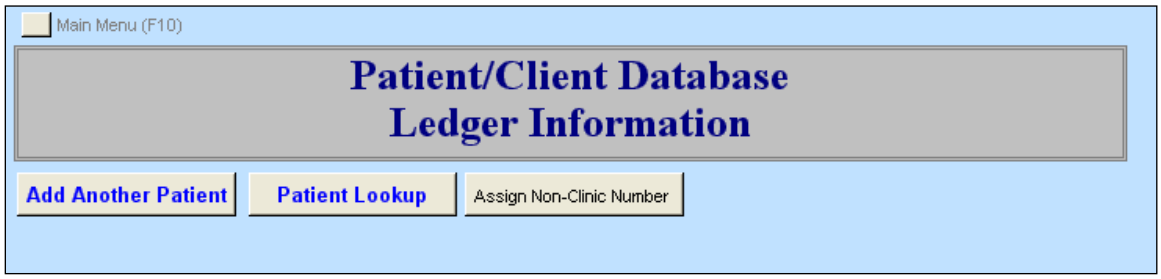
Write Off Instructions:

Follow these instructions using the 121 day and older Aged Account Balances report.

Office Managers must sign on using their Office Manager User Id and Password.

From the E-Day Sheet Main Menu select Patient/Client Records.

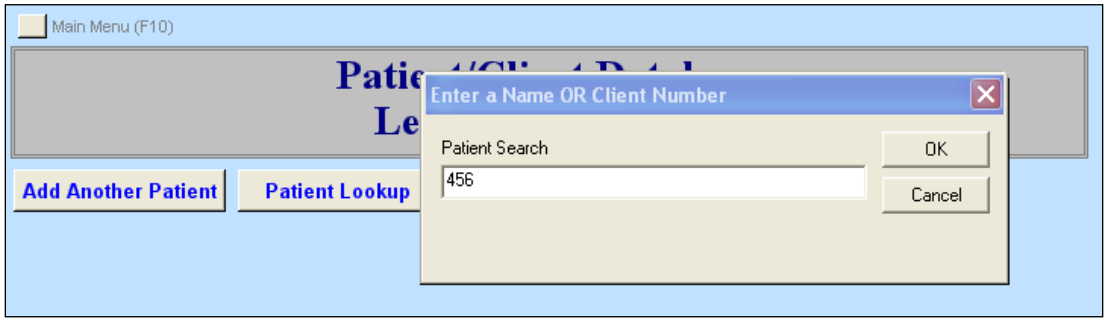




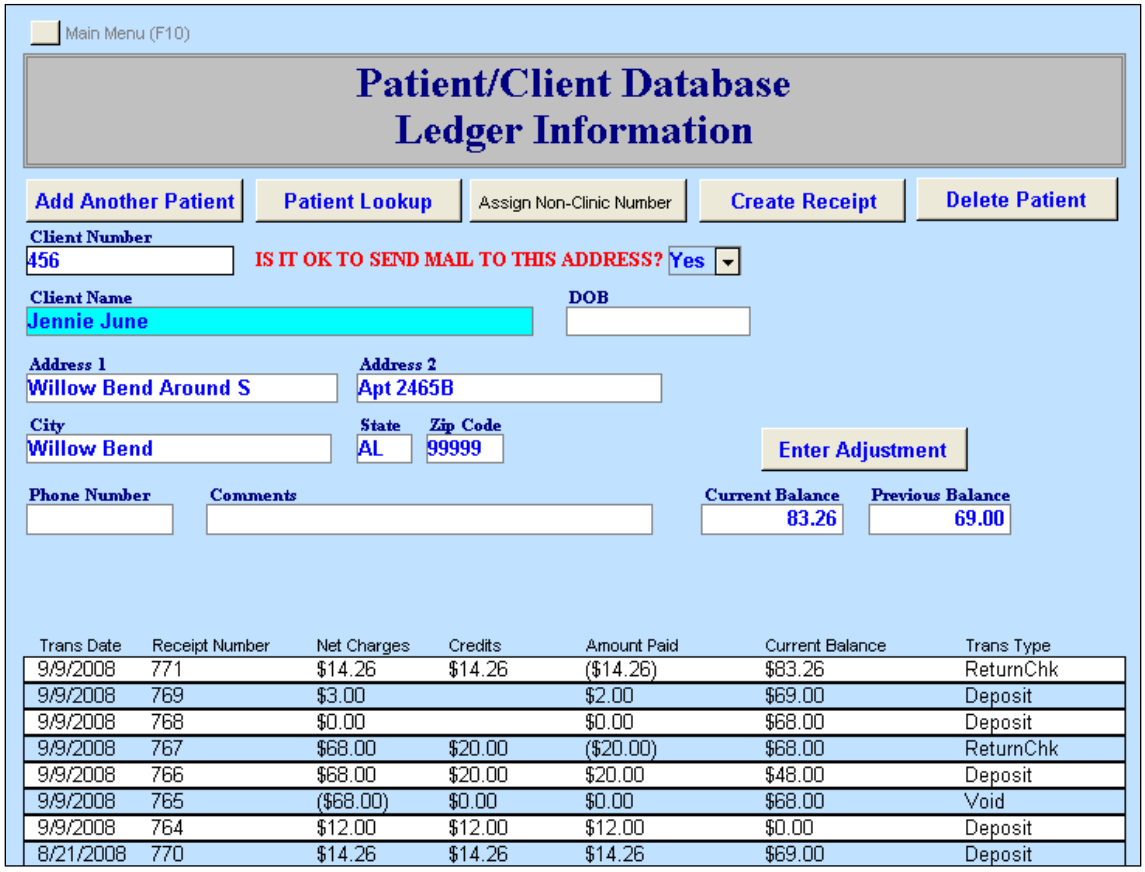
From the Patient/Client Database Ledger Information click on Patient Lookup.

Enter either the Client Number or the Client Name to search for the Client listed on the 121 days and older Aged Accounts Report.

Click Ok to display the selected client ledger card.



Verify the correct client is displayed on the screen.



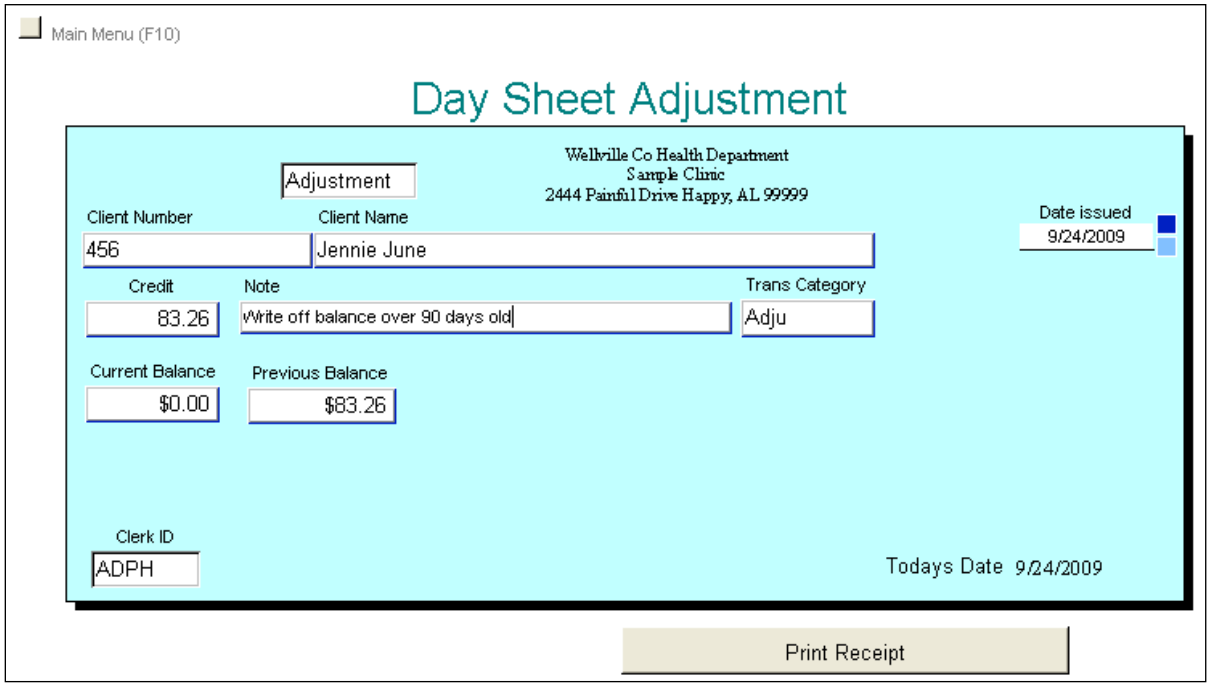
Click on the Enter Adjustment box.

NOTE: Follow the instructions below very carefully. At first there will be a lot of research and more balances than normal so there could be lag time between running the report and writing off balances. The goal is to get the balances in a managed environment so that reports, invoices, and write off transactions occur in the same day to avoid changes in Current Balance amounts.

Compare the aged balance on the 121 days and older report to the Current Balance box on the Client Ledger screen. If they are equal, use the Current Balance amount to write off. If they are not equal, research and determine the reason. If the client came in and acquired an additional charge for a new service the Current Balance box would be more than the report and you would use the amount on the REPORT to write off.

Enter the balance to be written off in the Credit box as dollars and cents.

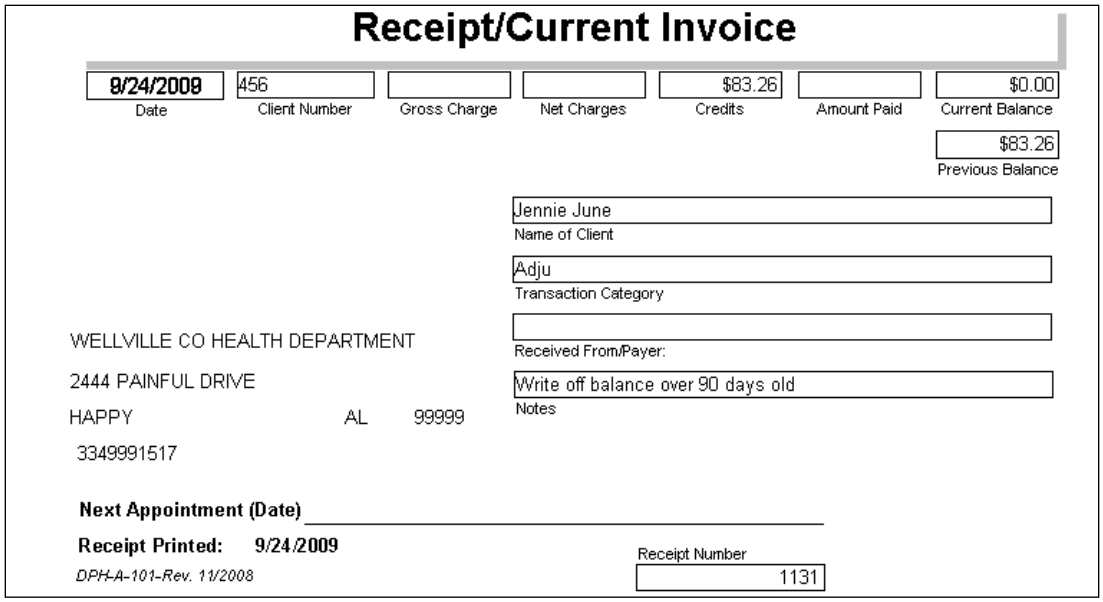
Enter **REQUIRED** documentation in the Note box.



Refer to the above example.

Click on the Print Receipt button.

Refer to the sample receipt below.



Receipt/Current Invoice

9/24/2009	456			$83.26		$0.00
Date	Client Number	Gross Charge	Net Charges	Credits	Amount Paid	Current Balance

$83.26
Previous Balance

Jennie June
Name of Client

Adju
Transaction Category

WELLVILLE CO HEALTH DEPARTMENT
2444 PAINFUL DRIVE
HAPPY AL 99999
3349991517

Received From/Payer:

Write off balance over 90 days old
Notes

Next Appointment (Date) _____

Receipt Printed: 9/24/2009

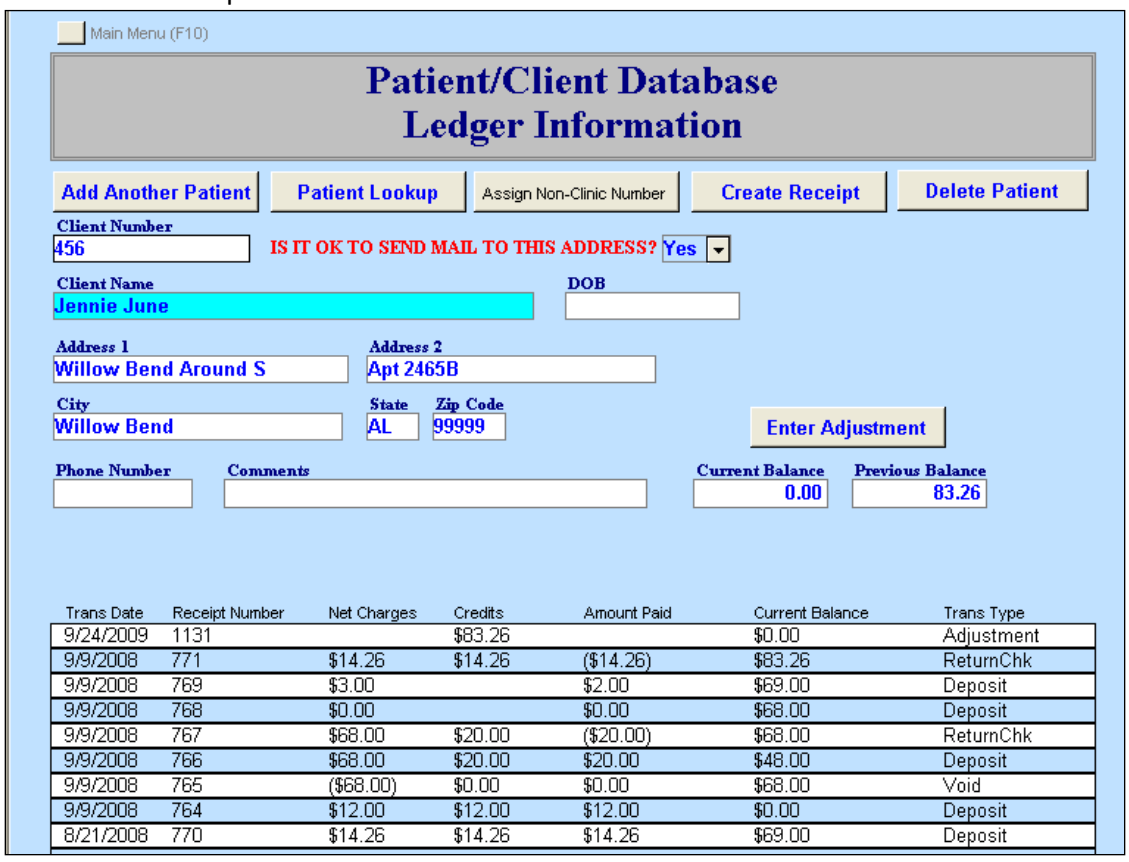
DPH-A-101-Rev. 11/2008

Receipt Number 1131

Attach the receipt to the back of the 121 days and older report and file for audit purposes.

The receipt will be listed in the individual receipt information on the ledger card and it will have the Transaction type of ADJUSTMENT.

Refer to the example below.



Main Menu (F10)

Patient/Client Database
Ledger Information

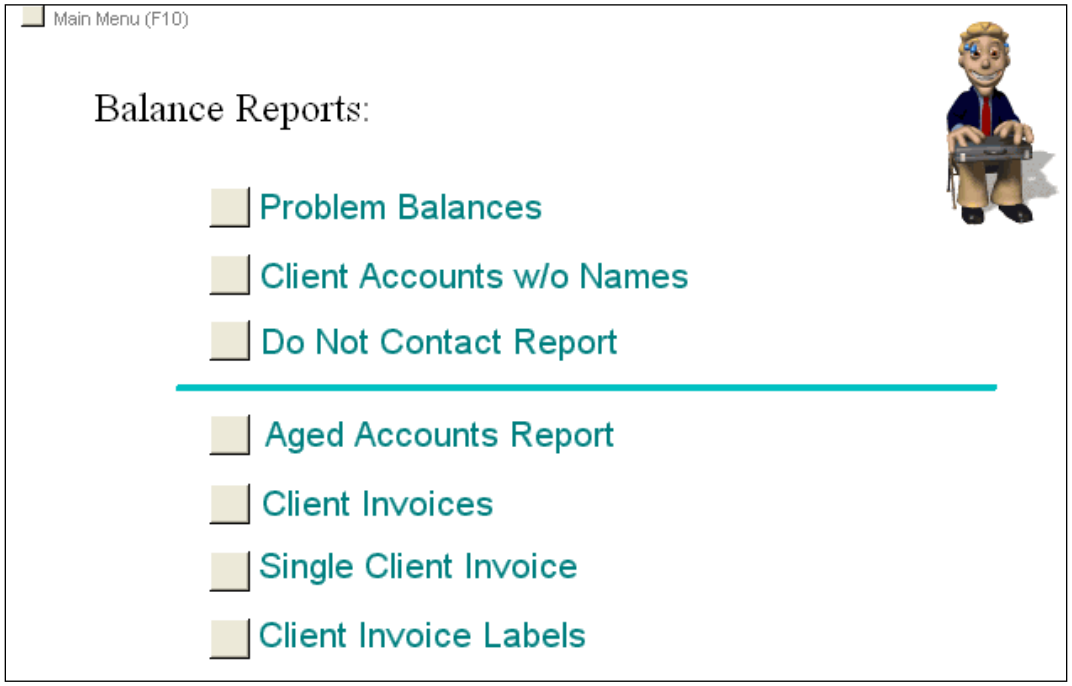
Add Another Patient | Patient Lookup | Assign Non-Clinic Number | Create Receipt | Delete Patient

Client Number: 456
IS IT OK TO SEND MAIL TO THIS ADDRESS? Yes
Client Name: Jennie June
DOB:
Address 1: Willow Bend Around S
Address 2: Apt 2465B
City: Willow Bend
State: AL
Zip Code: 99999
Enter Adjustment
Phone Number:
Comments:
Current Balance: 0.00
Previous Balance: 83.26

Trans Date	Receipt Number	Net Charges	Credits	Amount Paid	Current Balance	Trans Type
9/24/2009	1131		$83.26		$0.00	Adjustment
9/9/2008	771	$14.26	$14.26	($14.26)	$83.26	ReturnChk
9/9/2008	769	$3.00		$2.00	$69.00	Deposit
9/9/2008	768	$0.00		$0.00	$68.00	Deposit
9/9/2008	767	$68.00	$20.00	($20.00)	$68.00	ReturnChk
9/9/2008	766	$68.00	$20.00	$20.00	$48.00	Deposit
9/9/2008	765	($68.00)	$0.00	$0.00	$68.00	Void
9/9/2008	764	$12.00	$12.00	$12.00	$0.00	Deposit
8/21/2008	770	$14.26	$14.26	$14.26	$69.00	Deposit

If the Client returns after the greater than 120 day balance has been written off and wants to pay, the Office Manager will need to do an adjustment with a NEGATIVE amount to add the written off amount back to the Current Balance. Then a receipt can be issued for Payment on Account.

From the Client Balance Reports Menu (F4) select Problem Balances



No selection criteria are required to run this report. The report will contain any client with a Current Balance that is blank or Negative.

Problem Balances — Randy's Clinic

Patient Number	Patient Name	Current Balance
222	Jamie Bullock	($3.00)
143	Johnson Funeral Home	($20.00)
510000	Monty Gomery	
243	Tessy Pest	
133	Victor Victoria	($12.00)
		($35.00)

Examine this report to determine why the balances are either blank or Negative. Blank balances could be the result of establishing the Ledger Card balance from the One-Write system. At first there was not a requirement to enter anything in the Current Balance box and some were left blank. If you determine the Current Balance should be ZERO or if there is a Current Balance owed you will need to enter the amount in the Current Balance.

If you have a Client with a NEGATIVE Current Balance, research and determine the reason for documentation purposes and document the findings.

If your research determines the Client is owed a refund follow the instructions in the Fee System Manual Debra Thrash for clarification. DO NOT bring the Current Balance to Zero until all refund procedures have been followed and documented.

If the Client is NOT owed a refund follow the Write Off instructions in this document except enter the CREDIT Amount as a NEGATIVE.

VitalChek SWIPE MACHINE

VITAL STATISTICS CERTIFICATES:
Please follow these instructions when Vital Statistics certificates are paid for with the VitalChek swipe machine.

When you receive the check from VitalChek, issue a receipt with the E-Day sheet as you have been doing for Vital Statistics making sure you do the following:

CLIENT NAME on the Non-Clinic number will be the name of the person *APPLYING* for the Certificate.

Received From/Payer will be *VitalChek.*

If the Certificate is not for the applicant put the name the certificate is for in the NOTES section of the receipt.

Receipts from the VitalChek Machine:
Two receipts will print from the VitalChek swipe machine. Both will show the breakdown of the charges - amount for the certificate(s), convenience fee, and total amount of transaction.

If the transaction is a credit card transaction, the customer will need to sign the receipt. Keep the original signed receipt and attach it to the *vital statistics application(s)*. Give the customer their copy of the receipt.

If the transaction is a debit transaction, the receipt will indicate "no signature needed." Keep one receipt and attach it to the *vital statistics application(s)* and give the other receipt to the customer.

Settling the VitalChek Machine:
At the end of your business day when you "settle" the machine, a summary of the transactions that have taken place since the last time you "settled" the machine will print. That settlement tape should be stapled to the day sheet for that day.

Checks from the VitalChek Machine:

When the check prints, you will get the "real" check which should be deposited per the instructions above. The non negotiable check "copy" that prints should be kept with the application(s) just as the VitalChek receipt should be.

Other Services Paid for using the VitalChek Swipe machine:

Other services may be paid for using the Swipe machine. Follow the same instructions as above **except:**

ENVIRONMENTAL: Two receipts will print from the VitalChek swipe machine. Both will show the breakdown of the charges - amount for the service provided, convenience fee, and total amount of transaction.

If the transaction is a credit card transaction, the customer will need to sign the receipt. Keep the original signed receipt and attach it to the *environmental application*. Give the customer their copy of the receipt.

If the transaction is a debit transaction, the receipt will indicate "no signature needed." Keep one receipt and attach it to the *environmental application* and give the other receipt to the customer.

OTHER CLINIC SERVICES: Two receipts will print from the VitalChek swipe machine. Both will show the breakdown of the charges - amount for the service provided, convenience fee, and total amount of transaction.

If the transaction is a credit card transaction, the customer will need to sign the receipt. Keep the original signed receipt and attach it to the back of the *Day sheet* for that day. Give the customer their copy of the receipt.

If the transaction is a debit transaction, the receipt will indicate "no signature needed." Keep one receipt and attach it to the back of the *Day sheet* for that day and give the other receipt to the customer.

CHAPTER 10

COUNTY IMPREST FUND

Revised August 2013

GENERALINFORMATION

Purpose

The Imprest Account is a local county bank account that is used to write checks for expenses.

History

The Imprest Account was established in the late 1980's by withholding fees from deposits with approval of Financial Services.

Today

The amount of the approved fund balance is determined by the administrator and by ADPH Financial Services. The amount varies from county to county but usually represents up to two and one-half of the month's local expenditures. The amount of the fund can be increased or decreased at any time by the administrator with approval from the Chief Accountant in Financial Services.

FUND REQUIREMENTS

The imprest account is referred to as a non-expendable account. This means that any payments from the account must be replaced by reimbursement warrants from Financial Services. At all times, the balance in the checking account plus any unreimbursed expenditures must equal the established fund balance. The only difference would be interest earned on the account. Any other differences are referred to as overages or shortages.

FUND REQUIREMENTS (continued)

The Imprest Account must be a bank account. Cash accounts and change funds are not allowed. The requirements for maintaining account are:

- Checks must be preprinted and prenumbered.
- Checks must require two signatures; one must be that of the assistant area administrator or higher. In absence of assistant area administrator, Health Officer or area administrator may be authorized to sign checks.
- A letter from the Area Administrator or Local/Area Health Officer must be on file designating employee authorized to sign checks.
- Blank checks must not be presigned.
- Cancelled checks or imaging of cancelled checks must be returned with statements if they are available. Statements cannot be truncated to prevent the return of these items.
- Voided checks must be marked void and retained.
- Bank and fund reconciliations must be performed promptly each month by employee without signature authority over account.
- Bank and fund reconciliation must be reviewed by employee other than the preparer.

The County Imprest Account:

- **provides local purchasing power of less than $500 at the county health departments for:**
  County employee travel reimbursements
  - (federal or multi-county employees cannot be reimbursed)

  Operating expenses such as postage (no limit)

  Supplies

  Utility bills (no limit)

- **must be a bank account.**
  - No cash fund or change fund is acceptable
  - Established fund amount must be approved in writing by:
    Alabama Department of Public Health
    Financial Services - Chief Accountant
    201 Monroe Street
    Montgomery, AL 36104

THE COUNTY IMPREST ACCOUNT (continued)

- **must consist of reimbursement warrants and adjustments after initial deposit.**
  At all times, the balance of the checking account plus any unreimbursed expenditures must equal the established fund balance.

  - Shortages in account must be replaced by administrator who is responsible for account.

  - Overages must be corrected immediately, contact the office of Program Integrity or Financial Services - Payable Section for assistance.

- **may earn interest.**
  - Earned interest must be transferred to Fee Depository Account each January.

- **may not be used for**
  - Automotive equipment used for transportation activities
  - Advance payments for subscriptions, books, etc.
  - Checks written to CASH
  - Employee's Per Diem
  - Employee's personal use (coffee, awards, etc.).
  - Equipment.
  - Federal employee's travel (WIC, FP, etc.)
  - Gifts or flowers
  - Multi-county employee's travel
  - Payroll
  - Parties or Christmas decorations
  - Presigned blank checks
  - Recurring monthly, quarterly, semiannual or annual expenses (other than utilities)
  - Refreshments for meetings
  - Registration fees
  - Salary or travel advances to employees

CERTIFICATION

All employees performing duties pertaining to the imprest account must be certified to handle cash including:

- Administrators
- Nurses
- Clerks
- Environmentalists, etc.

Certification procedures involve:

- Assigning responsibility,
- Certifying responsible staff through training and testing and
- Preparing a cash accountability plan.

Before certification can be accomplished, the tasks to be performed must be defined:

- Approve expenditures.
- Ensure that checkbook and deposit slips are locked up when not in use.
- Deposit reimbursement warrants from Financial Services on the day received.
- Obtain appropriate support documentation for all expenditures.
- Write check for expenditures.
- Post the check stub each time a check is written, a deposit is made, or an adjustment is made. (Check stub must be posted at time of each transaction and must always be kept up to date.)
- Cross-reference payments to supporting documentation. (Supporting invoices should be stamped paid and marked with check number, date, and amount paid. When multiple invoices are being paid by one check, mark the amount paid for each particular invoice and the number of the payment check on each invoice.)
- Submit requests for reimbursement in a timely manner so that the balance in the account is not depleted (monthly).
- Reconcile the bank statement once per month (initial & date).
- Reconcile the fund balance once per month (initial & date).
- Review the bank reconciliation (initial & date).
- Review the fund balance reconciliation (initial & date).

After the tasks have been defined, a primary and alternate employee must be identified on the cash accountability plan.

CERTIFICATION (continued)

When employees have been identified, each must be formally trained, tested, and certified to handle cash.

- Testing material is available from the county office manager or area clerical director.
- Training, testing, and certification take place at the county health department.
  - The FeeSystemManual and training video are reviewed with the training agenda before the test is given to employees.
  - A passing score of 102 or above must be obtained for certification.
  - The rated test is placed in the employee's file at each county health department for review by the Office of Program Integrity.

TESTS ARE RATED BY	FOR
County Office Manager	County Employees
Area Clerical Director	County Office Managers
Clerical Director	Area Clerical Directors

SEPARATION OF DUTIES

Separation of duties is required as much as possible with existing staff. **One employee should not perform the following tasks related to the imprest account:**

- Approve expenditures AND complete checks. **(Required)**
- Sign checks AND reconcile bank statement. **(Required)**
- Prepare reimbursement requests AND reconcile fund balance. **(Required)**
  - Complete checks AND sign checks.
  - Reconcile bank statements AND deposit reimbursement warrants.

CASH ACCOUNTABILITY PLAN

A cash accountability plan must be prepared and maintained on-site by each county health department. You must update the cash accountability plan when there are changes in staff assignment. A sample cash accountability plan is shown on pages 8-29 and 8-30. Each cash accountability plan must be reviewed and signed by the area clerical director and area administrator. Each plan identifies:

- The tasks to be performed.
- The primary employee responsible for the tasks.
- The alternate employee.
- When certification was accomplished

IMPREST FUND
CASH ACCOUNTABILITY PLAN
_____ COUNTY HEALTH DEPARTMENT
_____ LOCATION _____ DATE

ANYONE INVOLVED WITH THE IMPREST FUND MUST BE CERTIFIED

1. Is responsible for shortages:
   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

2. Approves the expenditures for travel (signs the State of Official Travel):
   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

3. Approves the expenditures other than travel:
   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

4. Fill out the checks:
   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

5. Signs the checks:
   Signatures which must be on check: Others who may co-sign checks:

   Date Certified: _____ Date Certified: _____
   _____ _____

   Date Certified: _____ Date Certified: _____
   _____ _____

6. Maintains office copy of invoice and cross-references it to the check:

   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

IMPREST FUND
CASH ACCOUNTABILITY PLAN

_____ COUNTY HEALTH DEPARTMENT

_____ LOCATION

_____ DATE

ANYONE INVOLVED WITH THE IMPREST FUND MUST BE CERTIFIED

7. Prepares reimbursement requests:

   Primary Responsible Person: _____ Date Certified: _____

   Alternate: _____ Date Certified: _____

8. Reconciles reimbursement warrants with reimbursement requests:

   Primary Responsible Person: _____ Date Certified: _____

   Alternate: _____ Date Certified: _____

9. Reconciles the bank statement:

   Primary Responsible Person: _____ Date Certified: _____

   Alternate: _____ Date Certified: _____

10. Maintains office copy of invoice and cross-references it to the check:

    Primary Responsible Person: _____ Date Certified: _____

    Alternate: _____ Date Certified: _____

11. Deposits reimbursement warrants:

    Primary Responsible Person: _____ Date Certified: _____

    Alternate: _____ Date Certified: _____

12. Other (explain)

    Primary Responsible Person: _____ Date Certified: _____

    Alternate: _____ Date Certified: _____

Signed: _____

Area Clerical Director:
Date: _____

Signed: _____

Area Clerical Director:
Date: _____

SUPPORTING DOCUMENTS

- **Checks can only be written with approved supporting documentation for all expenditures:**
  - Vendor invoices.
  - Travel claims.
  - Receipts.
- **All supporting documentation must be reviewed for accuracy to ensure correct amount is paid.**
- **Only current charges can be paid from the imprest account.**
  - No arrears.
  - No previous balances.
  - No sales tax.
- **Supporting vendor invoices must be:**
  - Stamped paid.
  - Marked with check number, date paid, and amount paid.
  - Initialed by the local administrator.
- **Multiple invoices from one vendor can be paid with one check**.
  - Mark the amount paid on each invoice.
  - Post the check number on each invoice.
  - Identify by date
  - Initialed by local administrator.

TRAVEL CLAIMS

Supporting travel claims must be approved and initialed by employee's immediate supervisor.

- If administrator approves travel, the employee's immediate supervisor must initial travel claim.
- If supervisor approves travel, the local administrator must initial travel claim.

Travel claims must be stamped with:

- Amount paid
- Date
- Check number.

All amounts listed on the Field Voucher (HF-2) must match the attached supporting documentation.

Travel reimbursements:

- must have travel claims attached in the same order as listed on the job cost sheet.
- may be submitted separate from miscellaneous invoices.

REIMBURSEMENT WARRANTS

Reimbursement warrants must be:

- deposited the day received.
- reconciled when received.

Overages and Shortages must be investigated and resolved immediately.

OVERAGES AND SHORTAGES

Overages and shortages in the county imprest account are amounts over-reimbursed or under-reimbursed by Financial Services - Payable Section.

Shortages:

The only shortages in the account are amounts not reimbursed by Financial Services - Payable Section. All unreimbursed items must be repaid by the employee responsible for the fund, if additional documentation to the Payable Section does not prove acceptable for reimbursement. When repayment deposits are made, deposit the amount on a separate deposit slip marked "payment of items (specify check number or type of error) not reimbursed by Payable Section."
EXAMPLE: "Sales tax paid in error, CK # 1756."

Overages:

Duplicate reimbursements or reimbursements greater than the amount of the check result in an overage. This does sometimes happen, identify what caused the overage (submitted travel voucher twice for payment and paid twice).

To correct Overages or Shortages:

- **Adjust the vendor's next check, whenever possible.**

  For example, this is vendor used on a regular basis.

  - Telephone bill is over paid on previous balance by $30.
  - County health department submits Field Voucher for reimbursement.
  - Financial Services deducts $30 from Field Voucher (HF-2) and check.
  - Imprest account is $30 short.
  - When the next telephone bill is received for current charges of $50.
  - Write a check for $20 to telephone company to offset $30 paid the previous month.
  - Submit Field Voucher for reimbursement of $50 for current charges.
  - Financial Services will reimburse current telephone expense for $50.
  - The imprest account is in balance and no longer short by $30.
  - The telephone company is paid up-to-date.

OVERAGES AND SHORTAGES (continued)

- **If unable to adjust vendor's next check, contract the Office of Program Integrity at 334-206-5312.**
- **The local administrator is responsible for unresolved shortages and must be repaid.**
  - Deposit the shortage on a separate deposit slip with explanation and include:
    1. Item not reimbursed
    2. Check number
    3. Field voucher date

The requirements for the Imprest Account state that:

- **Checks must:**
  - be preprinted,
  - be prenumbered,
  - be written in sequential order, and
  - Have two signatures (one signature must be the assistant area administrator or higher classification. In absence of the assistant area administrator then the Health Officer or Area Administrator may be authorized to sign checks if they are on the signature card. Authorization to sign checks below the level of assistant area administrator must be granted by Area Administrator or higher classification.) Authorization of more than two signatures on the check must be approved by ADPH Chief Accountant in writing. Several names may be on the signature card and these names must be designated by the Area Administrator.
- **Voided checks must be retained in numerical sequence by fiscal year.**
- **Cancelled checks, debits, and credits must be:** returned with bank statement each month and maintained by fiscal year for audit purposes.
- **Outstanding checks for over three month must be investigated and results documented.**
- **Bank statements must be given to preparer unopened.**
- **Bank statement reconciliation must be:**
  - formal
  - written
  - completed every month
  - initialed and dated by preparer
  - reviewed, dated, and initialed monthly by someone other than preparer.
- **Fund balance reconciliations must be:**
  - completed every month
  - signed and dated by preparer
  - reviewed, dated, and initialed monthly by someone other than preparer

USE OF CREDIT CARDS

The use of charge cards for local purchases is not much different from the local "charge accounts" that some of our counties currently have with some of their vendors. The basic thing to remember, imprest account rules and restrictions still apply. Credit card purchases are still limited to $500 per vendor per reimbursement period (in this case you are looking at the reimbursement period being one month or one billing cycle).

Authorization: The administrator, also being responsible for county operations and shortages in the imprest account, needs to specify who has the authority to open accounts in the health department's name. This function can only be performed by the Area or Assistant Area Administrator.

The charge card needs to be in the name of the county health department. (For example Etowah County Health Department) If possible, do not put an individual's name on the card. This potentially limits the flexibility of allowing someone other than the named employee from using the card. Also, having the individual's name on the card could potentially impact their personal credit ratings, etc. If the vendor requires a specific name, make sure the county health department name is also present.

Administrators must then determine who may use the cards and have a letter on file (maintained locally) that specifies the individuals who may use the cards. This is similar to the letter maintained locally which specifies who can sign checks for the imprest account.

Administrators also need to determine who will authorize specific purchases. Since administrators are responsible for the shortages in the account, in theory, administrators should be approving all purchases. Some office managers have been given great latitude in authorizing certain purchases through mostly informal means. However, administrators should communicate expectations and authorizations to the employees in writing. The administrator should also communicate any spending restrictions for those individuals. (For example, purchase of items over $200.00 requires administrator approval.)

Purchases: An employee, identified on the list of authorized card users, will sign a log showing they have received the card from the health department to make purchases (Credit Card check out/check in log). They will then go to the store and purchase the items with the card. The sales receipt will be signed by the employee who used the card for the purchases. (If the employee's electronic signature from the keypad does not print on the receipt, the employee making the purchase will physically sign the itemized sales receipt.) Another employee will verify the items were purchased and received at the health department.

Purchases with charge cards cannot exceed any limits or restrictions for other purchases through the imprest account. Credit cards cannot be used to obtain cash advances. ***Utilize state contracts instead of charge cards, charge accounts, or the imprest account when possible.***

Documentation: Itemized sales receipts, signed by both the purchaser and the employee who verified receipt of the goods, must be maintained and matched with the monthly billing statements. The monthly billing statement will be processed through the local imprest account. The monthly billing statement and the itemized sales receipts must be submitted to Health Finance with the imprest account reimbursement request. Remember, if credit card purchases exceed imprest limitations, the imprest account will reflect a shortage. The administrator is responsible for shortages in the imprest account.

Security: The administrator needs to know how many cards are on the account and who has them. Do not allow employees to maintain these cards in their possession; instead, keep the cards in a secure location at the health department and issue to employees to make purchases only when needed. This is similar to the requirement to maintain the blank check stock in a secure location. Administrators will also maintain a "Credit Card check out/check in" log to assist with accountability of purchases.

Credit Card Account Limitations: When establishing the account with the vendor, keep the credit limitation to $1,500.00 or less. This will allow ample time for payment processing and continued use of the credit card. It will also limit liability should the card become lost or stolen.

SOME WHERE
2/ 9/96

JANUARY 1996

Page 1

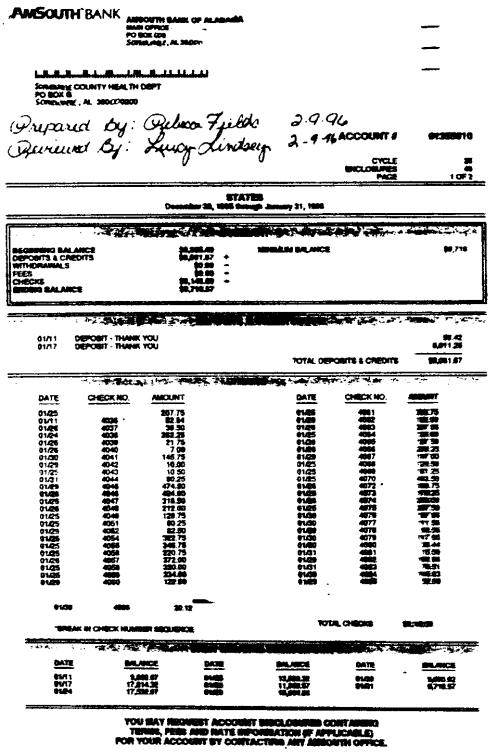
RECONCILIATION SUMMARY

BANK STATEMENT -- CLEARED TRANSACTIONS:

Previous Balance:		9,805.49
Checks and Payments:	49 Items	-8,148.59
Deposits and Other Credits:	2 Items	8,061.67
Ending Balance of Bank Statement:		9,718.57

YOUR RECORDS -- UNCLEARED TRANSACTIONS:

Cleared Balance:		9,718.57
Checks and Payments:	3 Items	-697.71
Deposits and Other Credits:	0 Items	0.00
Register Balance as of 2/ 9/96:		9,020.86
Checks and Payments:	0 Items	0.00
Deposits and Other Credits:	0 Items	0.00
Register Ending Balance:		9,020.86


AmSOUTH BANK

Prepared by: Rebecca Tibbs 2.9.96
Reviewed By: Lucy Lindsey 2-9-96

STATES

SOMEWHERE
2/ 9/96

JANUARY 1996

Page 2

UNCLEARED TRANSACTION DETAIL UP TO 2/ 9/96

Date	Num	Payee	Memo	Category	Clr	Amount
Uncleared Checks and Payments						
1/22/96	4050	SUSAN M. RONIE	DEC 95 TRAVEL	Travel/HH		-113.50
1/22/96	4053	NELLIE L. GLAZE	DEC 95 TRAVEL	Travel/HH		-410.50
1/23/96	4088	WAL-MART STORES,	4247953, & 4247	GEN.OPR/HH & CL		-173.71
Total Uncleared Checks and Payments				3 Items		-697.71
Uncleared Deposits and Other Credits						
Total Uncleared Deposits and Other Credits				0 Items		0.00
Total Uncleared Transactions				3 Items		-697.71

INTEREST CHECKING AND FUND BALANCE RECONCILIATION

Somewhere COUNTY HEALTH DEPARTMENT

FOR MONTH OF: January ,1996

BANK RECONCILIATION

BANK BALANCE (date)_____ _____

	Add	
DEPOSITS-IN-TRANSIT [not on this statement] (list on reverse side)	+	_____
	Sub-Total	_____
	Subtract	
CHECKS OUTSTANDING [not on this statement] (list on reverse side)	-	_____
This should equal your CHECK BOOK BALANCE (date)_____	Total	_____

Prepared by:_____ Date:_____

FUND BALANCE RECONCILIATION

CHECK BOOK BALANCE (date) 2-9-96		9020.86
	Add	
UNREIMBURSED EXPENDITURES (list on reverse side)	+	10,979.14
	Sub-Total	20,000.00
	Subtract	
INTEREST [year to date]	-	0
FUND BALANCE	Equals =	20,000.00
APPROVED AMOUNT 20,000.00		
EXPLAIN:	+	_____
	Difference	
	-	_____

Prepared by: Rebecca Fields Date: 2-9-96

NOTE: Attach this to a copy of your bank statement and send to Internal Audit. If you are using Quicken software, just ignore the bank reconciliation on this form. Instead, attach a copy of your Quicken bank reconciliation along with the copy of your bank statement and complete the "Fund Balance Reconciliation" section on this form.

OIA-BR/FBR-1/92

Reviewed by: Lucy Lindsey

DEPOSITS-IN-TRANSIT

date	amount
	Total

CHECKS OUTSTANDING

date	amount	number
	Total	

UNREIMBURSED EXPENDITURES

date	amount
12-19-95	698.54
1-18-96	1526.64
2-16-96	7594.25
2-9-96	1159.71
	10,979.14 Total

COUNTY IMPREST FUND REIMBURSEMENT

After expenditure has been incurred and the invoice has been received.

- **Prepare a Field Voucher (HF-2) with the following information:**
  - County Health Department name
  - Program name
  - Current date
  - Vendor's name and address
  - Date paid
  - Specified paid service
  - Reimbursement amount
  - Invoice number
  - Imprest Fund Reimbursement for the period _____.
  - Authorized signature

- **Attach original vendor's invoices to white HF-2.**
  - in same order as listed on HF-2.

- **Attach copies of vendor's invoices to pink HF-2.**
  - in same order as listed on HF-2.

- **Attach blue HF-2**
  - Maintain the yellow copy of the HF-2 and copies of the vendor's invoices.

- **Mail white, pink, and blue HF-2 with vendor's invoices to:**
  Alabama Department of Public Health
  Financial Services - Payable Section
  201 Monroe Street
  Montgomery, Alabama 36104

- **The Payable Section will process the HF-2. A reimbursement warrant and the blue copy of the HF-2 will be mailed to county health department.**

STATE OF ALABAMA
STATE HEALTH DEPARTMENT

FIELD VOUCHER

Date 04/05/96

COUNTY Health Department

Program

To (Payee) COUNTY HEALTH DEPARTMENT AGCY0119100

Address 1451 SOMEWHERE AVENUE

SOMEWHERE, ALABAMA (Zip) 38000

Check #	Payee	Articles or Services (Itemized)	Acct. Code	Cost Code	
9012	ALABAMA GAS CORPORATION		0700-03	651-001	1031.53
9013	DELTACOM		0700-05	651-001	185.87
9014	VOID		0900-04	651-070	0.00
9015	HARDY'S ELECTRONIC CENTER, INC.		0900-17	651-001	30.36
9016	AMERICAN HEART ASSOCIATION		0900-04	651-090	155.00
9017	CURTIN MATHESON SCIENTIFIC, INC.		0300-04	651-001	112.79
9018	WILSON & WILSON, INC.		0900-02	651-001	228.11
9019	MOORE BUSINESS PRODUCTS		0900-02	651-001	160.16
9020	OFFICE DEPOT, INC.		0900-02	651-001	153.40
9021	WAL-MART OF MONTGOMERY		0900-04	651-001	24.68
9022	DURR-FILLAUER MEDICAL, INC.		0900-04	651-001	34.19
9023	PITNEY BOWES, INC.		0900-04	651-001	25.14
9024	MEDIA SOUTH COMPUTER SUPPLIES, INC.		0900-02	651-001	184.85
9025	SEALS & STAMPS UNLIMITED		0900-02	651-001	42.60
9026	SOME WHERE WATER WORKS		0700-02	651-001	421.45
9027	BELL SOUTH		0700-05	651-001	2510.30
9028	BUCK TAYLOR MANUFACTURING SALES		0900-17	651-001	194.62
9029	DURR-FILLAUER MEDICAL, INC.		0900-04	651-001	226.95
				TOTAL	6,521.76

10-16

I certify that the items listed on this voucher were purchased and received and/or Service performed in the official business of the Health Department and are approved for payment.

Paid by Voucher Number

AUTHORIZED SIGNATURE

ADPH-P-OP-System, 12-93

HELPFUL HINTS FOR SPEEDY REIMBURSEMENTS ON IMPREST ACCOUNT

INVOICES:

- Must be credited instead of marking through original invoices.
- Must have descriptions rather than item numbers.
- Must be separated by originals and copies, and in the order listed on field voucher.
- Must be charged to an appropriate cost center. The cost center coding should be listed on field voucher.
- Must include a copy of advertising ads with the invoice/or sworn copy (affidavit) for payment.
- Must be original bills unless the original goes to the vendor. When orders are placed for special checks or pamphlets with specific information on subscriptions, the vendor will accept copies of the subscription notice and the original should be submitted to Financial Services-Payable Section.

FIELD VOUCHERS:

- Require approval signatures. Before mailing, check the field voucher for signatures.
- Must include itemized description, such as batteries, i.e. dopplers, Home Health recorders/beepers, clocks, flashlights, etc. and must be charged to specific cost center codes.
- Serves as material receipt. When submitting a field voucher for reimbursement to imprest account, do not submit a material receipt.

NOTARY COMMISSIONS:

- Must be on a separate field voucher for approval by Risk Management.

TRAVEL TEMPLATE:

- Is a time-saver. If you do not have this template, contact your Area Clerical Director.

COPIES:

- Send two copies of everything.

Unclaimed Property Reporting Requirements and Instructions

The State of Alabama Unclaimed Property Act of 2004 provides that the State Treasurer shall serve as the custodian of property or funds deemed abandoned under its provisions. The law requires an annual report be filed and unclaimed property remitted to the State of Alabama Treasurer's Office, Unclaimed Property Program. An annual report must be filed with the State Treasury before November 1 of each year for the unclaimed property accounting period July 1 through June 30. The law also requires holders of unclaimed property to report and remit unclaimed property which was not reported, but due, from earlier report years. A holder who fails to report, pay or deliver property within the prescribed guidelines shall face a civil penalty.

Public Health just recently became aware of unclaimed property reporting requirements that apply to dormant vendor and expense checks written from the Imprest accounts. The Treasurer's Office is allowing the 2008 report year to be the compliance catch up year for the department for all previous years. Penalties that are usually accessed for failure to file an unclaimed property report will be waived for this catch up year.

Please follow the guidelines below when submitting funds to the Unclaimed Property Division:

- Outstanding checks written from the Imprest Fund for mileage expense reimbursements and vendor payments that are over three years old (dormancy period for expense and vendor checks) must be remitted to the State Treasurer's Office, Unclaimed Property Program.

- The current report year is 2008, covering the period July 1, 2004 to June 30, 2005. Any outstanding checks that become three years old during this period must be included on the 2008 report. As this is the compliance catch up report year for Public Health, all prior year outstanding checks dated June 30, 2004 or before **must** also be included on the current year's report.

- A written notice must be sent to the apparent owner at his/her last known address informing him/her that the county health department is in possession of property that may be presumed abandoned. The notice must be sent not more than 120 days or less than 60 days before filing the report. A standard notification form letter is attached. The letter should be printed on department letterhead and sent by first class mail to the owner.

- The annual report is due on or prior to November 1 of each year. Public Health requires each county to submit Unclaimed Property reports on October 15th of each year. In order to give the required notice, the notification letters to the owners should be sent between July 1 and August 15 of each year. The owners should be given thirty days to respond.

- No written notice is required if there is no known address or the property has a value of less than $50.

- Alabama Treasury Department Report Form 1 and Report Form 2 must be submitted along with a check made payable to the Treasurer's Office for the total amount of the outstanding checks. The required forms are attached.

- A copy of all the required paperwork should be kept on file in the county health department. The Office of Program Integrity will provide guidelines for record retention to ensure compliance with the Alabama Uniform Disposition Act of 2004. They will also provide guidance on how to handle the transaction in the Imprest Fund when property is remitted to the Treasurer's Office.

- No Unclaimed Property report is required to be filed if there is no unclaimed property to remit for the report year.

Information is also available on the Department of Treasury's website at:

http://www.treasury.state.al.us/Content/Business_Owners.htm.

July 30, 2012

Owner's Name
Address
City, State and Zip Code

NOTICE OF UNCLAIMED FUNDS

Our records indicate that we are holding unclaimed property of at least $50 due to the *person/company* listed above. The owner may claim this property by contacting us at the address and/or telephone number listed below.

_____ County Health Department
Address
City, State and Zip Code
Telephone Number: County Health Department's Telephone Number

IF A RESPONSE IS NOT RECEIVED WITHIN THRITY DAYS FROM THE DATE OF THIS NOTICE, THE FUNDS WILL BE CONSIDERED UNCLAIMED/ABANDONED AND WILL BE TRANSFERRED TO THE ALABAMA STATE TREASURER'S OFFICE, UNCLAIMED PROPERTY DIVISION, AS REQUIED BY LAW. THE FUNDS WILL BE TRANSFERRED BY OCTOBER 15.

After November 1, the funds will be available from the State of Alabama Treasurer's Office. You can contact them at:

State of Alabama Treasurer's Office
Unclaimed Property Division
Post Office Box 302520
Montgomery, Alabama 36130-2520
Telephone Number: 1-888-844-8400

Sincerely,

Holder's Typed Name for Signature

COMMON QUESTIONS AND ANSWERS

IMPREST ACCOUNT

Question: What is done with interest earned on the imprest checking account?

Answer: The total interest earned for the year must be transferred to the depository account each January. To accomplish this, record the deposit as miscellaneous revenue on the day sheet (you must write a prenumbered receipt). The amount will be recorded on the monthly recap under other and designated as imprest account interest.

Question: Is the fund balance of the Imprest Account reconciled monthly?

Answer: Yes. The reconciliation is important. It is a good way to tell whether or not all expenditures have been reimbursed or whether reimbursement is pending.

Common reconciliation items consist of unreimbursed expenditures. For example, a lost receipt was never sent to the Bureau of Financial Services, or an expenditure, or part of expenditure, was not reimbursable by the Bureau of Financial Services.

Quicken Instructions

The Quicken software is used by the county health departments to process and track transactions of the local imprest accounts. The software can be obtained through the Department's Bureau of Information Technology. It accounts for all financial transactions, including deposits into the account, checks drawn on the account, and any adjustments. The Quicken software is also used to handle the monthly bank reconciliation.

The instructions that follow are not intended to address every situation you will encounter. It does not attempt to illustrate routine processes such as completing or printing checks. Rather, the instructions address functions that are often misunderstood or overlooked.

Security Requirements

- The account must be password protected. It is recommended that at least two people know the password, but the password for the program should not be common knowledge. The password should be changed periodically. It must be changed if responsibilities change.
    - If you are locked out of the account, then the Quicken software would have to be re-installed by assigned IT personnel.

- The check stock used with the Quicken software must also be secured when not in use.

- Retain voided checks.

Establishing a New Account

All imprest accounts are currently operating with the Quicken software. If you have the need to establish a new imprest account or miscellaneous account, please call the Office of Program Integrity for guidance.

Working With an Existing Account

- Deposits:
    - ✓ Deposits must identify the date of the transaction, the date deposited with the bank.
    - ✓ If the deposit includes multiple field vouchers, include only the total amount since the total of the deposit will be listed on the bank statement.
    - ✓ If separate deposit entries are made for each field voucher, list each deposit separately since the bank statement will also list the deposits individually.

- Checks:
    - ✓ Checks must be used in sequential order.
    - ✓ All checks must be accounted for on the check register. If a check is voided, the check must still be listed in the register.

- Voids
  - ✓ The "void function" in Quicken **can only be used in the current month to affect a current month's transaction**. [Edit – Transaction – Void or CTRL+V] For example, if you print checks today and notice the alignment is off, you can "void" the transactions. Quicken will replace the check amounts with a zero or a blank amount in the payment column and adjust the ending balance accordingly. The check numbers will be maintained in the number column so that there is no break in the sequence of check numbers.
  - ✓ The "void function" **must not** be used to void a check **from a previous month,** and **must not** be used to void a check in the **current month** that has **already been issued**. While Quicken will allow the void function to be used in this manner, it is not proper accounting procedures, doing so destroys the history and thus deletes the audit trail. It is like using the magic whiteout pen in the check register. To void a check from a previous month, or one that has already been issued:
    - Make an entry with today's date to add back lost/stale check number xxx (deposit entry). This is an offsetting entry in the same amount as the check that was originally written.
    - Issue a new check to replace the old check in the same amount as the original check. (Be sure to follow the Unclaimed Property Procedures should those apply.)
    - Do not ask for reimbursement of the newly issued check since you should have already received reimbursement from Health Finance for the original expenditure.
    - The next time you perform the bank reconciliation, mark the old check number and the offsetting deposit entry as cleared, even though neither transaction actually processed through the bank. The two transactions have a zero sum effect on the bank reconciliation since the payment amount and the deposit amount are the same.
    - The newly issued check will be reconciled only after it is processed by the bank.

Bank Reconciliations

- Bank reconciliations are to be prepared promptly. Promptly is defined as by the end of the following month. (January should be completed before the end of February.)
- Reconciliations need to be prepared as of the end of the month. (There are a few counties whose bank cut off dates are in the middle of the month. For these counties, reconciliations will still be through the end of the month even though the bank statement cutoff was earlier in the month. For example, the bank cutoff date is January 20. The bank reconciliation is prepared on February 5. The report date for the reconciliation will be January 31.)
- The person preparing the reconciliation needs to sign/initial and date the reconciliation to verify compliance with the county Cash Accountability Plan.
- The person assigned the responsibility to review the reconciliation will also need to sign/initial and date the reconciliation to verify compliance with the county Cash Accountability Plan.

- Bank Adjustments
  - ✓ Sometimes the bank will process a transaction for the wrong amount. For example, you wrote the check for $156.29 but the bank processed the check for $159.29. They took $3.00 too much from your account. You cannot correct this issue by adjusting the check amount, because you didn't write the check for that amount. Likewise, you do not need to let Quicken prepare the "balance adjustment" for you. The balance adjustment prepared by Quicken is nothing more than a plug figure to force the account to balance. There is no audit trail with this process. To properly handle this issue, consider the following:
    - Let us assume you are preparing the bank reconciliation for January 2013.
    - Open the register and record an entry in the register to reflect a transaction on the last business day of January. (Remember, you are reconciling through the end of the month.)
    - The number column will be blank.
    - The payee column will be "Bank Error."
    - In this case, the bank took $3.00 too much from your account, so you will need to record $3.00 in the payment column.
    - The memo line will reflect the check number that the bank processed in error.
    - Return to the reconciliation process and mark this entry as cleared, along with the check that processed through the bank.
    - You must contact the bank to bring the error to their attention, and tell them to correct the error.
    - The $3.00 will be shown as a shortage on the fund balance reconciliation since this represents an amount that Health Finance is not going to reimburse.
    - Unfortunately, errors of this nature usually take more than one month to resolve.

Reprinting Previous Reconciliations

Occasionally you have the need to reprint the previous bank reconciliation. You can only do this for the last reconciliation performed. For example, it is February 2013. You prepared the January 2013 reconciliation a few days ago, but you have misplaced the report. To reprint the report: select "reports" from the top row, below the blue Quicken title bar (not the reports icon). From the drop-down box, select "cash flow." This will bring up another drop-down box; select "reconciliation." Enter the report title (optional), and identify the report date. Remember, you want to "Show reconciliation to bank balance as of" the end of the month. For this example, you will use 01/31/2013.

End of Year Close-out

- <u>When should this be done</u>?

  This process is recommended at the end of the fiscal year in which the Office of Program Integrity performed an administrative audit. This occurs about every 3 years.

- Why should we perform year-end closeout?
  The year-end close out is designed to minimize the file size and therefore reduce the amount of time it takes to back-up your account data. It therefore minimizes the amount of data loss in the event of hardware or software failure.

- How do we perform Year-end close out? (Steps to start a new year – Quicken 2003 version)
  - ✓ Open register
  - ✓ Click "File" (at the top of the screen, below the blue Quicken title bar)
  - ✓ Click "File Operations"
  - ✓ Click "Year-end Copy"
  - ✓ Click "Start New Year." (Read this screen. It will help you understand what we are trying to accomplish.)
  - ✓ Type in file name for the backup. (I recommend county name and the year-end date (county 092012)).
  - ✓ Type in "start date" where prompted. (Use 09/30/2012 in this example.)
  - ✓ Identify file to use for New Year (this should be the default).

- What does this process do?
  - ✓ It sends everything up to 09/30/2012 (in this example) to a file (a backup file).
  - ✓ The computer identifies the "cleared" balance as of 09/30/2012 and uses it as the "opening" balance for the New Year's file.
  - ✓ Any transactions prior to 09/30/2012 that have not cleared the bank will be listed in the New Year's file and also in the old file. (These outstanding items will be listed in the new file, probably before the cleared balance of 09/30/2012 but this is OK. Also, the check numbers and dates of transactions will be pulled forward.)
  - ✓ When the outstanding items clear the bank, you will not have to go back to the old file. (When the item is cleared, it will only be listed in the new file since you are no longer working in the old file.)

Backups

- Backups of your data should be performed monthly.
- Store backup data in a secure location.

CHAPTER 11

MISCELLANEOUS BANK ACCOUNTS

Revised August 2013

Types of Miscellaneous Bank Accounts include but are not limited to:

- Building Fund
- Child Restraint
- Employee Fund
- Special Bank Accounts
  - Indigent
  - March of Dimes
  - Donation

The Building Fund:

- Maintains funds.
- Accumulates interest for constructing a new or remodeled health department facility.
- Exists only with approval from Financial Services.
- Requires a member of Financial Services and the county administrator to validate withdrawals.
- Requires guidelines for expenditures.

Child Restraint Fund:

- is maintained in a few counties.
- is used to deposit rentals for the car seats and any donations.
- Expenditures are generally for the return of rental deposits when the seat is returned during the specified time and in good condition.
- Other expenditures are for new car seats.

Employee Funds must be:

- Authorized by Local Administrator
- Disclosed annually to Program Integrity
- On Voluntary Participation
- Separated from state funds. Any commingling of State/Employee moneys becomes state money.

Special Bank Accounts

- are maintained for some public health aspect.
- are specific as to the way funds may be expended
- are generally started by donations from someone in the community.
  - One example would be a transportation account used to help high risk maternity patients reach doctor's appointments in Birmingham.

REQUIREMENTS

- All accounts must be authorized. Special accounts must have a letter of intent which identifies the type of donations to be placed in these accounts. (General donations to the health department are placed in the Fee Account).
- All cash handling, fee certification, and separation of duties requirements apply.
- Bank account requirements similar to Imprest Account apply. (Exception: The administrator does not have to be a required signature on the account unless other requirements specify.)

These accounts must have documentation for expenditure and revenue requirements on file at the county health department. These accounts are subject to all departmental policies and procedures for all bank accounts, i.e. security, separation of duties, two signatures on checks, etc.

Bank signature cards must be on file in the county health department for each account.

A financial statement for each of these accounts must be submitted to the Office of Program Integrity at the end of each fiscal year. A sample of a financial statement is located on page 11- 7.

CERTIFICATION

All employees performing duties pertaining to the miscellaneous bank account must be certified to handle cash including:

- Administrators
- Nurses
- Clerks
- Environmentalists, etc.

Certification procedures involve:

- Assigning responsibility,
- Certifying responsible staff, and
- Preparing a cash accountability plan.

Before certification can be accomplished, the tasks to be performed must be defined:

- Collecting fees and posting entries to Prenumbered Receipt Book.
- Balancing and closing out the day's business.
- Preparing the bank deposit and making the deposit.
- Preparing the monthly reports.
- Reconciling the bank account.

After the tasks have been defined, a primary and alternate employee must be identified on the appropriate cash accountability plan.

When the employee has been identified he/she must be formally trained, tested, and certified to handle cash.

- Testing material is available from the county office manager or area clerical director.
- Training, testing, and certification take place at the county health department.
  - The Fee System Manual and training video are reviewed with the training agenda before the test is given to each employee.
  - A passing score of 102 or above must be obtained for certification.
  - The rated test is placed in the employees' file at each county health department for review by the Office of Program Integrity.

TESTS ARE RATED BY	FOR
County Office Manager	County Employees
Area Clerical Director	County Office Managers
Clerical Director	Area Clerical Directors

SEPARATION OF DUTIES

Separation of duties helps prevent and detect errors. Duties must be separated as much as possible with available staff. This may mean rearranging duties and/or cross-training employees.

The minimum requirement for separation of duties includes that the same employee cannot:

- Approve expenditures AND complete checks
- Sign checks AND reconcile bank statement

CASH ACCOUNTABILITY PLAN

A cash accountability plan must be prepared and maintained on-site by each county health department. You must update the cash accountability plan when there are changes in staff assignment. Each cash accountability plan must be reviewed and signed by the area clerical director and administrator. Each plan identifies:

- The tasks to be performed;
- The primary employee responsible for the tasks;
- The alternate employee; and
- When certification was accomplished.

BLANKET FIDELITY BOND

All merit system employees are covered by the blanket fidelity bond. The bond basically covers mismanagement or embezzlement of funds. If this occurs, the Health Department collects any damage from the bonding company and the bonding company prosecutes the employee.

UNCLAIMED PROPERTY REPORTING

Refer to pages 10-18 through 10-20 for any unclaimed vendor payments through the miscellaneous accounts.

MISCELLANEOUS BANK ACCOUNT
CASH ACCOUNTABILITY PLAN

_____ **COUNTY HEALTH DEPARTMENT**

_____ **LOCATION**

_____ **DATE**

ANYONE INVOLVED WITH THE MISC. BANK MUST BE CERTIFIED

1. Is responsible for shortages:
   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

2. Approves the expenditures:
   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

3. Fill out the checks:
   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

4. Signs the checks:
   Signatures which must be on check: Others who may co-sign checks:

   Date Certified: _____ Date Certified: _____
   _____ _____

   Date Certified: _____ Date Certified: _____
   _____ _____

5. Maintains office copy of invoice and cross-references it to the check:

   Primary Responsible Person: Alternate:

   _____ _____
   Date Certified: _____ Date Certified: _____

MISCELLANEOUS BANK ACCOUNT
CASH ACCOUNTABILITY PLAN

_____COUNTY HEALTH DEPARTMENT
_____LOCATION
_____DATE

ANYONE INVOLVED WITH THE MISC. BANK MUST BE CERTIFIED

6. Reconciles the bank statement:
   Primary Responsible Person: _____ Date Certified: _____
   Alternate: _____ Date Certified: _____

7. Reconciles the fund balance:
   Primary Responsible Person: _____ Date Certified: _____
   Alternate: _____ Date Certified: _____

8. Other (explain) :
   Primary Responsible Person: _____ Date Certified: _____
   Alternate: _____ Date Certified: _____

Signed:_____ Area Clerical Director:
Date: _____

Signed:_____ Area Clerical Director:
Date: _____

000 02 01

PEOPLES EXCHANGE BANK
OF SOMEWHERE LOUAN
P.O. BOX000 — P.O. BOX 000
ANYWHERE, AL 36000 — SOMEWHERE, AL 36000
(334) 000-0000 — (334) 000-0000

SOMEWHERE COUNTY HEALTH DEPT 30
INFANT SEAT LOANER PROGRAM 1
P O BOX 000 0
SOMEWHERE, AL 36000

CHECKING ACCOUNT: 1006691
11/01/95 THRU 11/30/95
PAGE 1

FDIC INSURED

FOR INFORMATION CONCERNING EFT'S, PHONE 575-4555
JUST A REMINDER OF OUR SATURDAY BANKING HOURS, MONROEVILLE ONLY
8:30 TILL 12:00 DRIVE-THRU

CHECKING ACCOUNT 1006691

DESCRIPTION	DEBITS	CREDITS	DATE	BALANCE
BALANCE LAST STATEMENT			10/31/95	150.43
DEPOSIT		15.00	11/08/95	165.43
BALANCE THIS STATEMENT			11/30/95	165.43

TOTAL CREDITS (1) 15.00
TOTAL DEBITS (0) .00
TAX ID NUMBER 63-6000619

DEPOSIT TICKET
SOMEWHERE CO. HEALTH DEPT.
INFANT SEAT LOANER PROGRAM
1006691
PEOPLES EXCHANGE BANK
11-7-95
CURRENCY 10 00
COIN 5 00
TOTAL 15 00
TELLER
DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL
⑆062102593⑆ 10 066 91⑈ 012 ⑈0000001500⑈

State of Alabama
Department of Public Health
Somewhere County Health Department
301 West Somewhere
P. O. Box 000
Somewhere, Alabama 36000
(205) 000-0000

INFANT SEAT LOANER PROGRAM

Monthly Financial Statement

December 07, 1995

Beginning Balance: November 01, 1995 — $150.43

Revenue:

Deposit $15.00 (11-7-95)
Total: 15.00

Total Available: $165.43

Expenditures:

Total: ______

Ending Balance November 30, 1995 — $ 165.43

Signed: Teresa Anderson

Date: December 7, 1995