NEW MEXICO PUBLIC HEALTH DIVISION
FAMILY PLANNING PROGRAM FEE COLLECTIONS

List of Exhibits

Family Planning Program Goal

It is the goal of the Family Planning Program to make the fee collection process as efficient as possible; input from the local health office staff is vital to fulfillment of this goal.

A. INTRODUCTION

Requirement for Fees
Federal regulations governing family planning projects require that fees be assessed for services rendered to clients with incomes above a certain level. The charges for various services are based on the actual cost of providing these services.

Requirements for Providing Services
All family planning services will be provided in accordance with legal and constitutional requirements and grantee policy, and will be provided without regard to age, gender, ethnic origin, religion, handicap, marital status, sexual preference, tribal affiliation, citizenship, ability to pay, contraceptive preference, or number of pregnancies, except as determined by statute or as otherwise validly specified in program regulation. Family Planning services will be provided without residency or physician referral requirements. Services must be provided in a manner, which protects the dignity of the individual.

Sliding Scale Fees
Fees will be assessed on a sliding scale based on current Federal Poverty Guidelines and a client's ability to pay. Both family size and gross annual (monthly, weekly) family income will be used to determine the percentage of actual costs that a client will be assessed. No one will be denied services because of the inability to pay.

Disposition of Fee Revenues
Fees collected by the program will be used to meet the increasing costs of providing family planning services and to expand services in order to more adequately meet the needs of those who are not receiving care in the community. These revenues will be budgeted in the manner prescribed by the State and Federal policies covering government-related income.

ALL STATE LAWS AND DOH/PHD ACCOUNTING PROCEDURES MUST BE FOLLOWED WHEN COLLECTING FEES FOR THE FAMILY PLANNING PROGRAM.

Financial Management System
Maintaining an effective financial management system for a family planning project involves the needs of the agency, the requirements to adhere to federal guidelines, and especially the needs of the clients served. Financial responsibility is an important matter for all employees in a family planning project; it cannot be left only to the clerks in order to be effective, but must be supported by the clinical staff as well. A **team approach** in maintaining effective financial management is as important as a team approach in providing professional health services.

Confidentiality
Since it is the responsibility of the staff to insure confidentiality, it is recommended that a private space be provided to make appointments, obtain proof of income, and fill out laboratory slips. Confidential Client must have a Red Alert in the INPHORM system “Confidential do not contact”, a red dot on the outside of the chart on the label with client’s name, and a red dot inside on the Client Information Form on the labels with the client’s name and current visit date are. When the client is no longer a Confidential Client draw a black line through the red dot on the outside label. It is imperative that the client’s confidentiality is upheld within the INPHORM system. Clerks are required to shut down or lock their workstations when leaving their computer area.

Medicaid coverage can be used for confidential clients with Medicaid and Salud! Coverage should be billed to Medicaid. Explanation of Benefits (EOB) or correspondence will not go to the client’s home.

THE DISTRICT DIRECTORS ARE RESPONSIBLE FOR ENSURING THAT LOCAL HEALTH OFFICE STAFF COMPLY WITH THESE REGULATIONS. NURSE MANAGERS AND DIRECTORS OF NURSING SERVICES (DNS) WILL ASSIST WITH QUALITY ASSURANCE IMPLEMENTATION.

B. DEFINITIONS

Ability to pay: Means an evaluation of a client's family size and gross annual family income to determine the percentage of assessed charges that will be billed to client.

Adolescent: (growth & development definition) Any individual between the ages of 12 - 19 years (age 19 included, but not age 20).

Adjustment: (Discount) the dollar amount deducted from the client's charges based on the client's Percentage Pay Rate.

Bankruptcy Notice: The form on which the client legally declared that they were unable to pay their debts.

Billing: A set of activities, using CPT4 codes and ICD9 codes approved by the American Medical Association required to determine the client's fee's and the reconciliation of those fees due, in accordance with DOH HIPPA policies.

Cashier: The staff person responsible for obtaining proof of income, requesting and accepting payment, and documenting the transactions. *This individual is usually the custodian of the cash fund.*

Charges: The true, full costs of services and supplies received by the client (determined by relative value scales and Federal guidelines).

Charge/Statement/Receipt: The record of all charges for the type of visit or itemized costs of services and supplies received by the client during the current visit.

Checkout: The last stop in the client's visit where the client learns of the charges and adjustments to the bill and pays the fees (if any).

Client: (Patient) Any person who is requesting services.

Collection: The act of receiving money from the client or third party payor.

Cost: The true expense of an item or service.

Discounts: (Adjustments) the dollar amount deducted from the client's charges based on the client's Percentage Pay Rate.

Economic Unit: Consists of the individuals (and their dependents) living in a household who provide food and shelter for the family unit.

Eligibility: Determination of a client's entitlement to services by the evaluation of client's age, gross income, economic unit, and special circumstances.

Emancipated minor: A person who is sixteen (16) years of age or older who:
1) Is or has been validly married (annulment or marriage of 15 year old will not count);
2) Is on active duty with the armed forces; or
3) Has obtained a declaration of emancipation from district court.

NOTE: No one under sixteen (16) can be emancipated. A person at least sixteen years old may apply for and obtain a declaration of emancipation if s/he is:
1) Willingly living separate and apart from parents or guardian and,
2) Managing her/his own financial affairs.

Full Pay: The designation for clients who receive no adjustment to their incurred charges.

Fee Adjustment Schedule: See Family Planning Program Poverty Guidelines Percent Pay Rate Schedule.

Fees: The amount due from the client, which reflects the charges after any adjustment.

Financial Record: Folder for each percent pay client. It should contain client's encounter forms, receipts billing letters, and sometimes returned billing letters. It could also have copies of the proof of income such as a pay sub, letter from employer, federal income tax return, etc… It should be filed with the most recent form generated on top and filed in alphabetic order by last name.

Gross Income: Earned income before deductions (used in calculating % pay for clients).

Hardship Case: Clients may experience problems beyond their control which constitute a temporary financial hardship, like death or illness in the family, fire, theft, high medical bills, drug abuse, bankruptcy, etc… The charges for that day only….. can be discounted to 0. See page 7, Special Circumstances and page 36 Credit Memo-Adjustment Code 83.

Income and Family Size Declaration: The form on which the client attests to family size and gross income to establish their Percentage Pay Rate. *Remember teens/adolescents are to be considered under their own income.*

MCO: Managed Care Organization – An organization that is licensed to manage, coordinate and assume financial risk on a capitated basis for the delivery of a specified set of services to enrolled members in a given geographic area.

Medicaid Waiver- 1115- 35F: A provision of Federal law that allows HCFA to approve a Family Planning program in the State's Medicaid plan. In New Mexico the waiver applies to women at 185% of poverty or below.

Partial Payment: The designation for clients who receive an adjustment to their charges in setting their fee.

Patient Account Card/ Ledger Card: The individual patient account card reflecting all charges, adjustments, and payments made on a historical basis. McBee Ledger Cards must be kept for percent pay clients. *(It should be noted that under certain circumstances, cards may not match what is in INPHORM, for instance. if patient visits and pays at more than one site.* ***In such cases INPHORM governs****.)*

Payment: The amount received from a client or third-party payor, other than a donation.

Percentage Pay Rate: That percentage of the actual charges incurred that the client is required to pay, based on their family size and gross income and Federal Poverty Guidelines.

Percentage Pay Rate Schedule: The client's percentage pay will be calculated by INPHORM once an encounter is generated in the INPHORM system. This schedule will be updated on a yearly basis and automatically entered into INPHORM. (Issued by the Federal Government annually). Notice of changes to the Percentage Pay Rate schedule will be issued to the LPHO's prior to the system change being implemented.

Receivable: Accounts awaiting or requiring payment.

Salud: A word used to represent the three Managed Care Organizations contracted by Medicaid to provide medical coverage for financially eligible individuals. Presently they include:

1. Presbyterian 2. Lovelace 3. Molina

Services: Those clinical activities performed for a client.

Sliding Fee Scale of Billing: The fee schedule of the facility establishing adjustments on the basis of ability to pay and the resultant actual charge to the client for services rendered (based on Federal Poverty Guidelines).

Supplies: Those items delivered to a client.

Un-collectible Accounts: The amount owed, but which, for practical reasons, cannot be expected to be collected in due course. Clerks can enter a green alert in INPHORM so clerks at other health offices will know to collect from the client.

Write-off: Write-offs are no longer be done at the local level. Contact the Fee Collection Liaison if there are special circumstances, such as bankruptcy or death. If a client owes a balance, do not archive the financial file, even if the client has not received services for several years. If and when the client appears at any health office in the future, the documentation can be found and the charges can then be explained to the client.

C. TELEPHONE APPOINTMENT SCREENING - Important information to obtain to determine priority of clients served: The Family Planning Program's priority is providing services to adolescents and low income clients, and women with high risk factors. The Family Planning program encourages partner involvement in all Family Planning related health visits. Family Planning client's partners are always welcome.

1. **Age**

2. **Income Bracket**: As part of the preliminary consultation, the client should be advised that there is a sliding scale charge for the services to be rendered which is based on gross family income and family size and that payment at the time of services is expected. You can explain that the fee is necessary in order to continue operations and to expand the program. Ask the client to bring a proof of income. Although a family planning client's income is used to determine the amount to be charged for services, proof of income is **not required.** Offices may **request** proof of income, but they may not require it. Thus, if a client has no proof of income, but provides a self-declaration of income, the office should accept the self-declaration and charge the client based upon what he or she has declared. This must be documented in the client financial record. Do not assess the client at 100% of the charge if they do not have proof of income, as this may present a barrier to the receipt of services

   If a minor (age 19 included, but not age 20) is unemancipated and confidentiality of services is not a concern, the family's income must be considered in determining the charge for services.
   Adolescents (including age 19) attending clinic and who want confidential services, will be considered as a separate economic unit and have only their own income assessed. Inform the caller that they can be assessed on their own income and not their parent's income.
   (This is meant to reduce any barrier to service for the adolescent concerning family planning services).

3. **Number in the Household** (Economic Unit)

4. **High Risk Factors:** Examples are *adolescents, women over 35, history of pregnancy difficulties, pregnancies spaced less than two (2) years, and income at or below 185% of poverty.*

5. **Current Family Planning balance due**: If the client has a current balance, a payment to reduce the balance should be requested before services are provided or supplies dispensed. If the client cannot make a payment, review their account card - remind them of the date the charges were incurred and the date of any payments made. Also, emphasize that the family planning clinic prioritizes scheduling the zero pay clients and that there may be a possibility that a zero pay client may be scheduled before them and they may be put on a waiting list. (Exceptions will be made only for documentation of hardship).

   Although not directly related to fees, the complete telephone information to be related to each client is given in Section 1.4, Clinic Services of the Family Planning Protocols.

6. **Medicaid Coverage:** New Mexico Public Health Department (NMPHD) is an assigned Medicaid Provider. However, if the office has a waiting list, be sure that clients with **Medicaid coverage** are

aware of other Medicaid providers in your area. Clients who are enrolled in a Medicaid MCO can be seen at the health office without a referral from their Primary Care Provider. Family Planning staff are encouraged to offer a Medicaid application to all non-Medicaid clients for the Family Planning Medicaid 35F/1115 Waiver. Explanation of Benefits (EOB) or correspondence will **not** go to the client's home. A Copy of Medicaid application is on page 41 and 44 of this section.

7. **Private Medical Insurance:** Any client with private medical insurance should submit bills /receipts of PHD services to their private insurance company. DOH Federal Tax ID number is necessary for billing purposes. Give this Tax # **85-6000-565** to the client so they can submit it to their insurance company. Responsibility for paying Family Planning charges remains with the client instead of PHD.

D. SYSTEM COMPONENTS AND POLICIES

1.The Family Planning Fee Collection system is made up of the following components:

a. Declaration of Family Size and Income Verification (Income Worksheet - Exhibit 1)
b. Actual Costs and Charges for Family Planning Services (FP Charge for Services - Exhibit 2, PHD Individual Services Encounter Form)
c. Accounting System (Computer System INPHORM - Patient Account Module)
d. Patient Account Cards (McBee ledger cards) (under certain circumstances cards and INPHORM may not match. In cases when there are charges and/or payments not found on you ledger card, INPHORM governs, as it is possible there are additional charges and/or payments made at another Local Public Health Office. To check, look up the encounters in question and see if they were done at another site.)
e. Correcting a ledger card error, use a pen to draw a line through the error and initial it, then enter the correct information on the next line. Do not use **white out**, erase or alter the error.

Each component of the Family Planning Fee Collection System is designed to satisfy the requirements for a good accounting system. Used according to the instructions contained in this manual, this system will provide an effective means of assessing, receipting, posting, and reporting fee charges and collections.

2. Declaration Of Family Size And Income Verification

a. Income Worksheet and Income Affidavit (Exhibit 1- Pages 8.**)**
On the first encounter of the Initial visit, and thereafter at the time of the Annual visit, the client will be asked to provide information to complete the Income Worksheet. All persons living under one roof are not necessarily counted as members of the family/household. The family/household is defined for the purpose of family planning as an economic unit. If the client is unable to provide proof of income, the Income Affidavit can be filled out and signed in place of, or in addition to, the Income worksheet, and is considered sufficient proof of income.

(Note: The General Consent for Services form needs to be signed by each new client and by each returning client if it can not be found in the client's chart.)

(Note: The clerk needs to speak with Family Planning clients in a private area or in a low tone of voice in order to ensure the client's privacy. The clerk may even need to ask any person standing close enough to overhear the conversation to take a seat and wait to be called.)

b. Examples of acceptable proof of income include:
   i A pay check stub showing wages for all members of the economic unit who are gainfully employed; or,
   ii A federal income tax return from the previous year for all members of the economic unit who filed federal income tax returns; or,
   iii A letter from an employer stating wages earned and the time period in which the wages were earned; or,
   iv If the client is self-employed, a statement or letter showing amount of money earned or net profit for the past month.
   v If the client has a WIC "Income Worksheet" dated within the last twelve (12) months, it may be

used as proof of income.

Income documentation must be requested from the participant at the initial/annual visit. It is the clerk's responsibility to review income documentation, verify the income, sign the income worksheet, and return the documentation to the client. (It is not necessary to keep copies of the income documentation, but you can if you choose to. It can be kept in the financial record.) The charge for services is based on a sliding scale fee schedule, which follows current Federal Poverty Guidelines. If proof of income is not provided, ask the client to fill out the Income Affidavit to the best of their knowledge and sign it. You can accept this as proof of income. **Under no circumstances should income documentation become a barrier to a client receiving services.**

A new income declaration may also be made at the request of the client whenever their financial situation changes significantly. Re-verification of Income and Family Size must be documented on the new Income worksheet or Income Affidavit.

It is recommended that clients be screened for Medicaid eligibility. This will improve access to the federally funded Family Planning Waiver Program.

DETERMINATION OF CLIENT INCOME IS A MAJOR FACTOR IN PRIORITIZING CLIENT SERVICES.

Remember that ***all income worksheets must be kept for three years***. (Archiving Purposes)

3. Special Circumstances

a. Documented Hardship: A client can document hardship. Occasionally clients may experience problems beyond their control which constitute a temporary financial hardship, like death or illness in the family, fire, theft, high medical bills, drug abuse, bankruptcy, etc… An explanation should be noted briefly on the back of the Income Worksheet. The nurse may determine that past services should have been documented under financial hardship and, after documenting the hardship in the medical record, may instruct the clerk to adjust fees for past services. **The charge for services that day only will be assessed at zero**. The clerk and nurse should take a team approach in making the decision. The hardship must be recorded as a green alert status in the INPHORM System, along with the date and encounter number applicable to the hardship. The clerk does a credit memo in the Patient Accounts Module and use Code 83 to make the charges Zero (0) for that day's Family Planning services. Document the Hardship in the McBee ledger card. Advise the client to bring in proof of income for the next visit or they will be asked to sign an income affidavit again.

A client is able to document hardship as many times as necessary.

b. Adolescents (19 years of age or less): **The only time an adolescent's income is based on that of their parents' or guardian's economic unit is when there is absolutely no issue with confidentiality.** Clients who are attending clinics with their parents' knowledge can still be assessed on their own income and **not** on the basis of their family's economic unit and income if there is any confidentiality concern. **Adolescents who are seeking confidential services can do so and therefore be assessed only on their own income**. Local Health Office staff should determine the income status of adolescents, and those with incomes should have that income assessed as their own economic unit, unless there is absolutely no concern regarding confidentiality. Inform adolescents that discussion of their visit with their parents will not change their ability to be assessed on their own income. (This is to stress that discussion with parents is encouraged at all times by the clinic).

Adolescents who are legally emancipated should be assessed on the basis of their own economic unit and income.

c. Students: Students, who are age 19 are treated as adolescents, until their 20th birthday (see above). Students 20 and above should be treated as adult clients and assessed on the basis of their own economic unit. Local Health Office staff should ask students for proof of income since some students do work.

d. Sterilizations: When a client decides to apply for sterilization, the procedure is entered into INPHORM and the **client pays if there is a percent due before the procedure**. It is important to explain to the client that we are unable to give a refund if they do not have the procedure done, but that the payment will be applied as a credit for future Family Planning services.

Client label here or print name:

EXHIBIT 1 - INCOME WORKSHEET **Name:_____**

Teens: Are you here with your parent's consent?

Adolescentes: ¿Estás aquí con el consentimiento de tus padres? Yes/Si: ☐ No: ☐ **Date of Birth**: _____

INCOME WORKSHEET

Please write down any money you **AND** anybody else in your family or household received weekly, bi-weekly, semi-monthly, monthly, or annually. Favor de idicar **TODO** el dinero que se recibió entre la familia por semana , quincena, mensual, semi-mensual, o anualmente.	Amount
Working at a job or business (before taxes) Salario de empleo o negocio (ante de inpuestos) Check Stub ☐ Letter from Employer ☐ Other ☐ _____	$_____
Any other sources: Qualquier otro ingreso:	$_____
Number in household supported by this income: **Numero de personas en la casa sostenida por estos ingresos:**	# _____
☐ Weekly Por semana MULTIPLY BY 52 ☐ Bi-Weekly Quincena MULTIPLY BY 26 ☐ Semi-Monthly 2 veces-mes MULTIPLY BY 24 ☐ Monthly Mensual MULTIPLY BY 12 ☐ Annual Annual MULTIPLY BY 1 STAFF USE: **Client is at _____% Percent Pay** **Total**	$_____ $_____ $_____ $_____ $_____ $_____ $_____

I have seen this document and witness client signatures

STAFF SIGNATURE & TITLE:_____ Date:_____

INCOME AFFIDAVIT
DECLARACION DE INGRESO

On the following lines, please tell how much you provide for your basic needs. Who pays rent, utilities, food, etc.? If you receive cash, how much and from whom? Is this full time, part time or seasonal employment?

En las siguiente líneas, por favor díganos como provees por sus necesidades básicas. ¿Quién paga el alquiler, las utilidades, la comida, etc.? Si usted recibe el dinero en efectivo, cuanto y de quien? ¿Este trabajo es de tiempo completo, medio tiempo o por temporadas?

Staff: The client should answer the above questions for this affidavit to be considered complete.

_____

_____

_____

I have told the truth about ALL sources of my family's income. To the best of my knowledge. I have not given false or

withheld information. I understand that if I do, I may be prosecuted, taken off the program or made to pay back the benefits I receive.

He dicho la verdad en cuanto todos los ingresos de mi familia. Según mi entender, no he mentido ni retenido información. Comprendo que si miento, puedo ser proseguido, tenminado del programa o tener que reponer los beneficios que he recibido.

Client initial:_____

Client label here or print name:

EXHIBIT 1 - INCOME WORKSHEET **Name: Ruby Applebee**

Teens: Are you here with your parent's consent?

Adolescentes: ¿Estás aquí con el consentimiento de tus padres? Yes/Si: ☐ No: ☐ **Date of Birth**: **01/05/75**

INCOME WORKSHEET

Please write down any money you **AND** anybody else in your family or household received weekly, bi-weekly, semi-monthly, monthly, or annually. Favor de idicar **TODO** el dinero que se recibió entre la familia por semana , quincena, mensual, semi-mensual, o anualmente.	Amount
Working at a job or business (before taxes) Salario de empleo o negocio (ante de inpuestos) Check Stub ☐ Letter from Employer ☐ Other ☒ **Verbal**	$**1,375.00**
Any other sources: Qualquier otro ingreso:	$_____
Number in household supported by this income: **Numero de personas en la casa sostenida por estos ingresos:**	# **3**
☐ Weekly Por semana MULTIPLY BY 52 ☐ Bi-Weekly Quincena MULTIPLY BY 26 ☐ Semi-Monthly 2 veces-mes MULTIPLY BY 24 ☒ Monthly Mensual MULTIPLY BY 12 ☐ Annual Annual MULTIPLY BY 1 STAFF USE: **Client is at** **0** % **Percent Pay** **Total**	$_____ $_____ $_____ $**16,500.00** $_____ $_____ $**16,500.00**

I have seen this document and witness client signatures

STAFF SIGNATURE & TITLE: Lucille Duran , **Clerk Specialist**

Date:**01/12/06**

INCOME AFFIDAVIT
DECLARACION DE INGRESO

On the following lines, please tell how much you provide for your basic needs. Who pays rent, utilities, food, etc.? If you receive cash, how much and from whom? Is this full time, part time or seasonal employment?

En las siguiente líneas, por favor díganos como provees por sus necesidades básicas. ¿Quién paga el alquiler, las utilidades, la comida, etc.? Si usted recibe el dinero en efectivo, cuanto y de quien? ¿Este trabajo es de tiempo completo, medio tiempo o por temporadas?

Staff: The client should answer the above questions for this affidavit to be considered complete.

My husband works and I stay at home taking care of our baby.____

I have told the truth about ALL sources of my family's income. To the best of my knowledge. I have not given false or withheld information. I understand that if I do, I may be prosecuted, taken off the program or made to pay back the benefits I receive.

He dicho la verdad en cuanto todos los ingresos de mi familia. Según mi entender, no he mentido ni retenido información. Comprendo que si miento, puedo ser proseguido, tenminado del programa o tener que reponer los beneficios que he recibido.

Client initial: **X**____RA___

EXHIBIT 2- Consent

CONSENT for FAMILY PLANNING SERVICES

CONSENTIMIENTO PARA SERVICIOS DE PLANIFICACIÓN FAMILIAR

1. I am voluntarily requesting family planning services from the New Mexico Department of Health, Public Health Office. I understand that I have the right to accept or refuse these services without being denied other services from this agency.

   Solicito voluntariamente los servicios de Planificación Familiar del Departamento de Salud de Nuevo México. Entiendo que tengo el derecho de aceptar o negar estos servicios sin que se me nieguen otros servicios de esta agencia.

2. I understand that my records will be kept confidential and will be released only as permitted or required by law and that my health information will not be released to an outside agency or person except as specified in "Notice of Privacy Practices" which I have received a copy of. I understand that in cases of abuse or neglect of minors or medical emergencies such as risk for suicide or hurting someone else, a referral or a report to a legal authority will be filed, as required by law.

   Entiendo que mis expedientes se mantendrán confidencialmente y serán compartidos sólo con mi permiso o en caso que sean requerido por la ley y que mi información de la salud no será compartido a otra agencia o otra persona excepto, como especifica el "Aviso Acerca de la Privacidad de las Prácticas de Salud"; de la cual he recibido una copia. Entiendo que en caso de abuso o la negligencia de menores, o en las emergencias médica tales como riesgo de suicidio o riesgo de lastimar a otra persona, una referencia o un informe a una autoridad legal será archivado, como es requerido por la ley.

3. I understand that if I am seen in the clinic and I receive Family Planning services and supplies I may be charged from a sliding fee scale. I will be responsible for these charges if they apply.

   Entiendo que si recibo tratamiento en la clínica y recibo los servicios de Planificación Familiar, seré responsable de los costos según el nivel de mis ingresos. Seré responsable por los costos de los servicios recibidos.

Client's Signature: Date:
*Firma de Cliente:*_____ *Fecha:* _____

4. Explanation Of Family Planning Service Visit

Please refer to "Using the INPHORM Encounter Form" Manual, Appendix A, "Decisions for Use of Clinical Visit Codes" located in the GII for detailed information when selecting the type of visit.

New Patient/Initial Visit
Problem Focused (Brief) 10 minutes, CPT Code 99201 or
Expanded Problem Focused, 20 minutes, CPT Code 99202 or
Detailed, 30 minutes, CPT Code 99203 or
Comprehensive, Moderate, 45 minutes, CPT Code 99204 or
Comprehensive, High, 60 minutes, CPT Code 99205

Established Patient/Annual Visit
Expanded Problem Focused, 15 minutes, CPT Code 99213 or
Detailed, 25 Minutes, CPT Code 99214 or
Comprehensive, 40 minutes, CPT Code 99215

a. Initial/Annual Exam: - This service includes all required care components:

COUNSELING	**LABORATORY**	**MEDICAL**
- Pre-exam education	- UA (if indicated)	- Height
- Post-exam (contraceptive) education	- Pap Smear	- Weight
- Medical History	- Hematocrit	- Blood Pressure
	- RPR (if indicated)	- Thyroid Palpation
	- GC	- Heart/Lung Auscultation
	- Chlamydia	- Breast Exam
	- Pregnancy Test (if applic.)	- Abdominal Exam
		- Extremities Check
		- Pelvic Exam
		- Recto-Vaginal Exam
		- Testes Exam
		- Prostate Check

Other services which may be included in the Initial/Annual: immunizations, vaginal smear and wet mount, screening test for urine infection, glucometer blood glucose screen, additional counseling services, and any other necessary medications as ordered by clinician.

b. New Patient
Problem Focused (Brief) 10 minutes, CPT Code 99201
This covers visits for pregnancy tests, ECP, Quickstart, blood pressure check for new clients. (If the pregnancy test is positive, a Medicaid Presumptive Eligibility application needs to be done at the time of the visit if the client qualifies and the clerk needs to be informed that today's visit should be billed to Medicaid.)

c. Established Patient Visit
Minimal, 5 minutes, CPT Code 99211 or Problem Focused, 10 minutes, CPT Code 99212
This covers visits for re-supply, blood pressure check, Depo Provera injection, ORTHO EVRA, Quickstart, ECP and pregnancy test. (If the pregnancy test is positive, a Medicaid Presumptive Eligibility application needs to be done at the time of the visit if the client qualifies and the clerk needs to be informed that today's visit should be billed to Medicaid.)

d. Established Patients, Medical/Problem Visit
Problem Focused, 10 minute, CPT Code 99212 or
Expanded, 15 minutes, CPT Code 99213 or
Detailed, 25 Minutes, CPT Code 99214 or
Comprehensive, 40 minutes, CPT Code 99215
This covers: visits made as a result of a **complication** involving a client's contraceptive method, such as IUD removal due to health problems; visits made to follow-up results or repeat of a suspicious or abnormal Pap smear, visits made to change contraceptive methods at other than the annual exam, or visits to apply for sterilization (tubal or vasectomy). Extended counseling sessions or complicated referrals, which take a lot of staff time may be charged to this code. The medical staff depending on time spent with client should make this determination.

e. No Charge Visit (CPT Code 99211NC)
This category should be used for NO CHARGE visits ONLY, such as: repeat of inadequate Pap smear, additional packs of pills if we originally did not have them in stock, or follow-up visits for sterilization clients.
(Determination should be made by medical staff.)

f. IUD Insertion (CPT4 code 58300)
This is a procedure. A visit code must also be chosen on the encounter form.

g. Norplant Removal (CPT4 code 11976)
This is a procedure. A visit code must also be chosen on the encounter form. Call the Help Desk if you are not familiar with the billing procedure. In some cases, the "Certificate" from the Norplant Foundation Removal Assistance Network will be taken from the client in lieu of payment for the visit.

h. IUD Removal (CPT4 code 58301)
This is a procedure. A visit code must also be chosen on the encounter form.

Family Planning Procedures Charges:

Can be found in the GII. Click on Training and scroll down to:
Charges Barrier Methods
Charges Depo Provera
Charges ECP's Pregnancy Test – IUD
Charges Norplant
Charges OCP's
Charges Prenatal
Charges STD & Refugee & Other -EPI
Charges Sterilizations
Charges TB
Note: This is an old form and costs have not been updated. Costs can be seen on the new encounter form in this protocol. The training stays the same.

EXHIBIT 3 ENCOUNTER FORM PAGE 1

Clinical Encounter Form 2006 Programs, Visits, Pregnancy, EDC and Procedure Codes

Name:

DOB:

Date:

% Pay

SP	Program Codes	CODE	SP	Program Codes	CODE	MOSAA Codes SP	MOSAA Codes CODE
16	Adult Health	AH	5	Immunization	IM	17	MFF
8	Breast and Cervical Cancer	BCC	12	Refugee Health	RH	18	MFP
11	Child Health	CH	9	Prenatal	PN	19	MIM
3	Children Medical Services	CMS	4	STD/HIV/AIDs	STD	20	MOT
15	Epidemiology	EPI	7	Tuberculosis	TB	21	MPN
1	Family Planning	FP				22	MTB
						23	MWC

SNAP	Payor	CODE		SNAP	Payor Class	CODE	

SNAP	Encounter Visit Type	Code		SNAP	Encounter Visit Type	Code	

SP	Visit Codes	CODE	COST
	Office Visit -- New Patient		
	Problem Focused (Brief)	99201	$ 57.44
	Expanded Problem Focused	99202	$ 88.97
	Detailed	99203	$ 112.66
	Comprehensive, Moderate	99204	$ 136.35
	Comprehensive, High	99205	$ 152.14
SP	**Office Visit --Establish Patient**	**CODE**	**COST**
	Minimal	99211	$ 25.80
	Problem Focused	99212	$ 48.17
	Expanded	99213	$ 81.08
	Detailed	99214	$ 104.76
	Comprehensive	99215	$ 128.45
	No Charge Visit (documented in chart)	99211nc	$ -
SP	**Home Visit -- New Patient**	**CODE**	**COST**
	Problem Focused (Brief)	99341	$ 94.76
	Expanded Problem Focused	99342	$ 142.14
	Detailed	99343	$ 189.52
	Comprehensive, Moderate	99344	$ 236.90
SP	**Home Visit -- Establish Patient**	**CODE**	**COST**
	Problem Focused (Brief)	99347	$ 47.38
	Expanded Problem Focused	99348	$ 71.07
	Detailed	99349	$ 94.76
	Comprehensive, Moderate	99350	$ 118.45
	Home Management of Gestational Diabetes	S9214	$ 47.38

Alert: **Date:**

SP	Telephone Counseling	CODE	COST
	Problem Focused (Brief)	99371	$ 7.90
	Detailed	99372	$ 15.79
	Comprehensive High	99373	$ 47.38
SP	**Prenatal - Visit Codes**	**CODE**	**COST**
	Prenatal Visit 1-3 use reg. Visit codes		
	Prenatal Visit #5,6,7,8.9.10+	49212	$ -
	Prenatal visit #4	59425	$ 280.00
	Prenatal visit #7	59426	$ 504.89
SP	**Patient Training Code**	**CODE**	**COST**
	Diabetes SMT services, individual per 30 min.	G0108	$ 47.38
	Diabetes SMT services, group (2 or more) per 30 m.	G0109	$ 47.38
SP	**Medicaid**	**CODE**	**COST**
	MOSAA Application	9999M	$ 73.18
	Presumptive Eligibility Application	9999P	$ 73.18
	Disposition		
	Family Planning Application		
	Child Health Application		
	Prenatal MOSAA Application		
	Prenatal Presumptive Eligibility		
	Child Health Presumptive Eligibility		
SP	**Pregnancy Intendedness**		
	Did you want this pregnancy ---now,		
	---sooner		
	---later		
	---never		
	EDC?- Date: mmddyy		

Notes:

Programs, Visits, Pregnancy, EDC and Procedures Codes 2006
Page 2

Name: **DOB:** **Date:**

SP	Procedures	CODE	COST
	Clinical Breast Exam	G0101	$ -
	Destruction of a Lesion (Wart Tx)	17110	$ 17.90
	Diaphragm Fitting	57170	$ 57.86
	Intramuscular Injection of Antibiotics	90788	$ 11.59
	IUD Insertion	58300	$ 41.54
	IUD Removal	58301	$ 75.54
	Norplant Removal (***With Certificate)	11976	$ 155.89
	Norplant Removal (***Without Certificate)	11976	$ 155.89
	Sonogram--BPP	76818	$ 175.00
	Sonogram--Limited	76815	$ 120.00
	TB Skin Test	86580	$ 17.17
	TB X-ray (AP and lateral view)	71020	$ 82.00
	TB X-ray (single view)	71010	$ 54.00
	Tubal Ligation Dr. Office	5800DO	$ 750.00
	Tubal Ligation - Hospital	58600	$ 1,400.00
	Vasectomy	55250	$ 350.00
	VAST Screened	99420	$ -
	Venipuncture, fingerstick, heelstick, earstic	36415	$ 14.74
	Venipuncture, under age 3	36400	$ 25.80

SP	Lab Procedures	Code	COST
	CH Metabolic Screen-PKU	84030	$ 47.79
	Epi B cereus/S.aureus Culture	87077	$ 31.21
	Epi Clostridium perfingens toxin (GM)	87230	$ 52.79
	Epi Culture, Stool/Fecal	87045	$ 55.79
	Epi Diptheria	86648	$ 35.79
	Epi Insect Identification--ticks only	87168	$ 21.06
	Epi Parasitology (fecal)	87177	$ 33.63
	Epi Parasitology-blood (Malaria smear)	87207	$ 30.63
	Epi Pertussis (Culture)	87070	$ 24.31
	Epi Pertussis (DFA)	87265	$ 25.79
	Epi Plague culture and FA	87040	$ 36.79
	Epi Plague FA	87206	$ 21.06
	Epi Rubella Immune Status (titer)	86762	$ 25.13
	Epi Rubella Serological Diagnosis	87299	$ 67.13
	Epi Rubeola Immune Status	86765	$ 28.13
	Epi Rubeola Serological Diagnosis	87283	$ 67.13
	Epi Varicella-Zoster Virus-Immune Status	87290	$ 28.63
	Epi Vibrio culture	87046	$ 45.79
	Epi Viral Culture	87252	$ 90.79
	Lab Blood Glucose-Office machine	82962	$ 15.79
	Lab CBC w/differential (SED)	85025	$ 18.08
	Lab DFA for T. Pallidum	86781	$ 22.63
	Lab GC Chlamydia - (urine/swab)	87801	$ 35.79
	Lab GC culture	87081	$ 35.79
	Lab Gram Stain	87205	$ 29.69
	Lab Hemoglobin	85018	$ 19.84

SP	Lab Procedures	CODE	COST
	Lab Hepatitis A Diagnosis	86709	$ 57.63
	Lab Hepatitis A Immune Status	86708	$ 31.63
	Lab Hepatitis A,B,C Diagnostic	80074	$ 100.63
	Lab Hepatitis B High Risk	86704	$ 34.13
	Lab Hepatitis B Post Immunization	87341	$ 31.13
	Lab Hepatitis B: Pre Immunization	86705	$ 42.63
	Lab Hepatitis C Antibody	86803	$ 32.63
	Lab Hepatitis High Risk + Hepatitis C	86707	$ 51.63
	Lab HIV 1	86701	$ 31.69
	Lab Pap Smear	88165	$ 38.93
	Lab Syphilis/RPR	86592	$ 20.63
	Lab UCG Pregnancy Test	81025	$ 21.96
	Lab Urinalysis multidip	81002	$ 15.79
	Lab Vaginal pH	83986	$ 12.63
	Lab Viral Culture for Herpes	87253	$ 87.63
	Lab Wet Prep	87210	$ 15.79
	Lab wet prep KOH	87220	$ 15.79
	PN Antibody Elution	86860	$ 38.79
	PN Antibody identification, RBC Abs.	86870	$ 22.28
	PN Antibody Screen	86850	$ 22.28
	PN Antibody titer	86886	$ 26.33
	PN Blood typing, ABO	86900	$ 16.73
	PN Blood typing, RH Du	86901	$ 16.73
	PN Glucose blood 1 hr post 50 gm glucose	82950	$ 22.39
	PN Group B Strep Vaginal/Rectal Swab	87071	$ 31.13
	PN GTT Fasting specimen	82952	$ 23.74
	PN GTT, post glucose 1,2,3 hr, spec. post 100gm	82951	$ 40.09
	PN Hepatitis Prenatal (HBsAg)	87340	$ 19.38
	PN MSAFP3-Alpha feto-protein, serum	82105	$ 27.70
	PN MSAFP3-Estriol	82677	$ 27.70
	PN MSAFP3-hCG	84702	$ 27.70
	PN Rubella titer	86406	$ 28.29
	PN Sensitivity Studies (Group B or urine)	87184	$ 26.69
	PN Urine culture, colony count	87086	$ 26.69
	PN-Urine-organism ident if culture positive	87088	$ 42.49
	TB Chem 7 (Basic Metabolic Panel) (SED)	80048	$ 18.43
	TB Comprehensive Metabolic Panel (SED)	87053	$ 20.21
	TB Culture, Fungus and ID (SLD)	87102	$ 80.79
	TB DNA Fingerprinting (CDC LAB)	83892	$ 181.59
	TB Hepatic Function Panel(SED)	80058	$ 20.78
	TB Mycobacteriology & ID (SLD)	87116	$ 50.79
	TB Mycobacteriology DNA Probe +	83896	$ 106.59
	TB Mycobacteriology MTB Susceptibility Studies	87190	$ 111.59
	TB Mycobacteriolgy RNAamp	83898	$ 216.59
	TB Sputum Induction	94799	$ 106.59
	TB Therapeutic Drug Level (NJ)	80299	$ 283.59

EXHIBIT 3 ENCOUNTER FORM PAGE 2

DIAGNOSIS 2006

Name: DOB: Date:

SP	DIAGNOSIS	CODE		SP	DIAGNOSIS	CODE
	CH-Child Health-Well Check	V20.2			FP-Pregnancy Test-Negative or Equivocal	V72.4
	CH-Newborn-Metabolic Screen	V77.3			FP/PN-Pregnancy-Supervision normal 1st	V22.0
	DIA-Diabetes	250.1			FP/PN-Pregnancy-Supervision normal other	V22.1
	DIA-Diabetes Mellitus	250			FP-Prescription of Oral Contraceptive	V25.01
	DIA-Diabetes Mellitus w/o compl. tp II or unspec.type uncontrolled	250.02			FP-Sterilization desired	V25.2
	DIA-Diabetes mellitus w/o compl. type I uncontrolled	250.03			FP-Surveill. of Previously Prescr. Methods, Subdermal Contracept.	V25.43
	DIA-Diabetes mellitus w/o comp. type II not stated as uncontrolled	250.00			FP-Surveill. of Previously Prescribed Methods, Oral Contraceptive	V25.41
	DIA-Diabetes mellitus w/o complications	250.0			FP-Surveillance, other	V25.49
	DIA-Gestation Diabetes	648.8			FP-Unspecified Contraceptive Management	V25.9
	EPI-Campylobacter	008.43			GEN-Abnormal Breast Exam	611.9
	EPI-Contact to communicable diseases	V01.8			GEN-Abnormal Mammogram	793.8
	EPI-E.Coli	008.00			GEN-Adverse Drug Reaction	995.3
	EPI-Giardia	007.1			GEN-Anemia-unspecified	285.4
	EPI-Hepatitis A-Acute	070.10			GEN-Breast Mass	611.72
	EPI-Hepatitis A-Past history	V12.00			GEN-Breast, Pain in (Mastalgia)	611.71
	EPI-Hepatitis B-Acute	070.30			GEN-Cellulitis/Abscess-unspecified site	682.9
	EPI-Hepatitis B-Carrier	V02.61			GEN-Dental Caries	521.0
	EPI-Hepatitis B-Past history	V12.09			GEN-Drug use (abuse)	305.9
	EPI-Hepatitis C-Acute	070.41			GEN-Elevated Blood Pressure	401.9
	EPI-Hepatitis C-Chronic	070.54			GEN-Elevated Blood Sugar	790.6
	EPI-Hepatitis E	070.53			GEN-General Medical Exam	V70.0
	EPI-Hepatitis-Unexplained	573.3			GEN-Gynecological Exam	V72.3
	EPI-Lice - Head	132.0			GEN-Hypertension	401.9
	EPI-Lice - Pubic	132.2			GEN-Mastitis	611.0
	EPI-Meningococcal H.Flu	036.0			GEN-MOSAA	M999
	EPI-Need for gamma globulin	V07.2			GEN-Non-compliance with medical treatment	V15.81
	EPI-Other Communicable Disease	V02.9			GEN-Obesity	278.00
	EPI-Parasites	136.9			GEN-Overweight	278
	EPI-Pertussis	033.9			GEN-Tobacco disorder	305.1
	EPI-Salmonella	003.9			GEN-Urinary Tract Infection	599.0
	EPI-Shigella	004.9			RH-Refugee-Medical Exam	V70.5
	EPI-Varicella	052.9			STD-Bacterial Vaginosis	616.11
	FP-Abnormal Pap-ASCUS	795.0			STD-Balanitis	112.2
	FP-Abnormal Pap-Mild or Moderate Dysplasia of Cervix (CIN I-II)	622.1			STD-Bartholin Gland Abscess	616.3
	FP-Abnormal Pap Severe Dysplasia or CIS of Cervix (CIN III)	233.1			STD-Bartholin Gland or Duct Cyst	616.2
	FP-Emergency Contraception	V26.8			STD-Candidal Vaginitis	112.1
	FP-Fibrocystic Breast Disease	610.1			STD-Chlamydia-Cervix	099.54
	FP-Galactorrhea-not assoc. w/childbirth	611.6			STD-Chlamydia-contact to	V01.7
	FP-Initial-Sterilization	V25.8			STD-Chlamydia-Urethra	099.41
	FP-Initiation of Other Contraceptive Measures	V25.02			STD-Cyst-Sebaceous	706.2
	FP-IUD check/removal	V25.42			STD-Dysuria	788.1
	FP-IUD Insertion	V25.1			STD-Epididymitis	604.9
	FP-Other FP Advice	V25.09			STD-Folliculitis-unspecified	704.8
	FP-Postpartum visit-Routine	V24.2			STD-Gonorrhea-Anus	098.7

DIAGNOSIS 2006			FAMILY PLANNING SUPPLEMENTAL				
Check if done	DIAGNOSIS	CODE	Check if Done	Family Planning Contraceptive service:		Check if done	Family Planning Contraceptive service
	STD-Gonorrhea-Cervix	098.15	Family Planning contraceptive before today's visit:			Family Planning Contraceptive Method:	
	STD-Gonorrhea-Contact to	V01.9		Abstinence		Primary contraceptive client left with: (continued)	
	STD-Gonorrhea-Genitourinary site	098.0		Cervical Cap			Male Condom
	STD-Gonorrhea-other site	098.89		Depo Provera			Method unknown
	STD-Gonorrhea-Throat	098.6		Diaphragm			Natural Family Planning
	STD-Herpes, Genital-Penis	054.13		ECP			No Method/Other reason
	STD-Herpes, Genital-Vulvovaginal	054.12		Female Condom			One Month Hormonal Injection
	STD-Herpes, other places	54.9		Hormonal Implant			Oral contraceptive
	STD-HPV-Genital Warts	078.10		IUD			Other method
	STD-Molluscum Contagiosum	078.0		Male Condom			Partner Pregnant or Seeking Pregnancy
	STD-Mucopurulent Cervicitis	616.0		Method unknown			Patch
	STD-NGU	099.40		Natural Family Planning			Pregnant or Seeking Pregnancy
	STD-NGU-Contact to	V74.5		No Method/Other reason			Rely on Female Method
	STD-No Evidence of STI	V71.9		One Month Hormonal Injection			Spermicide
	STD-Pelvic Pain	625.8		Oral contraceptive			Sponge
	STD-Penile Discharge	788.7		Other method			Tubal Ligation
	STD-PID	614.9		Partner Pregnant or Seeking Pregnancy			Vaginal Ring
	STD-Rash, non-specific	782.1		Patch			Vasectomy
	STD-Scabies	133.0		Pregnant or Seeking Pregnancy			Withdrawal
	STD-Syphilis-Congenital	090		Rely on Female Method		Family Planning Visit Type:	
	STD-Syphilis-Contact to	V01.6		Spermicide			ECPs
	STD-Syphilis-Early Latent	092.9		Sponge			Quick Start Depo
	STD-Syphilis-Late Latent	097.1		Tubal Ligation			Quick Start OCPs
	STD-Syphilis-Neurosyphilis	094.9		Vaginal Ring		Family Planning Contra Referral:	
	STD-Syphilis-Primary, Genital	091.2		Vasectomy			---Method complication
	STD-Syphilis-Secondary	091.9		Withdrawal			---Sterilization
	STD-Syphilis-Unknown Duration	097.9	Choose 1 or 2--			Other	
	STD-Trichomonas Vaginalis	131.01		Education-All methods			Followup Abnormal Pap
	STD-Trichomonas-Contact to	131.9		Education-STD/Hiv			
	STD-Venereal Disease-Contact to	V01.6		Education-other		Providers:	
	TB-Health Certificate Given	A82z0	Primary contraceptive client left with:				CNM
	TB-Miliary	013.9		Abstinence			NP/PA
	TB-Negative skin test	V71.2		Cervical Cap			CHA/CHT (CLERK)
	TB-Positive PPD	795.5		Depo Provera			Nutritionist
	TB-Preventative Therapy	V07.3		Diaphragm			Lab Staff
	TB-Pulmonary	011.9		ECP			Physician
	TB-Skin Test	V74.1		Female Condom			Nurse
	TB-Tuberculous Infection, Primary	010.0		Hormonal Implant			Social Worker
				IUD			Health Educator

Family Planning Supplemental has four required fields for every Family Planning Client at each visit. They are:
History Option > Family Planning tab: Primary Contraceptive (prior to today's visit) and **Visit Option > Page 1**: Contra Service, Contra Method (after today's visit), and Provider.
In the case of special circumstances, enter as follows:

1. **If the client has a positive pregnancy test at today's visit**, History Option > Maternal tab: select Pregnancy Intendedness and enter EDC.
2. **If ECP and/or Quickstart are dispensed at today's visit, see the INPHORM Procedures Manual or Training Bulletin 2003-07 for specifics.**
3. **If a Family Planning referral is made**: Visit Option > Page 1: Contra Referral - select Sterilization or Method Complication.
4. **If today's visit includes counseling and/or a repeat pap to follow up an abnormal pap: Visit Option > Page 1:** Other - select Follow-up Abnormal Pap.

EXHIBIT 3 ENCOUNTER FORM PAGE 4

EXHIBIT 3 ENCOUNTER FORM PAGE 5

DRUGS 2006

Name **DOB** **Date:**

SP	MEDICATIONS	CODE	COST	UNITS	SP	MEDICATIONS	CODE	COST	UNITS
	Acetomino-Tylenol Chew 80mg-30	P0024	$ 4.36			Ferrous Sulfate E C Tab 5GRS 100	P0058	$ 4.76	
	Acetomino-Tylenol Drop 100mg-15ml	P0025	$ 4.45			Fluconazole Tab 150mg ea.	P0162	$ 5.12	
	Acetomino-Tylenol Susp 160mg--120ml	P0026	$ 3.89			Glucose Beverage--100mg	P0061	$ 5.03	
	Acyclovir 400mg #21	P0027	$ 5.38			Histofreezer	P0063	$ 7.66	
	Acyclovir 400mg #35	P0028	$ 6.50			Hurricane Gel	P0121	$ 9.98	
	Albendazole Tabs 200mg #1	P0124	$ 4.32			Isoniazid Syrup 50mg/5ml 500ml	P0133	$ 23.03	
	Albendazole Tabs 200mg #10	P0151	$ 73.15			Isoniazid 100mg #30	P0065	$ 4.54	
	Amoxicillin 500mg caps #21	P0029	$ 7.69			Isoniazid 100mg #60	P0066	$ 4.90	
	Amoxicillin 500mg caps #30	P0126	$ 9.40			Isoniazid 300mg #30	P0068	$ 3.74	
	Azithromycin 500mg 2 tabs	P0175	$ 12.60			Meclizine 25mg #5	P0163	$ 6.53	
	BAYRHO-D 300gm Syringe each	P0158	$ 109.30			Metronidazole 250 mg #28	P0070	$ 3.77	
	Bicillin Inj. 1.2M Units	P0032	$ 5.67			Metronidazole 250 mg #8	P0071	$ 4.75	
	Cefpodoxime 200mg #2	P0159	$ 3.80			Metronidazole 250 mg #90	P0135	$ 6.40	
	Ceftriaxone 250 mg vial	P0033	$ 7.82			Metronidazole 250 mg #15	P0072	$ 4.06	
	Cephalexin 250mg #28	P0149	$ 5.10			Mycobutin Cap 150mg #100	P0074	$ 261.44	
	Cipro 500mg #1	P0034	$ 8.79			Nitrofurantoin Cap 100 mg #12	P0075	$ 10.90	
	Ciprofloxacin 750mg #50	P0154	$ 180.88			Nitrofurantoin Cap 100 mg #40	P0076	$ 27.70	
	Clarithromycin 500mg #28	P0160	$ 56.34			Nystatin Topical Cream	P0082	$ 4.15	
	Clarithromycin 250mg #60	P0161	$ 88.40			Ofloxacin 400mg #28	P0164	$ 53.82	
	Clotrimazole vag cream 45gm	P0035	$ 5.65			Permethin 5% Cream 60m	P0165	$ 6.20	
	Combivir Tab 60mg #8	P0037	$ 60.16			Permethin Lotion 1% Lice Treatment	P0166	$ 6.96	
	Doxycycline 100 mg cap #6	P0128	$ 4.66			Phenazopyridine 200mg #9	P0088	$ 4.69	
	Doxycycline 100 mg cap #14	P0042	$ 5.03			Podophyllin 20% Topical	P0090	$ 35.02	
	Doxycycline 100mg cap #20	P0129	$ 6.90			Premarin Cream 42 g tube	P0146	$ 17.09	
	Doxycycline 100 mg cap #28	P0043	$ 8.18			Prenatal-S Vitamins 100	P0094	$ 5.69	
	Erythromycin 250 mg tab #56	P0048	$ 7.06			Promethazine Supp 25mg #4	P0167	$ 4.15	
	Ethambutol Tab 100mg #30	P0050	$ 15.70			Pyrazinamide 500mg #60	P0097	$ 46.85	
	Ethambutol Tab 100mg #60	P0051	$ 27.70			Pyrazinamide 500mg #90	P0098	$ 68.43	
	Ethambutol Tab 100mg #90	P0052	$ 39.70			Pyrazinamide 500mg #100	P0096	$ 76.81	
	Ethambutol Tab 100mg #100	P0049	$ 51.27			Rifamate 300/150--60	P0118	$ 68.18	
	Ethambutol Tab 400mg #30	P0053	$ 49.85			Rifampin 150mg #30	P0100	$ 23.64	
	Ethambutol Tab 400mg #60	P0055	$ 51.87			Rifampin Cap 150mg 4(EPI Authorization)	P0138	$ 6.36	
	Ethambutol Tab 400mg #90	P0054	$ 81.99			Rifampin 300mg #60	P0101	$ 44.21	
	Ethambutol Tab 400mg #100	P0131	$ 97.56			Rifampin Cap 300mg 8(Epi Authorization)	P0139	$ 9.06	

EXHIBIT 3 ENCOUNTER FORM PAGE 6

DRUGS 2006
Page 2

Name **DOB** **Date:**

SP	MEDICATIONS	CODE	COST	UNITS	SP	CONTRACEPTIVE SUPPLIES	CODE	COST	UNITS
	Rifampin Susp. 10mg/ml	P0141	$ 12.20			Alesse 28	P0007	$ 5.22	
	Rifampin Susp. Mixtures	P0142	$ 15.70			Condoms (female) each	P0123	$ 4.65	
	Rifater Tab 60	P0103	$ 45.45			Condoms (male) each	P0008	$ 0.40	
	Special Order TB - Azithromycin 500mg #30	P0168	$ 27.79			Contraceptive Film (VCF)	P0023	$ 9.65	
	Special Order TB - Azithromycin 500mg #3's	P0169	$ 31.96			Contraceptive foam w/app	P0009	$ 9.20	
	Special Order TB - Levaquin 750mg #20	P0170	$ 126.75			Contraceptive jelly w/app	P0010	$ 9.15	
	Special Order TB - Levaquin Tab 500mg #50	P0171	$ 49.70			CycleBeads	P0174	$ 8.20	
	Special Order TB - Streptomycin Inj 400mg/ml 1's	P0172	$ 11.23			Depo P. Generic Progesterone 150 mg.	P0173	$ 56.11	
	TCA 80% in alcohol 70%	P0106	$ 36.41			Lo-Ovral 28	P0157	$ 6.15	
	Terconazole vaginal cream 0.4%	P0107	$ 18.92			Micronor 28	P0013	$ 3.76	
	TMP-SMX Susp 200mg/40mg 180ml	P0108	$ 4.91			Mirena IUD	P0144	$ 406.70	
	TMP-SMX/DS Tab 160mg/800mg #20	P0122	$ 4.51			Nordette 28	P0014	$ 4.75	
	TMP-SMX/DS Tab 160mg/800mg #28	P0143	$ 4.82			Ortho-Cyclen Tabs 28	P0017	$ 5.31	
	TMP-SMX/DS Tab 160mg/800 mg #6	P0109	$ 3.94			Ortho Diaphragm- All Flex	P0020	$ 29.90	
	Triamcinalone Acet Cr. .1% 15mg	P0111	$ 3.95			Ortho Evra (single patch)	P0150	$ 16.34	
	Vagifem Tabs 18 tabs	P0147	$ 49.30			Ortho Evra (set of 3)	P0148	$ 49.35	
						Ortho-Novum 1/35	P0018	$ 3.76	
						Ortho-Novum 7-7-7	P0019	$ 3.76	
						Ortho Tri-Cyclen Lo	P0156	$ 6.90	
						Ovulation Thermometer (Digital)	P0004	$ 10.83	
						Paragard IUD	P0021	$ 362.50	
						Plan B	P0117	$ 10.56	
						Triphasil 28	P0022	$ 5.75	

EXHIBIT 4 – 2006 FEDERAL PROVERTY GUIDELINES

FAMILY PLANNING 2006 PERCENT PAY PER FEDERAL POVERTY GUIDELINES

Family Size	Low Income	High Income	Pay Percent	Poverty Percent	Family Size	Low Income	High Income	Pay Percent	Poverty Percent	Family Size	Low Income	High Income	Pay Percent	Poverty Percent
1	$0.00	$9,800.00	**0%**	100%	**6**	$0.00	$26,800.00	**0%**	100%	**11**	$0.00	$43,800.00	**0%**	100%
1	$9,800.01	$10,780.00	**10%**	110%	6	$26,800.01	$29,480.00	**10%**	110%	11	$43,800.01	$48,180.00	**10%**	110%
1	$10,780.01	$11,760.00	**20%**	120%	6	$29,480.01	$32,160.00	**20%**	120%	11	$48,180.01	$52,560.00	**20%**	120%
1	$11,760.01	$12,740.00	**30%**	130%	6	$32,160.01	$34,840.00	**30%**	130%	11	$52,560.01	$56,940.00	**30%**	130%
1	$12,740.01	$13,720.00	**40%**	140%	6	$34,840.01	$37,520.00	**40%**	140%	11	$56,940.01	$61,320.00	**40%**	140%
1	$13,720.01	$14,700.00	**50%**	150%	6	$37,520.01	$40,200.00	**50%**	150%	11	$61,320.01	$65,700.00	**50%**	150%
1	$14,700.01	$15,680.00	**60%**	160%	6	$40,200.01	$42,880.00	**60%**	160%	11	$65,700.01	$70,080.00	**60%**	160%
1	$15,680.01	$18,130.00	**70%**	185%	6	$42,880.01	$49,580.00	**70%**	185%	11	$70,080.01	$81,030.00	**70%**	185%
1	$18,130.01	$19,600.00	**80%**	200%	6	$49,580.01	$53,600.00	**80%**	200%	11	$81,030.01	$87,600.00	**80%**	200%
1	$19,600.01	$24,500.00	**90%**	250%	6	$53,600.01	$67,000.00	**90%**	250%	11	$87,600.01	$109,500.00	**90%**	250%
1	$24,500.01	$999,999.99	**100%**	251+	6	$67,000.01	$999,999.99	**100%**	251+	11	$109,500.01	$999,999.99	**100%**	251+
2	$0.00	$13,200.00	**0%**	100%	**7**	$0.00	$30,200.00	**0%**	100%	**12**	$0.00	$47,200.00	**0%**	100%
2	$13,200.01	$14,520.00	**10%**	110%	7	$30,200.01	$33,220.00	**10%**	110%	12	$47,200.01	$51,920.00	**10%**	110%
2	$14,520.01	$15,840.00	**20%**	120%	7	$33,220.01	$36,240.00	**20%**	120%	12	$51,920.01	$56,640.00	**20%**	120%
2	$15,840.01	$17,160.00	**30%**	130%	7	$36,240.01	$39,260.00	**30%**	130%	12	$56,640.01	$61,360.00	**30%**	130%
2	$17,160.01	$18,480.00	**40%**	140%	7	$39,260.01	$42,280.00	**40%**	140%	12	$61,360.01	$66,080.00	**40%**	140%
2	$18,480.01	$19,800.00	**50%**	150%	7	$42,280.01	$45,300.00	**50%**	150%	12	$66,080.01	$70,800.00	**50%**	150%
2	$19,800.01	$21,120.00	**60%**	160%	7	$45,300.01	$48,320.00	**60%**	160%	12	$70,800.01	$75,520.00	**60%**	160%
2	$21,120.01	$24,420.00	**70%**	185%	7	$48,320.01	$55,870.00	**70%**	185%	12	$75,520.01	$87,320.00	**70%**	185%
2	$24,420.01	$26,400.00	**80%**	200%	7	$55,870.01	$60,400.00	**80%**	200%	12	$87,320.01	$94,400.00	**80%**	200%
2	$26,400.01	$33,000.00	**90%**	250%	7	$60,400.01	$75,500.00	**90%**	250%	12	$94,400.01	$118,000.00	**90%**	250%
2	$33,000.01	$999,999.99	**100%**	251+	7	$75,500.01	$999,999.99	**100%**	251+	12	$118,000.01	$999,999.99	**100%**	251+
3	$0.00	$16,600.00	**0%**	100%	**8**	$0.00	$33,600.00	**0%**	100%	**13**	$0.00	$50,600.00	**0%**	100%
3	$16,600.01	$18,260.00	**10%**	110%	8	$33,600.01	$36,960.00	**10%**	110%	13	$50,600.01	$55,660.00	**10%**	110%
3	$18,260.01	$19,920.00	**20%**	120%	8	$36,960.01	$40,320.00	**20%**	120%	13	$55,660.01	$60,720.00	**20%**	120%
3	$19,920.01	$21,580.00	**30%**	130%	8	$40,320.01	$43,680.00	**30%**	130%	13	$60,720.01	$65,780.00	**30%**	130%
3	$21,580.01	$23,240.00	**40%**	140%	8	$43,680.01	$47,040.00	**40%**	140%	13	$65,780.01	$70,840.00	**40%**	140%
3	$23,240.01	$24,900.00	**50%**	150%	8	$47,040.01	$50,400.00	**50%**	150%	13	$70,840.01	$75,900.00	**50%**	150%
3	$24,900.01	$26,560.00	**60%**	160%	8	$50,400.01	$53,760.00	**60%**	160%	13	$75,900.01	$80,960.00	**60%**	160%
3	$26,560.01	$30,710.00	**70%**	185%	8	$53,760.01	$62,160.00	**70%**	185%	13	$80,960.01	$93,610.00	**70%**	185%
3	$30,710.01	$33,200.00	**80%**	200%	8	$62,160.01	$67,200.00	**80%**	200%	13	$93,610.01	$101,200.00	**80%**	200%
3	$33,200.01	$41,500.00	**90%**	250%	8	$67,200.01	$84,000.00	**90%**	250%	13	$101,200.01	$126,500.00	**90%**	250%
3	$41,500.01	$999,999.99	**100%**	251+	8	$84,000.01	$999,999.99	**100%**	251+	13	$126,500.01	$999,999.99	**100%**	251+
4	$0.00	$20,000.00	**0%**	100%	**9**	$0.00	$37,000.00	**0%**	100%	**14**	$0.00	$54,000.00	**0%**	100%
4	$20,000.01	$22,000.00	**10%**	110%	9	$37,000.01	$40,700.00	**10%**	110%	14	$54,000.01	$59,400.00	**10%**	110%
4	$22,000.01	$24,000.00	**20%**	120%	9	$40,700.01	$44,400.00	**20%**	120%	14	$59,400.01	$64,800.00	**20%**	120%
4	$24,000.01	$26,000.00	**30%**	130%	9	$44,400.01	$48,100.00	**30%**	130%	14	$64,800.01	$70,200.00	**30%**	130%
4	$26,000.01	$28,000.00	**40%**	140%	9	$48,100.01	$51,800.00	**40%**	140%	14	$70,200.01	$75,600.00	**40%**	140%
4	$28,000.01	$30,000.00	**50%**	150%	9	$51,800.01	$55,500.00	**50%**	150%	14	$75,600.01	$81,000.00	**50%**	150%
4	$30,000.01	$32,000.00	**60%**	160%	9	$55,500.01	$59,200.00	**60%**	160%	14	$81,000.01	$86,400.00	**60%**	160%
4	$32,000.01	$37,000.00	**70%**	185%	9	$59,200.01	$68,450.00	**70%**	185%	14	$86,400.01	$99,900.00	**70%**	185%
4	$37,000.01	$40,000.00	**80%**	200%	9	$68,450.01	$74,000.00	**80%**	200%	14	$99,900.01	$108,000.00	**80%**	200%
4	$40,000.01	$50,000.00	**90%**	250%	9	$74,000.01	$92,500.00	**90%**	250%	14	$108,000.01	$135,000.00	**90%**	250%
4	$50,000.01	$999,999.99	**100%**	251+	9	$92,500.01	$999,999.99	**100%**	251+	14	$135,000.01	$999,999.99	**100%**	251+
5	$0.00	$23,400.00	**0%**	100%	**10**	$0.00	$40,400.00	**0%**	100%	**15**	$0.00	$57,400.00	**0%**	100%
5	$23,400.01	$25,740.00	**10%**	110%	10	$40,400.01	$44,440.00	**10%**	110%	15	$57,400.01	$63,140.00	**10%**	110%
5	$25,740.01	$28,080.00	**20%**	120%	10	$44,440.01	$48,480.00	**20%**	120%	15	$63,140.01	$68,880.00	**20%**	120%
5	$28,080.01	$30,420.00	**30%**	130%	10	$48,480.01	$52,520.00	**30%**	130%	15	$68,880.01	$74,620.00	**30%**	130%
5	$30,420.01	$32,760.00	**40%**	140%	10	$52,520.01	$56,560.00	**40%**	140%	15	$74,620.01	$80,360.00	**40%**	140%
5	$32,760.01	$35,100.00	**50%**	150%	10	$56,560.01	$60,600.00	**50%**	150%	15	$80,360.01	$86,100.00	**50%**	150%
5	$35,100.01	$37,440.00	**60%**	160%	10	$60,600.01	$64,640.00	**60%**	160%	15	$86,100.01	$91,840.00	**60%**	160%
5	$37,440.01	$43,290.00	**70%**	185%	10	$64,640.01	$74,740.00	**70%**	185%	15	$91,840.01	$106,190.00	**70%**	185%
5	$43,290.01	$46,800.00	**80%**	200%	10	$74,740.01	$80,800.00	**80%**	200%	15	$106,190.01	$114,800.00	**80%**	200%
5	$46,800.01	$58,500.00	**90%**	250%	10	$80,800.01	$101,000.00	**90%**	250%	15	$114,800.01	$143,500.00	**90%**	250%
5	$58,500.01	$999,999.99	**100%**	251+	10	$101,000.01	$999,999.99	**100%**	251+	15	$143,500.01	$999,999.99	**100%**	251+

5. Accounting Procedures

All accounting will now be maintained through INPHORM fee collection program in conjunction with account cards.

a. Family Planning Change Funds

Twenty-five dollars ($25.00) will be issued as change funds to each office to be used for giving change. A Change Funds Custodian and a back-up person (someone usually in the office) should be assigned and the names documented with the Family Planning STATE Office and with the District Director. Family Planning change funds shall be the responsibility of the assigned Custodian and shall be kept in a locked strong box in a secure place (per ADM 01:12). Documented reconciliation of the change funds should occur both before and after transfer to the back-up person. If a client needs change to make a payment and neither the Custodian nor the back-up person is in the office, the client will have to come back at a later time. **Under no circumstances is anyone other than the Custodian or the back-up person to have access to the funds.** Monies collected daily should be kept in the locked change funds box until their deposit. Deposits are to be done by someone other than the **custodian** in order to ensure the integrity of the deposit process. (This procedure can be waived for small (one or two person offices) when only one staff person is in for the day and performing all clerical duties.

1) To establish a change fund:
   i. Contact Ferm Najera (State Office at 505-476-8877) if a change fund needs to be established or the custodian changed by phone and she will request the information that is required.
   ii. She will then initiate the memorandum to your District Financial Officer for their authorization.
   iii. After receiving authorization from your DFO Ferm submits a voucher to Dept. of Finance and Administration for the final authorization and they will issue the change fund warrant.
   iv. The warrant will then be sent directly to the health office and cashed by the assigned custodian for change.

2) To change a custodian:
   Submit a memorandum stating the name of the person replacing the primary custodian and the reason for the change. Send the memorandum to the attention of Kathy Tall Bear, General Accounting, PO Box 26110, Santa Fe, NM 87502.

3) Theft of a Change Fund:
   i. In the case that the change fund or a portion of the fund is stolen the police should be notified immediately.
   ii. Submit a memorandum addressed to Accounting Bureau and Dept. Finance and Administration stating the theft and the amount that needs to be replaced (attach the original police report). Send this documentation to the attention of Kathy Tall Bear, General Accounting, PO Box 26110, Santa Fe, NM 87502, with a copy to Ferm Najera, Family Planning Program, P.O.Box 26110, Santa Fe, NM 87502.

DEPOSITS MUST BE MADE DAILY AT THE DESIGNATED BANK WITHIN TWENTY-FOUR (24) HOURS OF RECEIPT (PER ADM 01:15.01).

Cash counts shall be made and documented as required by Title X Guidelines. Periodic, unannounced cash counts will be made by designated district staff or by auditors.

PLEASE ALSO NOTE THAT A CHANGE FUND AND A PETTY CASH FUND ARE UTILIZED IN TWO DIFFERENT WAYS, FAMILY PLANNING CHANGE FUNDS SHALL NOT BE USED FOR ANY PURPOSE OTHER THAN FOR GIVING CHANGE! PETTY CASH FUNDS ARE UTILIZED BY DESIGNATED STAFF TO PURCHASE OFFICE NECESSITIES.

b. Payments

Payments by cash, check or money order may be accepted at any time from clients. When a client pays by check, the back of the check must immediately be stamped with a "Family Planning - For Deposit Only" stamp. If a client wishes to make a payment in cash, the payment must be made to the Change Fund Custodian or the designated back-up person. The cash will then be kept in the locked change funds box until a deposit is made at the end of the day. Percent pay patient will be asked to pay their fees and any outstanding balances at the time of services. **No person shall be denied services because of inability to pay.**

Each District Director may designate specific hours when cash payments may be accepted by each Local Health Office. If cash payments cannot be accepted at any time during normal office hours, the specific hours in which cash payments may be accepted must be clearly posted in the Health Office.

c. Receipt
A receipt must be issued to **Pay Percent** clients for every visit and must be offered to all o% clients. A copy of the receipt must be filed in the client's Financial record. Follow the Computer procedures for issuing receipts. Receipts must also be issued to any client who comes into the clinic at a later date to make payment on their balance due. A manual receipt book should be kept on hand in the event that the INPHORM system is not functioning. Receipts can be generated by the INPHORM system for Pay Percent clients only, clients who have no charges can receive a receipt which is handwritten from the receipt book.

d. Bad Checks
If a client's check is returned by the bank for non-sufficient funds, let Kathy Tall Bear in General Accounting know ASAP. **The individual who made the check must be charged an additional $25.00 amount to their account in the INPHORM system (see Adjustments on page 37).** Attempt to contact the client by phone immediately. Oftentimes, she/he will want to pick up the check and just make the payment in cash. If the client wants you to redeposit the check, you may do so at once. If you redeposit, at that time the client should be recharged for the visit and then given credit for the payment. In the event that the check is returned a second time, recharge the client and send the check back to them. (A notice of NSF charges for bad checks should be visibly posted in each office.) **The individual who made the check must be charged an additional $25.00 amount to their account in the INPHORM system (see Adjustments on page 37).**

e. Bankrupt
If a client's attorney sends a Bankruptcy Notice, stamp the date received on it. Attach the Bankruptcy notice the back of the McBee Ledger card, enter a note in the chart, McBee card, and enter a green alert in the computer. Stop sending billing letters at this point. Follow the instructions on **Hardship Case** to enter the Bankruptcy Notice. **Do not send it to the Fee Collection Liaison.**

f. Overpayment
If a client sends you an overpayment, contact the client by phone immediately and try to ascertain the reason for overpayment. If the client meant the overpayment as a donation, handle it as such. However, if she/he wishes to have the overpayment applied as a credit to their account, you must do so. The account will then show a credit balance, which will remain until the client comes in for their next visit. The credit balance can only be applied to future services rendered and is not a cash refund. Refunds will not be issued to clients. **(**If the client does not return for a visit, the credit amount may be credited to donations after there has been no activity on the account for eighteen (18) months.)

g. Donations
Occasionally, clients may wish to make a donation. Voluntary donations from clients are permissible. Donations must not be a condition for the receipt of services or supplies. The Title X policy regarding the solicitation of donations from clients is that general solicitations, such as, posters in the waiting room or announcements in public presentations or in advertising are allowable.

h. Depositing
Checks and cash must be deposited daily at the designated bank within twenty-four (24) hours of receipt (per ADM 01:15.01). There are **NO** exceptions to this policy! A designated staff member can be given time at the end of the day to make the deposit in a timely manner. It is imperative that the individual who is preparing the deposit not be the individual who makes the deposit, this is for quality assurance purposes. (In cases of small one/two person offices, there may be no choice and the person who prepared the deposit also makes the deposit.)

The Fee Deposit Register should be used to record information about each deposit made by the health office. The original validated deposit slips are kept in the LPHO. Copies are sent in the Monthly report due on the 5th of each month.

i. Bank Withdrawals
On or about the fifteenth day and the last day of each month, authorized personnel (Kathy Tall Bear)

of the Administrative Services Division of DOH will draw checks against your respective bank balances. The amount of the withdrawal will be based on the deposit slips and the Family Planning Fee Deposit Register, which you send to State Office. It is important that you let Kathy Tall Bear (827-2692) know of any bounced checks to avoid negative balance charges to your account.

j. Billing and Fee Collection

Any "BALANCE DUE" should be brought to the client's attention. It is important for all clerks to do this. It is a requirement of our Federal Grant that we collect at least 85% of the fees charged to our percent pay clients. **Billing Letters should be sent to all accounts with a balance at a minimum of every other month.** Even if a client's balance is very old, a bill should be sent. If the bill is returned because the address is not correct, try to obtain the correct address by calling the client or other means. If you are not able to find the client's correct address, stop sending bills until you have an updated address. Enter a low level alert in INPHORM so any other office will see that the client's address needs to be updated and you need to be contacted with the update. It is also helpful to contact the WIC clerk in your office to see if the client has an updated address in their system. Stop sending billing letters to client with outstanding balances after 18 billing letters have been mailed or if the billing letter was returned by the United States postal service. Document each time a billing letter is sent on the McBee Ledger Card and when it was returned. Enter a green alert in INPHORM stating that the client has a balance and you have stopped sending billing letter.

Billing letters should include the current letterhead; (header with new governor and staff names and footer; your health office name, address and phone number,) with client's name, address, date of birth, balance, overdue since, and INPHORM account number. It also should include date of bill, health office phone number, and if paying by check or money order, please make it to: Family Planning Title X, health office name, address and attention Family Planning Clerk. (Example of billing letters are in the last 4 pages of this protocol.)

A copy of each billing letter sent should be kept in the client's financial file (alphabetize folder system by client and chronological order) along with the encounter forms. (Encounter forms do not go in the clinical chart.) This will aid you in reviewing the client's balance when you are requesting a payment the next time they come into the clinic. When the client comes in, the clerk should mention that a balance is due and state the amount to the client (see C. Tele Appt. Screen for appropriate language). Also, the nurse should be made aware of the balance due. The nurse can then reiterate that the account needs to be brought up-to-date. **Clinician support in the area of fee collections is imperative to the clerks**. If the client has "confidential" status, do not attempt to contact them or send them letters. You should have a current listing of confidential clients on file. *Ask the confidential clients for payment when they are in the office. If a confidential client cannot pay at the time of service, give them a bill to take with them and an envelope addressed to the office.*

k. Write-offs Are No Longer Be Done

Write-offs and r**einstatements** are no longer be done, due to the INPHORM system's ability to maintain tracking of clients' past due accounts. Remember "in the eyes of the State of New Mexico," **the account is not forgiven.** Client accounts will remain active within the INPHORM system. If client comes in who had an old balance, the PH Turbo write-off from their ledger card needs to be entered into the INPHORM System as a beginning balance. The only possible **exceptions** are **Bankruptcy** and **client deaths**. These need to be decided on a case by case basis with the Fee Collection Liaison at 476-8869.

l. Corrections

Corrections need to be made according to appropriate Systems directions. Corrections must be done with the help of the INPHORM help desk staff in order to maintain the integrity of the INPHORM System. The help desk number is 1-800-280-1618. Enter the call ticket number on the McBee card for documentation on percent pay clients.

m. Accounts Receivable Report (A/R) (Presently Waiting For INPHORM Reports Design.)

At present the Family Planning Payment Ledger (Exhibit 5) will serve as the **Accounts Receivable Report.** Until the INPHORM management along with the Family Planning Program can design and implement the reports for the Fee Collection piece. ***The clerk and the nurse manager should check these reports for accuracy before signing and submitting them.***

n. Monthly Report Packet – Due by the 5th of every month:

At the end of each month, the following reports are to be prepared as a packet. **A copy of the report is to be sent or faxed to <u>The Fee Collection Liaison, Family Planning Program, PO Box</u> 26110, Santa Fe, New Mexico 87502, (505) 476-8869, or FAX: (505) 476-8898. <u>Mail a separate copy to</u> Financial Control, Attn: Kathy Tall Bear, Runnels Bldg Room S3150, 1190 St. Francis, Santa Fe, NM 87502, Fax: 827-0873, phone: (505) 827-2693.**

The FP Fee Collection Liaison will review each Monthly Report Packet received to ensure that each local health office is complying with this requirement and that all reports are being submitted on time. The Fee Collection Liaison keeps track of the Monthly reports received from each office, including whether they were late or incomplete, as this is part of the clerks' PAD. **If you did not charge any clients or collect any money during the month, please make a note on the Payment Ledger and send it in by itself.**

The monthly packet should include in this order:

1). **Family Planning Payment Ledger.** (On top) (This is for "percent pay" clients. Medicaid clients and clients who are "0 pay" do not need to be listed.) Please fill in all the information requested on this form. **(**Exhibit 6)
2). **Federal Fee Deposit Register.** (Second from the top) **Please note at the bottom of the Fee Deposit Register form, under "Notes/Comments": Put in the date of when you mailed your last bills for Family Planning.**
3). **Copy of deposit slips, validated by bank.** (Attached to Fee Deposit Register form)
4). **Two Calculator Tape Tallies** on the following items:" (Please label each clearly and staple to the payment ledger.)

a. Monthly totals of all client **charges** (**after** the **sliding scale adjustment)** for the month.
b. Monthly totals of all **payments** of check or cash for the month.

THE MONTHLY REPORT IS NOT GENERATED BY INPHORM

Continue to maintain a file of the report packets by month in each local health office. A copy of actual billing letter goes in the financial record. Family Planning will reference these files when conducting audits in each local health office. Include any corrections and/or adjustments made to the Monthly Report in this file.

EXHIBIT 7 FAMILY PLANNING PAYMENT LEDGER (Example)

FAMILY PLANNING PAYMENT LEDGER 2006

Month January **Name of Health Office:** Santa Fe Public Health Office **Region:** *2* **Site Code #** **026A**

Date	Deposit #	Patient Name	Birth Date	File #	Today's Charges (after adj)	Previous Balance	Amount Paid	Donations	Payment Type	Balance Due
01/03/06	**001**	**Jane Doe**	**11/22/76**	**0001230**	**17.89**	**11.31**	**11.31**		**K**	**17.89**
01/05/06	**002**	**Candy Cane**	**01/06/73**	**0101010**	**45.76**	**119.42**	**40.00**		**Cash**	**125.18**
0109/06	**003**	**Page Press**	**06/10/84**	**1010320**	**56.12**	**17.95**	**56.00**		**K**	**00.12**
01/11/06	**004**	**Ruby Applebee**	**01/05/75**	**1021012**	**97.12**	**216.27**	**100.27**		**Cash**	**116.00**
01/17/06	**005**	**Honey Bee**	**02/14/76**	**321025**	**0**	**55.55**	**20.00**	**20.00**	**Cash**	**35.55**
Page Totals					**216.89**		**227.58**	**20.00**		

Total Checks:$67.31 **Lucille Duran, Clerk Specialist** **Month Total: (Cash & Checks) $227.58**

Total Cash: $160.27 **Clerk's Signature/Title** **Page: 1 of 1**

EXHIBIT 7 BLANK PAYMENT LEDGER

FAMILY PLANNING PAYMENT LEDGER 2006

Month _____ **Name of Health Office:** _____ **Region** _____ **Co-site #** _____

Total Checks $_____** **_____** **Month Total: (Cash & Checks)$_____

Total Cash: $_____ **Clerk's Signature/Title** **Page:_____ of_____**

Date	Deposit #	Patient Name	Birth Date	File #	Today's Charges (after adj)	Previous Balance	Amount Paid	Donations	Payment Type	Balance Due
Page Totals										

FEE DEPOSIT REGISTER 2006

Region 2
Site/Office Santa Fe
Submitted by: Lucille Duran
Phone Number: (505)476-8869
Fax Number: (505)476-8898

Deposit Number	Date of Deposit	Amount Deposited	Deposited by
1	01-03-06	11.31	RC
2	01-05-06	40.00	RC
3	01-09-06	56.00	RC
4	01-11-06	100.27	RC
5	01-17-06	20.00	RC

TOTAL OF DEPOSIT **$ 227.58**

Notes/Comments:

Billing Letters sent on: January 30, 2006

FEE DEPOSIT REGISTER 2006

Region _____
Site/Office _____
Submitted by: _____
Phone Number: _____
Fax Number: _____

Deposit Number	Date of Deposit	Amount Deposited	Deposited by

TOTAL OF DEPOSIT $_____

Notes/Comments:

Billing Letters sent on: _____

COPIES OF DEPOSIT SLIPS VALIDATED BY BANK
2006
Health Office_____
Month _____

ADDING MACHINE TAPES
2006
Health Office_____
Month _____

Today's Charges (after adj)

Tape the adding machine tape here

Amount Paid

Tape the adding machine tape here

EXHIBIT 9 Fax Sheet #1

NEW MEXICO
DEPARTMENT OF
HEALTH

FAX TRANSMITTLE SHEET

(505) _____

(Please Print)

DATE: _____
ATTENTION: Lucille Duran_____
AGENCY: Family Planning Program_____
SENT TO FAX # (505) 476-8898_____
OFFICE PHONE # (505) 476-8869_____
NUMBER OF PAGES: _____
SENT BY: _____
HEALTH OFFICE NAME: _____
CITY_____
COUNTY_____
REGION_____
MESSAGE: Monthly Report for:_____

Comments: _____

IMPORTANT CONFIDENTIALITY NOTICE

THE INFORMATION CONTAINED IN THIS FACSIMILE MESSAGE IS CONFIDENTIAL AND INTENDED SOLELY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF THE READER OF THIS MESSAGE IS NOT THE INTENDED RECIPIENT, OR THE EMPLOYEE OR AGENT RESPONSIBLE FOR DELIVERING IT TO THE INTENDED RECIPIENT. YOU ARE HEREY BY NOTIFIED THAT ANY DISSEMINATION DISTRIBBUTION, COPYING, OR UNAUTHORIZED USE OF THIS COMMUNICATION IS STRICTLY PROHIBITED (and possibly illegal). IF YOU HAVE RECEIVED THIS FACSIMILE TRANSMISSION IN ERROR, IT SHOULD BE RETURNED TO THE SENDER AS SOON AS POSSIBLE.

NEW MEXICO
DEPARTMENT OF
HEALTH

FAX TRANSMITTLE SHEET

(505) _____

(Please Print)

DATE: _____
ATTENTION: Kathy Tall Bear_____
AGENCY: Administrative Services Division of DOH_____ _____
SENT TO FAX # ____(505) 827-0873_____
OFFICE PHONE # ___(505) 827-2693_____
NUMBER OF PAGES: _____
SENT BY: _____
HEALTH OFFICE NAME: _____
COUNTY_____
REGION_____
MESSAGE: _____Monthly Report for:_____

Comments: _____

IMPORTANT CONFIDENTIALITY NOTICE

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o. Appointment Book/Log
For audit purposes, it is essential that each health office keep its appointment books/logs for three (3) years

p. Satellite Offices
If your office provides services at a satellite office, the completed encounter forms and income worksheets should be taken back to the main office for data input. You may issue a temporary receipt for any client paying in cash.

q. Family Planning Fee Collection Committee
The Fee Collection committee consists of experienced FP clerks from each Region. They assist the Fee Collection Liaison in updating the fee collection protocol and policies, and act as a resource for other clerks in their area who need fee collection training.

Region 1: Marie Buck in Farmington at 505-327-4461
Dianna McCune in Bloomfield at 505-634-0229
Wanema Garcia in Grants at 505-285-4601
Region 2: Irene Madrid in Espanola at 505-753-2794
Sandra Buiton in Taos at 505-758-4719
Madeline Casados in Mora at 505-387-2748
Ginny Lopez in Mora at 505-387-2748
Region 4: Joyce Miller in Roswell at 505-624-6050
Nicole Montgomery in Carlsbad at 505-885-4191
Region 5: Cari Riley in Moriarty at 505-832-6782
Dolores Munoz in Deming at 505-546-2771
Frances Rodriguez in T or C at 505-894-2716

Fee Collection Liaison – Monthly Report Packet
Lucille Duran, Family Planning 476-8869 Fax # (505) 476.8898

Financial Accounting --- Monthly Report Packet
Kathy Tall Bear, Financial Control 827-2692 Fax# (505) 827-2693

r. Calendar
Monthly: Monthly Reports Packet (**due at State Office by the 5th of each month**) If, for some reason, you are unable to send the reports in, it is necessary to call the Family Planning Fee Collection Liaison at (476-8869). Please also let the Fee Collection Liaison know if you are behind in your Family Planning data entry. If your Monthly Report is late, please let Financial Accounting know the amount of your deposits for the month. And Monthly billing is preferable to every other month.

Bimonthly Every Other Month, Billing Letters must be sent to any non-confidential clients who owe a balance. (Monthly is preferable)

s. Record Retention
Retain all records, appointment books, monthly reports, encounter forms, billing letters, and Medical Records (if inactive for 3 years) for 3 years. Family Planning encounter forms, and all copies of billing letters sent are to be kept in a locked, alphabetical file, separated from the client charts. Monthly Reports and Ledger Cards are also to be kept in a locked file.

Monthly reports can be shredded after 3 years. If a client has not been in for 3 years and owes no balance, archive the Medical Record and shred the ledger card, encounter forms, and billing letters. **If the client owes a balance, keep the account card and encounter forms and billing letters active until the balance is paid.**

t. Use of Norplant Certificate - **Call the Help Desk if you are not familiar with the procedure**.
All Local Health Offices are now listed as providers in the Norplant Foundation Removal Assistance Network. We hope the following Questions and Answers will help you in giving services to women who have certificates from the Foundation.

What is the "certificate"?
The certificate is a document mailed to eligible Norplant users anywhere in the USA to pay for the removal of their implants. The assistance is provided by The "Norplant Foundation Removal Assistance Network".

Is this assistance "certificate" provided through the local health office(s)?
NO, **the certificate for assistance can only be obtained by calling 1-(800) 760-9030**. HOWEVER, all local health office(s) can accept the certificate as payment for removing the Norplant implants.

How does a woman obtain the certificate?
Any Norplant user may call the Norplant Removal Foundation Assistance Network at **1(800)-760-9030**. She will be asked a few questions to determine eligibility, and if eligible, will be mailed the certificate in about a week.

What assistance does the Foundation give an eligible Norplant user?
The Foundation will mail her the following: 1) a list of health care professionals in her area who participate in the program 2) the "Certificate" that enables her to get her Norplant system removed at no charge 3) an eligibility requirements fact sheet 4) a postage paid envelope to be given to the clinician who removes the device (clerk will mail it in).

Can only Family Planning clients apply for the certificate?
NO, any Norplant user may apply by calling **1(800)-760-9030**. This number may be given to anyone who inquires about removal services. Established clients who call inquiring about removal should always be referred to talk to a nurse for counseling before scheduling a removal. **Review FP Protocol section 5 p.p. 21&22 with all staff.**

Can a Norplant be removed by Family Planning without using the certificate as payment?
YES, by charging the Norplant user under the sliding fee scale. HOWEVER, please encourage the use of the Norplant Foundation Assistance Network, as the certificate provides full payment rather than the smaller sliding scale amount.

Does the woman have to bring the certificate at the time of her scheduled appointment?
YES, the certificate must be presented before the removal can take place. If the implants have already been removed, a certificate cannot be signed and accepted after the fact.

What if a certificate holder wants to schedule a removal but is not an established client?
Follow your local health office(s) regular scheduling procedures. This may mean a birth control class and/or a new client intake appointment. The woman may also wish to choose alternate birth control method after having her implants removed. These additional services will be charged using the sliding fee scale.

What if a new client complains about a long wait to schedule a removal appointment?
Every certificate holder has received a list of at least three providers; suggest that she contact another provider who may be able to schedule her sooner. No one should be denied services, but do stick to your local health office(s) regular scheduling procedures in prioritizing appointments.

What if I have a question that is not answered here?
Please keep us informed of any other questions that arise. Call the Help Desk at (800) 280-1618. We want to be sure that the Norplant Removal Assistance Network works for both you and the clients.

u. Family Planning Services in STD Clinic
On occasion, a person seen in STD clinic may require Family Planning supplies or tests. This may include pregnancy testing, packs of OCP's, Emergency Contraceptive Pills, ORTHO EVRA or a Depo-Provera injection. In these cases, ask the client to complete an income affidavit and

calculate the percent pay.

The client is responsible for any charges for contraceptive or pregnancy tests. Document all services on the clinical encounter form for both an STD visit and a Family Planning visit. Some clinics streamline this procedure by keeping the needed forms in the exam rooms. If client falls into a percent pay category and paying for these services creates a barrier to service, see **Special Circumstances** (page 6) for Hardship Case criteria.

E. REQUESTS FOR INFORMATION (FRAUD)

At no time is information about a client and/or client record(s) to be given out to any non-Public Health Division employees without signed written authorization from the client. The Confidentiality of the client is to be observed both in the office setting and on the telephone. If someone requests information or copies of records, inform them that they need to submit a letter for any information along with a signed release from the client authorizing the release of the requested information to the person, organization or facility seeking the information. The letter must include the client's full name, current full address, telephone number, social security number and a statement of why copies of the records need to be obtained. The letter must be submitted to the local health office to the attention of the nurse manager. If the nurse manager declines to send the information or has any questions regarding the adequacy of the release, the nurse manager should contact the Department's Office of General Counsel (827-2993) for assistance.

F. INPHORM FEE COLLECTION

The Family Planning Program has evaluated its current Protocols regarding patient accounts billing and has determined the following practices will be applied by Family Planning Billing Clerks upon completion of INPHORM System Training. (See the INPHORM Training Bulletin # 2005-01.)

All Family Planning payment information is entered into the Patient Accounts module. All procedures that are entered through the Encounter Module, Procedure Details Tab with a charge associated with them will be brought forward to the Patient Accounts screen by the INPHORM system.

NOTE: Do **NOT** try to correct a transaction or try to reverse the entry. Should an error occur, contact the Help Desk at 1-800-1618 or 476-8526. Remember to enter the Call Ticket number on the McBee card for the percent pay clients for documentation.

PAYMENT TRANSACTIONS

1. Simple Client Payment

(a) If the client has a charge associated with a procedure, access the Patient Accounts screen.

(b) Press the "Pay/Adj." button.

(c) Go to the "Select Transaction Type." **Always** select the "Spread Patient Payment" radio button.

***Note*: Spread Patient Payment ONLY posts to client (Payor 6) charges. The system posts payment to the oldest charge (including Beginning Balance) first. Once the oldest charge is paid, the system automatically rolls to the next oldest client charge with any remaining balance.**

(d) Enter the $ Amount of the payment in the "Amount Box." Choose cash or check in the "Type" box and press the "Post" button.

(e) **Close** the Payments/Adjustments box. The payment will record in the grid as a "Payment Spread."

2. Payment Exceeds Charges

(a) If a payment is greater than the total amount owed, the INPHORM system will display a pop-up window with a message stating, "Payment more than patient owes." The INPHORM system will

NOT allow the payment to be posted.

(b) Close the pop-up window.

(c) Close the "Payments/Adjustments" box.

(d) In the right hand corner locate the "Payor 6" display field and the balance for "Payor 6".

(e) Using the Amount from the Payor 6 balance field, repeat steps listed under **"Simple Client Payment**."

(f) Refer to the "**General Instructions for Adjusting Payments**" section to post the remaining amount. Use "**Adjustment Code 58 - Overpayment**" as the adjustment code.

If this procedure does not work and you continue to get an error message, call the Help Desk.

3. Client Prepayment Entry

(a) From the Patient Accounts screen, select the "Pay/Adj. Button.

(b) Go to "Select Transaction Type" and activate the "Patient Prepayment" button.

(c) Enter the $ Amount of the payment in the "Amount" box. Choose Check or Cash in the "Type" box and press the "Post" button.

(d) Close the Payments/Adjustments box. The payment will record as a "Prepayment."

4. Back Out Client Prepayment Entry

If a client has prepaid for services and then comes in to the Health Office and receives the services, you must back out the prepayment entry and post the payment as a simple payment.

(a) From the Patient Accounts screen, select the "Pay/Adj. Button.

(b) Go to "Select Transaction Type" and activate the "Patient Prepayment" button.

(c) Enter the NEGATIVE $ Amount (Example **-75.00**) of the payment in the "Amount" box. Choose Check or Cash in the "Type" box and press the "Post" button.

(d) Close the Payments/Adjustments box. The payment will record as a "Prepayment."

(e) After you back out the Prepayment, follow the Simple Client Payment steps to enter the payment.

If you have questions about Backing Out Client Prepayment or need help posting Client Prepayment Entries, call the Help Desk.

5. ADJUSTMENTS

Adjustment Codes:

- **Overpayment - Adjustment Code 58**
  Use to record overpayments (credit balances) from clients **already registered in the INPHORM system who have received services**. Records as an Overpayment. Affects the Payment and Balance fields in the Blue Grid.

- **Donations - Adjustment Code 83**

(a) Use to record donations from clients already registered in the INPHORM system. Remove the Check mark on Show Zero Balance. Enter a check mark on Show Payor [Pick] and Show Charges. This is a list of unpaid charges. The first line of charges will be highlighted in dark blue. See the amount in the Charge Balance, post a payment for that amount or is the donations is less post the donation amount give. To post donation, click on Pay Adjust, then Adjust charge, Code Adjustment enter 83. In the Transaction note type **"THIS IS A DONATION".** Enter the amount in the Amount box and press Post button. This must be done to each of the charges listed in this area if posting a large donation.

- **Bad Check Return - Adjustment Code 71**
  Used to reverse a client payment previously made when a check is returned for non-sufficient funds. Records as a Bad Check Return. Appears in the Adjustments field in the Blue Grid. Used along with Adjustment Code 96 - Bad Check Charge.

- **Credit Memo - Adjustment Code 83**
  Used to adjust charges for percent pay clients deemed a **hardship case**. Records as a Credit Memo. Appears in the Adjustments field in the Blue Grid. In the Transaction note type **"THIS IS A HARDSHIP".** Enter the amount in the Amount box and press Post button. This must be done to each of the charges listed in this area.

  Note: This is **ONLY** to be used for hardship cases. **DO NOT reduce the client's income**. This credit properly adjusts the charge so that the client does not pay for today's visit.

- **Bad Check Charge – Adjustment Code 96**
  Record amount of $25.00 for fee. Used to **record the fee charged to the client** for a returned (Non-Sufficient Funds) check. Records as a Bad Check Charge. Appears in the Adjustments field in the Blue Grid. Used with Adjustment Code 71 - Bad Check Return.

***Note*: These are the ONLY adjustment codes to be used in the local public health offices for the Family Planning Program.**

6. General Instructions for Adjusting Payments

(a) Access the Patient Accounts screen. Highlight the procedure to be adjusted or paid and select the Pay/Adj button.

(b) From the "Select Transaction Type, select the "**Adjust Charge**" radio button - an "**Adjustment Code**" box will appear in the lower right corner.

(c) Select the appropriate adjustment code.

(d) Enter the $ Amount in the "Amount" box. Select whether the payment is by cash or check in the "Type" box and press the "Post " button.

(e) Close the Payments/Adjustments box.

Returned Checks

(a) Access the Patient Accounts screen.

(b) Press the Pay/Adj button.

(c) From the "Select Transaction Type, select the "**Adjust Charge**" radio button - an "**Adjustment Code**" box appears in the lower right corner.

(d) Select "**71 Bad Check Return**" in the Adjustment Code box. Enter the $ amount of the returned check in the "Amount" box. Press the "Post " button **ONCE** (entry will not show until after Payments/Adjustments box is closed).

(e) Select "**96 Bad Check Charge**" in the Adjustment Code box.

(f) Enter $25.00 in the "Amount" box. Press the "Post " button.

(g) Close the Payments/Adjustments box.

Hardship Case

(a) Access the Patient Accounts screen. Check the Show Payor (Pick)-> checkbox and highlight the Payor 6 (Patient Pay) row.
(b) Highlight the first transaction row from the "hardship case" encounter and press the Pay/Adj button.
(c) From the "Select Transaction Type, select the "**Adjust Charge**" radio button - an "**Adjustment Code**" box will appear in the lower right corner.
(d) Select "**83 Credit Memo**" in the Adjustment Code box.
(e) In the transaction note type **"THIS IS A HARDSHIP".** Enter the **$** amount in the Amount box. Post button.
(f) Enter the $ Amount in the "Amount" box. Press the "Post " button.
(g) Close the Payments/Adjustments box.
(h) Repeat the steps until all the procedures from the "hardship case" encounter are posted.

Donations

(b) Access the Patient Accounts screen. In the summary area, highlight the procedure you would like to apply the donation to. The procedure must be **"Payor 6", Patient Pay**.
(c) Remove the check mark on Show Zero Balance and enter a check mark on Show Payor [Pick] and Show Charges.
(d) Highlight the first charge and look at the amount.
(e) Click on **Pay Adjust** button.
(f) From the select transaction type box, click on the **adjust charge** button – an **Adjustment code box** will appear to the right of this button - select **83 Credit memo**.
(g) In the transaction note type **"THIS IS A DONATION".** Enter the **$** amount in the Amount box. Post button.
(h) Close the payments/adjustment box.

CORRECTIONS

Medicaid/SALUD Client Deemed No Longer Eligible

For clients who are listed as Medicaid eligible in the INPHORM system, then later determined to have been not eligible, the correction is as follows:

Registration - Financial:

(a) Go to the Financial Information summary screen and select the Third Party option. Double-click the row of the Third Party entry that need to be changed.
(b) Enter the End Date for Medicaid eligibility and save and close the record.

Encounters:

(a) Search for the correct encounter (Search – List Encounters – Double-click on correct encounter).
(b) Select the "Procedure Details" tab. Highlight the procedure that needs to be corrected.
(c) Change the Payor field entry to "Patient Pay."
(d) Save the record.
(e) This process needs to be done for EACH procedure detail. The Patient Account automatically reflects the transfer from a Medicaid responsibility to a client responsibility.

7. SPECIAL CIRCUMSTANCES REGARDING NORPLANT REMOVAL CERTIFICATES

Client with a Norplant Removal Certificate

(a) Create a new financial record under Registration – Financial Information - Third Party radio button.

(b) On the Payor Info tab, choose "Other Payor" for Payor Class field and "Norplant Foundation" for Insurance field

(c) Make sure both the Beginning and End Effective Dates from the certificate are entered.

(d) Save the record and create an encounter for the date of service.

(e) Ensure that Payor Class and Insurance on the Encounter, Procedure Details tab also have "Other Payor" and Norplant Foundation" displayed.

(f) In the Procedure field, select the new **CPT Code 11976NC**. This is the code to be used for Norplant Removal with a certificate.

(g) Complete the rest of the required fields and save the record.

Norplant Payment

(a) Access the Patient Account Screen. Highlight the "Payor Z7" line in the Blue Grid in the upper right hand corner of the screen.

(b) In the Light-colored grid highlight the correct Norplant Procedure.

(c) Hit the "Pay/Adj." Button. From the "Select Transaction Type," select the "Pay Specific Charge" radio button. The Selected Payor field should display "Z7."

(d) Enter the $ Amount in the "Amount" box.

(e) Insert the Check # in the "Check/Card #" box, select "Check" under the "Type" box, and press the "Post" button.

Close the "Payments/Adjustments" box. The payment will record as a "Simple Payment." **NOTE: If the amount posted pays the procedure in full, it will NOT show in the light-colored grid UNLESS the Show Zero Balance checkbox is marked**.

For further INPHORM Questions, please refer to the INPHORM User Manual and/or contact the Help Desk at (800) 280-1618 .

EXHIBIT 9 Billing Letter English #1 (Example)

(Print on letterhead)

Date:_____

_____
_____
_____

Dear _____:

According to our records, your account is _____ month(s) past due. Please remit payment or contact our office to make other payment arrangements. Your current balance as of _____ is $_____ for services you have received. Call (505)_____ if have any questions. Thank you for your attention to this matter.

Your balance is: $_____
Overdue since: _____
DOB: _____
Account #: _____

If paying by check or money order, please make it out to:

Mail to: **Family Planning Title X**
Your health office name
Your office address
Your city, state & zip code
Attention: Family Planning Clerk

Sincerely,

(Your Local Health Office) Staff

EXHIBIT 9 Billing Letter Spanish #1 (Example)

(Print on letterhead)

Fecha:_____

_____
_____
_____

Estimado Paciente: _____:

Según nuestros registros, su cuenta es ____mes(s) vencido. Remita por favor el pago o avise nuestra oficina para hacer otros arreglos del pago, Su equilibrio según ____ es $_____ para los servicios que usted ha recibido. Llama (505) _____ si usted tiene cualquiera pregunta. Gracias para su atención a esta cuestión.

Su equilibrio es: $_____
Atrasado desde que: _____
Fecha de nacimiento: _____
Numero de Referencia: _____

Si paga por cheque o giro postal, por favor haga lo a:

Envia el pago a: **Family Planning Title X**
Your health office name
Your office address
Your city, state & zip code
Atención: Family Planning Clerk

Sinceramente,

Oficina de Salud Publica

MEDICAID APPLICATION FOR WOMEN, CHILDREN, AND FAMILIES

INFORMATION FOR THE APPLICANT

Please complete all the spaces on the application about you and your household members. If more space is needed to answer any of the questions on this application, you may use another sheet. Return the application to the local Income Support Division (ISD) office or to the person who is determining your temporary Medicaid eligibility.

This is an application for the four Medicaid programs listed below. There are other Medicaid programs that require an application different from this one.

To qualify for Medicaid, your household must meet certain guidelines. You may be eligible for benefits for up to three months before your application date. You may ask about these guidelines by contacting the ISD office, or by calling toll free 1-888-997-2583.

- **JUL MEDICAID** provides Medicaid to parents or caretaker relatives with dependent children under age 19, even if the household does not qualify for cash assistance, or does not wish to apply for cash assistance. Medicaid is totally separate from cash assistance, and **receiving Medicaid benefits will not count toward the cash assistance time limit.**

- **MEDICAID FOR CHILDREN** provides coverage for children under age 19. Some children may be eligible under the State Children's Health Insurance Program (SCHIP). SCHIP children have small co-payment requirements. Native American children who are eligible for SCHIP do not make co-payments.

- **MEDICAID FOR PREGNANCY-RELATED SERVICES ONLY** covers only those services that are related to the pregnancy. Coverage for these services are provided for up to two months after the month in which the child is born or the pregnancy ends.

- **MEDICAID FOR FAMILY PLANNING SERVICES** covers only those services that are related to family planning for women of child-bearing age.

You need to provide proof of the following:

- Income for the past four weeks.
- Social Security Number (SSN), or proof of application for SSN.
- Children's ages.
- Other health insurance, if any.
- Pregnancy due date.

If you need help filling in this application or in getting the needed information, contact your local ISD office.

After your application is received, all documents will be reviewed. If the documents are incomplete, you will be asked to provide the needed information. A decision on your application will be made within 45 days, unless you ask for more time to get information. You will be sent a letter about your application.

APPLICANT: Please keep this sheet for your records.

If you are a person with a disability and you require this information in an alternative format or require a special accommodation to participate in any public hearing, program or services, please contact the NM Human Services Department toll-free at 1-800-432-6217, or TDD 1-800-609-4TDD or through the New Mexico Relay System TDD at 1-800-659-8331. The Department requests at least 10 days advance notice to provide requested alternative formats and special accommodations. (4/23/01)

MAD 023 Revised 9/27/02 *(replaces MAD 049)*

MY RIGHTS AND RESPONSIBILITIES
Read carefully before completing the application.

BY SIGNING THIS APPLICATION, I AGREE TO THE FOLLOWING:

- **To provide all information and proof needed to determine eligibility.**
- **To provide a Social Security Number for every household member who is applying for benefits.**
- **To permit the Human Services Department (HSD) to contact persons or agencies to verify needed information if I am not able to provide the information.**
- **To allow all information I give to HSD to be matched by computer with other federal, state, and local agencies.**

HSD will use the information I give to decide on my eligibility, so the information must be as correct as possible.

If the information I report is false, incorrect, or incomplete, my benefits may be denied or ended.

- **If I knowingly give false, incorrect or incomplete information, I may be prosecuted for that crime.**
- **I understand that I must pay back any benefits I am not eligible to receive.**

FAIR HEARING RIGHTS - I understand I may request a fair hearing, either by telephone, in person, or in writing, within 90 days of the date the decision was made on my case. I may have another person represent me. I understand that if I do not agree with any decision made on any matter concerning my case, I have the right to look at my case record and other documents used to decide my case before the hearing.

CONFIDENTIALITY - All information I give to HSD is confidential. This information will be given to HSD employees who need it to manage the programs for which I have applied. Confidential information may also be released to other agencies managing federal or federally funded programs. All information will be used to determine eligibility and/or to provide services.

RESPONSIBILITY TO REPORT CHANGES - The information I give during the application process is used to determine eligibility. It is my responsibility to report changes within ten (10) days of the date of the change or as otherwise required. This includes changes in address, income, resources, health insurance, and persons living with me.

ASSIGNMENT OF RIGHTS TO PAYMENT - I understand that by getting Medicaid benefits for myself and/or other persons, I automatically give HSD all rights to medical support and to payment for medical care from a third party. A third party can include an absent parent, an insurance company, or another person who must pay for medical care and services.
I understand that I must help HSD:

- Identify the father of a child who gets Medicaid and who was born outside of marriage, and
- Identify any third parties who may have to pay for medical care and services.

I understand that if I do not help HSD, I may not get Medicaid benefits or may lose my benefits, unless I can show a good reason for not helping HSD.

RELEASE OF MEDICAL INFORMATION - By signing this application, I allow HSD to examine medical records needed for eligibility decisions and/or for payment of benefits.

CIVIL RIGHTS STATEMENT - All programs administered by HSD are equal opportunity programs. It is unlawful for HSD to discriminate against an applicant for or recipient of any program due to race, color, national origin, sex, age, religion, political beliefs, or disability. Complaints of discrimination may be filed with the New Mexico Human Services Department central office, the local Income Support Division County office, the U.S. Department of Health and Human Services, the U.S. Department of Justice, or the Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (202) 720-5964 (voice and TDD).

☐ PE/MOSAA

AGENCY USE ONLY					
Status ☐ Application ☐ Redetermination	Former Recipient ☐ Yes ☐ No	Cat.	Application Date	Date Mailed	Date Received
ISD Worker Number		Appointment Date			Time

HEAD OF THE HOUSEHOLD

NAME - *Last* *First* *Middle*	Home Telephone or Message Number
STREET ADDRESS - *Number / Street or Road / P.O. Box Number*	Work Telephone Number
City State	Zip Code
MAILING ADDRESS - (if it is different from your home address)	
City State	Zip Code

Have you ever used another name? ☐ Yes ☐ No If Yes, list other name(s) and date(s) they were used:

1. 2. 3.

HOUSEHOLD MEMBERS - List all children and other people living in the home. Answer all the questions for everyone listed.

NAME	Social Security Number*	Race	Sex M/F	Date of Birth Mo.	Day	Yr.	Relationship	U. S. Citizen* Yes	No	Legal Alien* Yes	No	Date of Entry Into U.S.*
							SELF					

***This information is required only for those who are applying for Medicaid.**

MEDICAL NEEDS

Is anyone in the household pregnant? ☐ Yes ☐ No If Yes, who? _____
Due Date: _____

Has anyone in the household received medical services within the last three (3) months which have not been paid?
☐ Yes ☐ No If Yes, Who has the unpaid bills and for which months? _____

HEALTH INSURANCE

Does anyone in your household have health insurance? ☐ Yes ☐ No If Yes, list person(s) below.
(MAD 009 must be completed)

1. 2. 3.

Has insurance for a child or children been dropped within the last six months? ☐ Yes ☐ No

Yes, provide name(s) of child or children and date(s) the insurance was dropped:

1. 2. 3.

Explain why insurance was dropped: _____

INCOME – List all money received by people in your household. This includes: money from job training or work, self-employment, government benefits (SSA, VA, etc.), alimony, royalties, pensions, trusts, investments, property income, child support, unemployment, and any other earned or unearned money from any source.

Name of Person Receiving Money	Name of Employer, Person, or Agency Providing the Money	How Often is the Money Received?	Total Amount (before deductions)

DEPENDENT CARE

Do you pay anyone to care for a child or other household member, so you can work or train for a job? ☐ Yes ☐ No
Who is being cared for?

1. 2. 3.

Who Provides the Care?	Amount Paid	How Often is the Amount Paid?

COMPLETE THIS SECTION ALSO IF YOU ARE APPLYING FOR PRESUMPTIVE ELIGIBILITY.

Are you or your child(ren) receiving Medicaid now? ☐ Yes ☐ No
If Yes, tell the agency or doctor you or your child(ren) already have Medicaid and show your Medicaid card.

If you or a household member are pregnant, has presumptive eligibility been granted for this pregnancy? ☐ Yes ☐ No
If Yes, you are not eligible for presumptive eligibility for the remainder of this pregnancy.

Has your child(ren) received presumptive eligibility within the last six months? ☐ Yes ☐ No
If Yes, your child(ren) is not eligible for presumptive eligibility.

I have read all of the information in this application, or it has been read to me. This application is only for Medicaid.
I swear under penalty of law that the information I have given in this application is true, complete and correct to the best of my knowledge.
I give my permission to HSD to contact persons or agencies to obtain needed information about me.
I have been given my Medicaid rights and responsibilities.

_____ _____
Applicant's Signature Date

_____ _____
Signature of Person Who Helped Complete the Application *Witness (if applicant signed with an X)*

SOLICITUD DE *MEDICAID* PARA MUJERES, NIÑOS Y FAMILIAS

INFORMACIÓN PARA LA PERSONA QUE SOLICITA - favor de rellenar todos los espacios en blanco en la solicitud respecto a Ud. y las personas que viven en su hogar. Si necesita más espacio para responder a cualquiera de las preguntas, use una hoja de papel. Devuelva la solicitud a la Oficina Local de Asistencia Económica (*Income Support Division*) (*ISD*) o a la persona que está a cargo de determinar si Ud. tiene derecho de recibir los beneficios temporales de *Medicaid*.

Esta es una solicitud para los cuatro programas de Medicaid indicados en la lista más abajo. Hay otros programas de *Medicaid* que requieren una solicitud distinta que no sea ésta.

Para que Ud. califique para recibir los beneficios de *Medicaid*, las personas que viven con Ud. en su hogar tienen que satisfacer ciertos requisitos que constan en las directivas. Ud. puede indagar acerca de esas directrices comunicándose con la oficina *ISD* o llame gratis al número 1-888-997-2583.

- ***JUL MEDICAID*** provee los beneficios de *Medicaid* a padres, madres o parientes que tienen niños menores de 19 años que dependen en alguna persona para que los sostenga, aún si la familia no califica para recibir asistencia en efectivo o no desea solicitar asistencia en efectivo. El programa de *Medicaid* está totalmente separado de la asistencia en efectivo, y los beneficios de *Medicaid* que la persona recibe no cuentan en el límite de tiempo de la asistancia que la persona recibe en efectivo.

- ***MEDICAID* PARA NIÑOS** facilita cobertura para los menores de 19 años. Algunos niños podrán tener derecho de recibir los beneficios conforme al Programa de Seguro de Salud para Niños (*State Children's Health Insurance Program (SCHIP)*. Los niños que tienen el programa *SCHIP* tienen que satisfacer los co-pagos mínimos. Niños Nativo Americanos que reúnen los requisitos para la cobertura *SCHIP* no pagan los co-pagos.

- ***MEDICAID* SÓLO PARA SERVICIOS RELACIONADOS CON EL EMBARAZO** cubre únicamente los servicios relacionados con el embarazo. Este programa cubre estos servicios hasta por dos meses después del mes en que la madre da a luz o cuando termina el embarazo.

- ***MEDICAID* PARA SERVICIOS DE PLANIFICACIÓN FAMILIAR** cubre únicamente los servicios relacionados con la planificación familiar para mujeres de edad en que pueden dar a luz.

Ud. tiene que proveer las siguientes pruebas:

- Sus ingresos durante las últimas cuatro semanas.
- El Número de su Seguro Social (NSS) o prueba que Ud. ha solicitado su número de seguro social.
- Las edades de sus niños.
- Otro seguro de salud que Ud. tenga, si tiene otro seguro de salud.
- La fecha que Ud. va a dar a luz.

Si Ud. necesita ayuda para rellenar esta solicitud o para obtener la información que Ud. necesita, comuníquese con la oficina de *ISD*.

Después de que recibamos su solicitud, reexaminaremos todos los documentos. Si los documentos no están completos, le pediremos que nos facilite la información necesaria. La decisión con base en su solicitud se tomará dentro de 45 días, salvo que Ud. pida más tiempo para obtener información. Le enviaremos carta tocante a su solicitud.

SOLICITANTE: Favor de guardar esta hoja para su expediente.

Si Ud. es una persona que tiene discapacidad y Ud. requiere esta información en un formato alternativo o requiere un acomodación especial para poder participar en cualquier audiencia pública, programa o servicio, comuníquese con el personal del Departamento de Servicios Humanos de NM gratis y llame al número 1-800-432-6217, o al 1-800-609-4TDDD, o a través del sistema de relais de Nuevo México TDD en 1-800-659-8331. El departamento solicita la comunicación previa por lo menos 10 días por anticipado para poder proporcionar los formatos alternativos a y acomodaciónes especiales que Ud. solicite. (10/2/02)

MADSP 048 Reexaminado 10/3/02 *(Replaces MAD 049 & MAD 050) (SEE: MAD 023 English)*

MIS DERECHOS Y OBLIGACIONES
Lea cuidadosamente antes de completar esta solicitud.

AL FIRMAR ESTA SOLICITUD, YO ME OBLIGO A LO SIGUIENTE:

- Proveer toda la información y las pruebas necesarias para determinar si tengo derecho a los beneficios.
- Proveer el número del Seguro Social para todas las personas que viven conmigo en mi hogar que solicitan los beneficios.
- Permitir que el Departamento de Servicios Humanos (*HSD*) se comunique con personas o agencias con el fin de verificar la información necesaria si yo no puedo proveer la información.
- Permitir que toda la información que yo le provea al *HSD* se compare mediante computadora con la de otras agencias federales, estatales o locales.

El personal del *HSD* utilizará la información que yo facilito para tomar la decisión si yo tengo derecho de recibir los beneficios, así es que la información debe ser la más correcta posible.

Si la información que yo facilite es falsa, incorrecta o incompleta, me pueden negar o terminar los beneficios.

- Si yo, con conocimiento e intencionalmenta facilito información falsa, incorrecta o incompleta, me pueden enjuiciar por motivo de ese delito.
- Entiendo que yo tengo la obligación de reembolsar la suma de todos los beneficios que yo no tenga derecho de recibir.

DERECHOS DE AUDIENCIA IMPARCIAL - Entiendo que yo puedo solicitar una audiencia imparcial, ya sea por teléfono, en persona o por escrito dentro de 90 días a partir de la fecha en que se expida la decisión en mi caso. Puedo nombrar a otra persona que me represente. Entiendo que si no estoy de acuerdo con cualquiera decisión tomada en cualquier asunto concerniente a mi caso, antes de la audiencia tengo el derecho de examinar el expediente de mi caso y otros documentos que se hayan utilizado para decidir mi caso.

INFORMACIÓN CONFIDENCIAL - Toda la información que yo facilite al *HSD* es confidencial. El *HSD* facilitará dicha información a los empleados del *HSD* que la necesiten para administrar los beneficios de los programas que yo he solicitado. Se podrá remitir la información confidencial a otras agencias que administran programas federales o programas financiados con fondos federales. Se utilizará toda la información con el fin de determinar si tengo derecho de recibir los beneficios que yo he solicitado y/o para que faciliten los servicios.

OBLIGACIÓN DE REPORTAR CAMBIOS - La información que yo facilito durante el tramite de la solicitud se usa para determinar si tengo derecho de recibir los beneficios. Dentro de diez (10) días a partir la fecha del cambio o según se requiera tengo la obligación de reportar cambios. Lo anterior engloba cambios de dirección, ingresos, recursos, seguro de salud, y de personas que viven conmigo en mi hogar.

CESIÓN DEL DERECHO DE PAGO - Entiendo que si recibo los beneficios de *Medicaid* para mí y/o para otras personas, automáticamente yo le cedo al *HSD* todos mis derechos de recibir apoyo médico y la suma para pagar la atención médica. Un tercero podrá incluir a un padre o madre ausente, a una compañía de seguro, o a otra persona que deberá pagar la atención médica y los servicios. Entiendo que tengo que ayudarle al *HSD* a:

- Identificar al padre del niño que reciba la cobertura de *Medicaid* y que nació sin que el padre haya estado casado con la madre del niño, y a
- Identificar a todos los terceros que tengan que pagar la atención médica y los servicios.

Entiendo que si no le ayudó al *HSD*, es posible que no reciba los beneficios de *Medicaid* o posiblemente pierda mis beneficios, salvo que yo indique porque no puedo ayudarle al *HSD*.

EMISIÓN DE INFORMACIÓN MÉDICA - Al firmar esta solicitud, le doy permiso al *HSD* que examine las hojas clínicas y expedientes médicos que sean necesarios para tomar decisiones sobre mis derechos y/o los pagos de beneficios.

DECLARACIÓN DE DERECHOS CIVILES - Todos los programas que administra el Departamento de Servicios Humanos (*HSD*) son programas en los que se observa la igualdad de oportunidades. Es ilícito que *HSD* discrimine en contra de la persona que solicita los beneficios de cualquiera de los programas debido a raza, color, origen nacional, sexo, edad, religión, creencias políticas, o discapacidad. Las quejas de discriminación se pueden presentar en la oficina principal del Departamento de Servicios Humanos, la oficina local de Asistencia Económica, en el Departamento de Servicios Humanos y Salud de los Estados Unidos, el Departamento de Justicia de los Estados Unidos o en la Oficina de Derechos Civiles, Sala 326W, Edific. Whitten, 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410 o favor de llamar al (202) 720-5964 (voz y TDD).

(4/30/02)

☐ PE/MOSAA

AGENCY USE ONLY

Status ☐ Application ☐ Redetermination	Former Recipient ☐ Yes ☐ No	Cat.		Application Date	Date Mailed	Date Received
ISD Worker		Appointment Date			Time	

CABEZA DE LA FAMILIA

Apellido	Primer Nombre	Segundo Nombre	Número de Teléfono Donde Trabaja
CALLE - *Número/Calle o Camino/Casilla de Correo*			Teléfono en Su Casa o para Mensajes
Ciudad	Estado		Zona Postal
Dirección Postal (Si es distinta a la de su casa)			
Ciudad	Estado		Zona Postal

¿Ha usado Ud. otro nombre? ☐ Sí ☐ No Si contesta Sí, escriba el otro nombre(s) y fecha(s) cuando lo(s) usó:
1. 2. 3.

FAMILIARES - Escriba el nombre de todos los niños y otras personas que viven con Ud. en su casa. Conteste por parte de todas las personas en la lista.

NOMBRE	Número de Seguro Social	Raza	Sexo H/M	Fecha de Nacimiento			Paren-tesco/ Rel.	Ciud. de Extr. E.U.* Legal				Fecha Que Entró a los E.U.*
				Mes	Fecha	Año		Sí	No	Sí	No	
							USTED					

***Se requiere esta información de los que solicitan *Medicaid*.**

NECESIDADES MÉDICAS

¿Hay mujer embarazada en su hogar? ☐ Sí ☐ No Si contesta Sí, ¿quién? _____
Fecha de espera de nacimiento: _____

¿Dentro de los últimos 3 meses alguna de las persona(s) que vive en su hogar ha recibido servicios médicos que no se han pagado? ☐ Sí ☐ No Si contesta Sí, ¿Quién tiene cuenta sin pagar y por qué meses? _____

SEGURO DE SALUD

¿Alguna persona(s) que vive con Ud. en su hogar tiene seguro de salud? ☐ Sí ☐ No Si contesta Sí, indique quienes más abajo. *(MAD 009 must be completed)*

1. 2. 3.

¿Se ha cancelado la cobertura de seguro para un niño o niños dentro de los últimos seis meses? ☐ Sí ☐ No
Si Ud. contesta Sí, favor de indicar el nombre del niño o de los niños y la fecha que se canceló el seguro:

1. 2. 3.

Explique por qué se canceló el seguro: _____

INGRESOS - **Indique más abajo la cantidad de dinero que reciben las personas que viven en su hogar con Ud. Incluya el dinero que reciben del entrenamiento para trabajar o de su trabajo, auto empleo, prestaciones del gobierno, (SSA, VA, etc.), pensión alimenticia, regalías, pensiones, fideicomisos, inversiones, ingresos de propiedades, sostenimiento de los niños, desempleo, y toda otra cantidad de dinero devengado o no devengado.**

Nombre de la Persona que Recibe el Dinero	Nombre del Empleador, Persona o Agencia que Provee el Dinero	¿Cada Cuánto Tiempo lo Recibe?	Total (sin deducciones)

CUIDADO DE CARGAS FAMILIARES

¿Paga Ud. a alguna persona para que cuide a un niño suyo o familiar, para que Ud. trabaje o se entrene para trabajar?
☐ Sí ☐ No ¿A quién cuida?

1. 2. 3.

¿Quién Facilita El Cuidado?	Suma de Dinero Que Paga	¿Cada Cuánto Tiempo Paga?

LLENE ESTA SECCIÓN SI ESTA ES SOLICITUD DE CALIFICACIÓN PRESUNTA. *(Presumptive Eligibility)*

¿Ud. o su(s) niño(s) está(n) recibiendo beneficios de Medicaid? ☐ Sí ☐ No
Si contesta Sí, dígale a la agencia o al médico que ya Ud. o su(s) niño(s) recibe(n) *Medicaid* y muéstrele su tarjeta de *Medicaid*.

Si Ud. o una de las personas que vive en su hogar con Ud. está embarazada, le han concedido derechos de calificación presuntos por este embarazo? ☐ Sí ☐ No
Si contesta Sí, Ud. no tiene derechos presuntos por el resto del plazo de este embarazo.

¿Han recibido su(s) niño(s) derechos de calificación presunta *(presumptive eligibility)* dentro de los últimos seis meses?
☐ Sí ☐ No Si contesta Sí, su(s) niño(s) no tiene(n) derechos presuntos.

He leído toda la información que consta en esta solicitud o me la han leído. Esta solicitud es únicamente para recibir los beneficios de *Medicaid*. Juro bajo pena de ley que la información que he incluído en esta solicitud es cierta, completa y correcta a mi mejor saber y entender.
Otorgo permiso al *HSD* que se comunique con personas o agencias con el fin de obtener la información necesaria acerca de mí.
Me han informado cuáles son mis derechos y obligaciones con respecto a *Medicaid*.

_____ _____
Firma del Solicitante Fecha

_____ _____
Firma de la Persona que Ayudó a Rellener esta Solicitud Testigo (si el solicitante firmó con una X)

MEDICAL ASSISTANCE DIVISION

MEDICAID ON-SITE APPLICATION ASSISTANCE (MOSAA) NARRATIVE

Category(s) applied for: ☐ 035 Pregnancy Related ☐ 035F Family Planning Services ☐ 032 Children under age 19	Application Date
CASE NAME - *Last, First, Middle*	Interview Date
MAILING ADDRESS - *Street, No. / P.O. Box / R. Rte.*	
City / State / Zip Code	

HOUSEHOLD COMPOSITION: List **all** HH members, relationship, ages and verification information.

Name	Relationship	How Verified			
		Age	Date of Birth	Citizenship	Social Security Number

ABSENT PARENT INFORMATION: List any child(ren) above who has one or both parents living outside the household. List the absent parent and information regarding his/her whereabouts. Complete the AP section of Mad 009.

1.	2.	3.

INCOME: List HH member(s) who receive income, source of income, name of employer, and how verified.

Name of Person Receiving Income	Name of Employer, Person, or Agency Providing the Income	How Often is the Income Received?	Total Amount (before deductions)	How Verified?

DEPENDENT CARE: List name of child(ren), name of provider, and how verified.

1.	2.	3.
Who Provides the Care?	Amount Paid:	How Often is the Amount Paid?
Name of Caregiver:		
Address of Caregiver:	Phone Number of Caregiver:	How Verified?

RETROACTIVE MEDICAID: List individual(s) who need coverage and month(s) needed. Attach proof of income for every month(s).

1.	2.	3.
Month(s)	Month(s)	Month(s)

THIRD PARTY LIABILITY: List all HH members who have health insurance. Complete MAD 009 and attach a copy of both sides of the insurance card.

1.	2.	3.

MAD 071 Issued 6/4/01

VERIFICATION CHECKLIST:

- ☐ Pregnancy initialed on appl. or separate document
- ☐ NM residency (rent receipt, statement, etc.)
- ☐ Social Security cards if available
- ☐ Immigration cards or INS letters
- ☐ Age for children (birth certificate, baptismal, etc.)
- ☐ Income for the four (4) weeks prior to MOSAA interview
- ☐ Health insurance card
- ☐ Verification of dependent care if needed for deduction
- ☐ MAD 009 for absent parents or TPL
- ☐ ISD 160 - What You Still Need
- ☐ Rights and responsibilities explained
- ☐ Tot To Teen (EPSDT) explained
- ☐ Use of Medicaid card and SALUD! explained
- ☐ **PRESUMPTIVE FOR PRENATAL CARE APPROVED**
- ☐ **PRESUMPTIVE FOR CHILDREN APPROVED**

MOSAA Interviewer:	Telephone Number
Name and Address of MOSAA Agency	

FOR ISD USE ONLY

SCANS and INCONSISTENCIES: _____

DISPOSITION: Date processed, reason for denial, certification dates, retroactive coverage, etc.

ISD Worker	Date