Manual: **Moore County Health Department Administrative Policies & Procedures**	
Section: ***Clinical Fees and Eligibility Policy***	
Approval Date:	Signatures/Titles:

I. Policy: Fees for services at the Moore County Health Department (MCHD) are determined annually based on the cost of providing those services. Financial eligibility for MCHD services is determined individually by program. Fees are determined when services are rendered. We accept voluntary donations from clients; however, clients must not be pressured to make donations, and donations must not be a prerequisite to the provision of services or supplies. For all other donations refer to the Gift Acceptance Policy.

II. Purpose: Fees are a means to help distribute services to citizens of the county and help finance and extend public health resources as government funding cannot support the full cost of providing all requested services in addition to required services. Fees are considered appropriate, in the sense that while the entire population benefits from the availability of subsidized public health services for those in need, it is the actual users of such services who gain benefits for themselves.

Fees for Health Department services are authorized under North Carolina 130A-39 (g), provided that 1) they are in accordance with a plan recommended by the Health Director and approved by the Board of Health and the County Commissioners, and 2) they are not otherwise prohibited by law.

Monies generated through reimbursement will be deposited by the Moore County Finance Office and identified in program line items in the Health Department budget.

III. Definitions:

A. ***Fees***: payment for health services rendered
B. ***Services***: health-related work performed for patients
C. ***Minor***: any person who has not yet reached the age of 18 years

IV. Applicable Law, Rules and References:

A. NCGS § 130A-39 (g). Powers and duties of a local board of health

V. Responsible Person(s): All Moore County Health Department Billing and Management Support Staff

VI. Procedures:

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Moore County Health Department Clinical Fees and Eligibility Policy

A. Fee Setting

1. In accordance with G.S. 130-A-39(g), which allows local health departments to implement a fee for services rendered, the Moore County Health Department, with the approval of the Moore County Board of Health and the Moore County Commissioners will implement specific fees for services and seek reimbursement. Specific methods used in seeking reimbursement may include third-party coverage (Medicaid, Medicare, and/or private insurance) and individual patient payment. The agency will adhere to billing procedures as specified by Program/State regulations in seeking reimbursement for services provided.
2. The Clinical Management Team (along with clinical staff) will meet annually to set a schedule of personal health care service fees that is at least equal to Moore County Health Department's estimated total costs for services provided. Moore County Health Department will analyze the costs associated with providing the personal health care services offered, utilizing the Medicaid Cost Analysis and the Medicaid Cost Study. The Clinical Management Team (along with clinical staff) may consider rates from Medicaid, Medicare, surrounding community healthcare providers and health departments, and the *National Fee Analyzer*, and locally available clinical cost data when determining Moore County Health Department's fees for services.
3. The Clinical Management Team(along with clinical staff) will recommend the schedule of personal health care service fees annually to the Health Director, who reviews the recommendation, revises the schedule as necessary, and presents the recommended fee schedule to the Board of Health. The Board of Health then recommends a fee schedule to the Board of County Commissioners for their consideration. After approval by the Board of County Commissioners, fees will be set for personal health care services.

B. Financial Eligibility Guidelines

1. Information regarding a patient's income and family size will be documented at least annually.
2. Any requests from clients for waiver of charges are referred to the Moore County Board of Commissioners for review and consideration.
3. **Determining Gross Income**

   a. ***Computation of Income:*** Financial Eligibility will be determined by using the income for the day of service, regardless of how long the patient has been employed. For example: If the patient is employed as of the day of service, their income will be calculated on an annual basis. If they are making $200.00 weekly (gross income), this amount will be multiplied by 52 weeks. If the patient is unemployed as of the day of service, their income will be assessed at zero. The interviewer must make certain that there are no other sources of income that should be counted, as described below, taking into consideration that the patient cannot live on zero income. For instance: ask patient who provides food, clothing, shelter, and pays light, water and medical expenses.

   b. ***Gross income*** is the total of all cash income before deductions for income taxes, employee's social security taxes, insurance premiums, bonds, etc. For self-employed applicants (both farm and non-farm) this means net income after business expenses. Gross income does not include money earned by children for baby-sitting, lawn mowing, and other tasks. Supplemental Nutrition Assistance Program (SNAP) benefits will not be counted as income.

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In general gross income includes:

1. salaries, wages, commissions, fees, tips
2. overtime pay
3. earnings from self-employment
4. earnings from stocks, bonds, savings account interest, rentals, and other investment income
5. public assistance moneys
6. unemployment compensation
7. alimony and child support payments excluding Family Planning
8. military allotments including re-enlistment bonuses, jump pay, uniform allowance, and cash allowances such as Family Subsistence Supplemental Allowances (FSSA)
9. Social Security benefits
10. Veterans Administration benefits
11. Supplemental Security Income (SSI) benefits
12. retirement and pension payments
13. workers compensation
14. student grants/stipends paid to the student for living expenses
15. Christmas bonuses, prize winnings
16. regular contributions from individuals not living in the household
17. all other sources of cash income except those specifically excluded
18. lawn maintenance, as a business
19. housekeeping, as a business
20. Other sources of income, generated by those "in" or "outside" the home

Example: Patient may receive income from someone "outside" the home, meaning the patient does not live with the person providing support. The person providing support may pay the patient's electric and water bill, buy the patient's groceries, give the patient a home to stay in free of charge, pay for the patient's gas, make the patient's car payment, etc. If the outside person gives the patient money or pays for the patient's expenses these amounts should be considered income for the patient.

c. ***Exceptions:*** Gross income does not include non-cash income or payments/benefits from federal programs/acts including:

1. military housing benefits (on-post or off-post)
2. value of in-kind benefits
3. reimbursement from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
4. payments to volunteers under Title I (VISTA) and Title II (RSVP, foster grandparents, and others) of the Domestic Volunteer Service Act of 1973
5. payments under the Low Income Energy Assistance Act
6. student financial assistance received from any program funded in whole or part under Title IV

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7. value of any child care payments made under section 402(g) (1) (E) Social Security Act
8. value of any child care provider or paid for under the Child Care and Development Block Grant Act
9. the value of assistance to children or families under the National School Lunch Act, the Child Nutrition Act of 1966 and the Food Stamp Act of 1977

4. Determining Family Size

a. A ***family*** is defined as a group of related or non-related individuals who are living together as one economic unit. Individuals are considered members of a single family or economic unit when their production of income and consumption of goods are related. An economic unit must have its own source of income. Also, groups of individuals living in the same house with other individuals may be considered a separate economic unit if each group supports only their unit.

b. Examples:

(1) A pregnant woman is counted as two in determining a family size unless this conflicts with the patient's cultural and/or religious beliefs.

(2) A foster child assigned by DSS is a family of one with income considered to be paid to the foster parent for support of the child. A foster child cannot confer adjunct income eligibility on family members.

(3) A student maintaining a separate residence and receiving most of her/his support from her/his parents or guardians may be counted as a family of one, with income based on the financial support the student receives from her/his parents.

(4) An individual or family in an institution is considered a separate economic unit.

(5) Income determination for minors or other Family Planning patients who request confidential Family Planning services shall be calculated solely on the minor's or patient's income; consider the minor or patient a family unit of one.

5. Following the initial financial eligibility determination, the patient will be asked if there has been a change in their financial status at each subsequent visit.

6. Patient fees are assessed according to the rules and regulations of each program. The program's recommended Federal Poverty Level Guidelines will be used to assess fees. All third-party payers are billed where applicable; third-party bills will show total charges without any discounts unless there is a contracted reimbursement rate that must be billed per the third-party agreement.

7. Moore County Health Department has the right to require "proof of income" when determining eligibility for all programs, with the exception of Communicable Disease/Tuberculosis, State-purchased Immunizations, and Breast and Cervical Cancer Control Program (BCCCP). For BCCCP services, the patient's verbal declaration of income is accepted. For employed patients receiving Family Planning and Maternal Health services, MCHD will accept copies of pay stubs or a statement of wages earned signed by the employer. For self-employed patients, MCHD will accept income tax filing documents or the patient may complete a statement detailing their monthly income.

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8. The interviewer has the right to verify income information by asking questions and completing a Source of Income form. The patient will be asked to review the information recorded on the Source of Income form and to sign it.

9. In extreme and/or unusual circumstances, the Health Director or Designee, in consultation with staff, is authorized to circumvent the guidelines, subject to subsequent review by the Board of Health.

10. Identification – At the beginning of each clinic, each patient should establish identity either with a birth certificate, driver's license, military I.D., passport, visa, or green card, etc. If patient does not have anything to prove identity, a picture will be taken and placed in the patient chart.

No patient will be refused services when presenting for care based on lack of documentation, however each patient will be billed at 100% until proof of income and family size is provided to the agency. The patient will have fourteen (14) days to present this documentation in order to change the previous 100% charge to a sliding fee. If no documentation is produced in fourteen (14) days then the charge stands at 100% for that visit. EXCEPTION: BCCCP patients presenting for services without proof of income will be charged based on their verbal declaration of income for that visit.

C. Programs and Services

1. Adult Health/Other Services

a. Services provided include:

(1) Foreign Travel consultations
(2) College physicals
(3) Foster Care physicals
(4) Employment physicals
(5) Administrative TB Skin Tests/TB Screenings
(6) Pregnancy Tests not associated with a Family Planning visit

b. Since Moore County Health Department does not receive any State/Federal funding to support this programs, these services are based on flat rate fees.

c. **Exception**: Patients presenting for pregnancy tests will not be refused services for the inability to pay. Health Department staff will have the patient sign a payment agreement. If the patient receives Medicaid within the next month, billing staff will bill Medicaid for services rendered.

2. Breast and Cervical Cancer Control Program (BCCCP)

a. Services provided include:

(1) Pap smears
(2) Breast exams
(3) Screening mammograms
(4) Assistance for women with abnormal breast examinations/mammograms, or abnormal cervical screenings to obtain additional diagnostic examinations

b. Targeted group includes women 50-64 years of age; refer to BCCCP Program Policies and Procedures regarding eligibility.

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c. Financial eligibility for BCCCP services is based on 250% Federal Poverty Guidelines.

3. Communicable Disease Control

a. Deals with the investigation and follow-up of all reportable communicable diseases, which may include testing, treatment, and/or referral. Provides testing, diagnosis, treatment, and referral as appropriate, of a variety of sexually transmitted diseases. Provides follow-up and treatment of TB cases and their contacts.

b. Eligibility: Communicable Disease and TB services are provided for Moore County Residents. STD patients are served regardless of residency. Medicaid can be billed. There is no charge for Communicable Disease and TB Control services. Patients will be charged for the following STD services:

(1) asymptomatic patients who request screening for non-reportable STDs (e.g. herpes serology);

(2) patients who request testing not offered by the State. Where testing is conducted through LabCorp, the patient will be charged by MCHD for specimen collection, if the only specimen collected is for testing not offered by the State, and charged a fee for the LabCorp test, based on MCHD's fee schedule. Where the patient has Medicaid or third party insurance, the patient will be billed by MCHD for specimen collection, if the only specimen collected is for testing not offered by the State, and LabCorp will issue a separate bill for testing.

4. Women's Health Services

a. Services Include:

(1) Prenatal Care
(2) Natural Family Planning Counseling
(3) Birth Control Methods
(4) Abstinence Counseling
(5) Physical Examination
(6) Pap Smear
(7) Clinical Breast Exam
(8) Pregnancy Test
(9) Domestic violence/Substance abuse counseling
(10) HIV/STD counseling
(11) Case Management

b. Appointments are required. Sliding fee scale based on 250% Federal Poverty Guidelines. Medicaid or insurance are billed where appropriate.

c. Clinics are to assist women in planning their childbearing schedule; detailed history, lab work, physical exam, counseling and education are given by appropriate provider.

d. The following shall apply to Family Planning patients:

(1) Family Planning (Title X) patients who present for services will be assigned to the sliding fee scale for services and supplies based on information shared verbally regarding income and sources.

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(2) Proof of income will be required. No patient will be refused services when presenting for care based on lack of documentation, however each patient will be billed at 100% until proof of income and family size is provided to the agency. The patient will have fourteen (14) days to present this documentation in order to change the previous 100% charge to a sliding fee. If no documentation is produced in fourteen (14) days then the charge stands at 100% for that visit.

(3) Clients whose documented income is at or below 100% of the Federal Poverty Guidelines must not be charged for services, though third parties may be billed.

(4) The sliding fee scale (SFS) is not applied to co-pays when billing private insurance. Medicaid copays are not charged. Clients below 250% Federal Poverty Level should not pay more in co-payments than they would pay when the SFS is applied.

(5) A Family Planning patient with a past due account of any amount will never be required to meet with the Health Director as an attempt to collect the past due amount.

(6) A Family Planning patient will never be refused a service due to an outstanding balance and clients are not subject to a variation in services due to ability to pay.

(7) All Family Planning patients will be given a receipt upon exit of the clinic reflecting their percentage of pay, balance and any adjustments made to their account.

(8) No minimum fee requirement or surcharge/flat fee is indiscriminately applied to all Family Planning patients.

(9) Where reimbursement is available from Title XIX of the Social Security Act (Medicaid), a written agreement with the Title XIX state agency exists at the state level.

(10) Eligibility: For women of childbearing age regardless of residency.

e. Maternal Health patients must be Moore County residents.

f. Federal Drug Pricing 340B Guidelines: Family Planning and post-partum patients subject to sliding fee scale will be charged a sliding fee for dispensed medications or devices purchased through the 340B plan. Medicaid patients will be given prescriptions for oral contraceptive pills (OCPs), Nuva rings, Ortho Evra patches, Plan B, and Ella. Medicaid will be billed according to current Division of Medicaid Assistance guidelines for Depo Provera, Intra Uterine Devices (IUDs), and Nexplanon administered to Medicaid Family Planning and post-partum patients.

5. Immunizations

a. Services Include:

(1) Primary/Booster Immunizations for Infants, Toddlers, and Children to 18 years

(2) Primary Immunizations for Adults

(3) Booster Immunizations for Adults

(4) Foreign Travel for all ages

(5) Pre-exposure Rabies Vaccine

b. Appointments are required for all Foreign Travel immunizations. Other immunizations may be offered on a walk-in basis.

c. Consult state guidelines regarding North Carolina Immunization Program (NCIP) vaccine fees for state-supplied vaccine.

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d. There is no residency requirement for any Childhood Immunization according to program rules and regulations. There is also no charge to patients for any vaccine that is purchased by the State.

e. If a patient has any form of third-party reimbursement, that payer may be billed, unless confidentiality is a barrier. Medicaid will be billed as the payer of last resort.

D. Fee Collection

1. Upon each visit, billing staff will determine the income and sliding fee status of each patient. Staff will be responsible for documentation of financial eligibility on the "Source of Income Form". Patients without required verification will be expected to pay full charge until income documentation is received, with the exception of patients in the Family Planning and BCCCP clinics.
2. All patient encounters will be initialed and checked by the Nurse, Nurse Practitioner, Physician or Lab Technician that provides services received on that day. This identifies the correct CPT Codes for billing staff. The CPT Code and number of units must be documented on the encounter sheet.
3. Fees will be calculated when services are rendered. If a patient is unable to pay their account balance in full at the time services are rendered, billing staff will have the patient sign a payment agreement. An itemized receipt will be provided to individuals who pay, and an itemized bill will be sent to individuals who do not complete payment. Enrollment under Title XIX (Medicaid) shall be presumed to constitute full payment for the service.
4. Private pay patients will be encouraged to pay at least a portion of the fee when services are rendered. Statements will be mailed monthly, where confidentiality is not jeopardized.
5. No letters or correspondence concerning outstanding charges, insurance, past due accounts, etc. will be sent to any patient who requests that their services be confidential.
   (a) Discussion of payment of outstanding debts shall occur at the time service is rendered.
   (b) If the patient is unable to pay in full at the time services are rendered, a receipt will be issued for partial payment, and the client will sign a payment agreement.
   (c) NO MAIL is keyed in the address field of the patient's electronic registration screen to ensure monthly bills are not sent by mistake.
   (e) Patients are reminded at each visit of the amount they still owe.
6. A computerized accounts receivable system will be used, which reflects the charge, adjustment, balance and amount collected. The accounts receivable system will be balanced on a daily basis.
7. At the end of the fiscal year, outstanding accounts having no activity in more than 12 months shall be evaluated and written off as bad debts (see Bad Debt Write Off Procedures) or submitted to the North Carolina Debt Setoff Program (see Debt Setoff Program Procedures).
8. Moore County Health Department provides services to all individuals without regard to religion, race, creed, national origin, handicapping condition, age, gender, number of pregnancies or marital status.
9. All staff members involved in fee collection services shall consistently follow the guidelines for fee collection established in this document, and shall hold all patients' information confidential.

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E. Rules and Regulations for Handling Cash

1. Daily Cashiering Operations

a. Each employee responsible for handling cash on a recurring basis will maintain an individual drawer or lockbox for which they are solely responsible. Two cash drawers will be maintained within the Moore County Health Department.

(1) Each cash drawer is locked throughout the day. The cash drawer will be unlocked when payments are accepted.

(2) Cash in the amount of $100 will be maintained and secured at all times in the assigned cash drawer by billing staff.

b. Upon receipt of a cash payment consisting of a $20 or larger denomination paper bill, staff will check the bill(s) for validity using available technology.

(1) If the bill is valid, proceed with the transaction.

(2) If the bill cannot be validated, discretely walk away with the bill to a phone and call the Sheriff's Department to notify them. Do not accuse the patient of anything; it is possible that the patient has no idea that the bill is counterfeit. You may explain to the patient that you have received a bill that is "suspect," and you need to have it checked by the Sheriff's Department. The Sheriff's Department will send someone over to collect the bill and talk to the patient. If the patient will not stay, be sure to record the patient's name so that the Sheriff's Department can interview them. Do not write a receipt or credit the patient's account until the situation is resolved.

c. During the cashiers' hours of operation, the following procedures will be observed to monitor the cash drawer.

(1) All cash and coins must be locked in the cash drawer, safe, or other secure location when not in use.

(2) The cash drawers must remain locked at all times, unless handling a payment transaction. Never leave the cash drawer unlocked when unattended.

(3) Never let anyone handle the drawer, unless under the direct supervision of the cashier responsible for the drawer.

(4) The cash drawer is never to be used for the purpose of cashing personal checks or providing temporary loans for the benefit of the cashier or other individuals.

(5) The cash operation in which each cashier works must have a permanent collection record.

(6) The deposit is done daily by a Processing Assistant or the Billing Supervisor who does not collect cash. Three separate forms are used in order to confirm the cash drawer balance: (1) Individual Cash/Checks and Credit Card Payments; (2) Cash and Checks Deposit Sheet; (3) Credit Card Deposit Sheet. (See attachments.) Once all three forms are completed they are placed in a locked safe with the deposit received. The following morning, an Administrative Assistant will open the safe and take the deposit sheets and enter the deposit information in the County Finance System. The Cash Receipts Batch Report and the Credit Card Receipts Batch Report are printed. Two copies of the Cash Receipts Batch Report and two copies of the Credit Card Receipts Batch Report are printed and taken to County Finance, where County Finance

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staff verify the amount of the deposits and sign off on the Batch Reports. One copy of each Batch Report is kept in the County Finance Department, and the other copies are returned to the Health Department. The Health Department Batch Report copies are stapled to the Deposit Sheets and maintained in accordance with the Local Health Department Records Retention Schedule.

2. Overages/Shortages/Losses

   a. An **Overage** occurs when a cashier has collected too much money and cannot immediately return the excess money to a specific patient.

   b. A **Shortage** is an unintentional collection error, such as an error made in making change, which results in less money than expected in the drawer.

   c. A **Loss** of County money is when a cashier has obtained physical custody of money and then, due to reasons of negligence (such as leaving the drawer unattended), an act of God (such as a hurricane), or an unlawful action (such as robbery), cannot deposit that money into the County treasury. Any loss must be immediately reported to the supervisor and to the County Finance Officer. The Finance Officer must be sent a detailed statement as to the circumstances of the loss, along with a copy of the Police Report within 24 hours of the loss.

3. Procedures for Deposit

   The Moore County Cash Management Plan governs the administration of funds through the central depository system the following day or as deemed appropriate. Change in the amount of $100 will be secured in each locked cash drawer.

F. Bad Debt Write-Off Policy

1. At the time services are received, Management Support Staff will inform the patient of the cost of the service for that visit and of the balance due on their account.
2. Payment is due and expected at the time services are rendered.
3. When the patient is unable to pay in full at the time services are rendered, a receipt will be issued for partial payment. The patient will sign a payment agreement, which is placed in the medical record.
4. When a patient requests no mail, discussion of payment of outstanding debts shall occur at the time service is rendered. Bills will not be sent to patients requesting confidential services.
5. If a patient is able to receive mail a bill will be sent monthly.
6. The account will be considered uncollectible when there has been no activity on the account for more than 12 months.
7. An itemized list of uncollectible outstanding patient balances that have not had any activity in 12 months will be prepared at the end of the fiscal year by the billing staff for the Health Director's review. All outstanding balances less than $50.00 will be written off permanently, per approval from the Health Director, the Moore County Board of Health, and the Moore County Board of Commissioners. All balances $50.00 and more will be sent to the Debt Setoff Program yearly.

G. Debt Setoff

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1. As authorized by North Carolina General Statutes, Chapter 105A, the Setoff Debt Collection Act (the "Act"), the Moore County Health Department will submit debts equal to or greater than $50.00 against any income tax refund that the patient may be entitled to receive. The Debt Setoff will be prepared annually and sent to the North Carolina Local Government Debt Setoff Clearinghouse.
2. A notification letter will be sent to the patient indicating the amount past due generated by the Debt Setoff Program referencing "Notice of Debt Owed to Moore County Health Dept., Intention to setoff debt."
3. The patient will be advised that in accordance with the Act, a local collection assistance fee of $15.00 will be added to each obligation or account described, if submitted for setoff.
4. The patient is notified that they have the right to contest the action, by filing a written request for a hearing with the Moore County Health Department, within thirty (30) days, from the postmarked date of the letter. They are further notified that they can request a hearing, within the specified time, via delivery to the Moore County Health Department or delivery by mail with postage prepaid and properly addressed to the local agency. The mailing address is specified, for their convenience.
5. They are advised that failure to pay the past due amount or request a hearing, within the 30 day time limit will result in the setoff of the debt. The local collection assistance fee will be added.
6. If the patient does not respond to the letter, the past due account will be entered into the debt setoff program.
7. Payments received from the North Carolina Local Government Setoff Debt Clearinghouse will be deposited into the Moore County Health Department Account, by direct transfer of funds. Funds are then transferred to the appropriate Health Department program.
8. Moore County Health Department will receive a Match Report designating the Social Security Number, Name, Account number and Setoff amount paid per patient.
9. Billing staff will post the amount paid to the account in the clinical billing system for each patient.
10. A Processing Assistant V will check the patient account, twice a month, to see if any payments have been applied to the account. If a payment has been made the account will be appropriately updated. The updated amount will be forwarded to the North Carolina Local Government Debt Setoff Clearinghouse.
11. If there is a discrepancy in the account, the Processing Assistant V will refund any amount owed to the patient and make certain that the adjustment is entered into the Department's electronic Accounts Receivable System.

Reference Plans and Policies: All Moore County Health Department Clinical Program Policies and Procedures

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Annual Review		4/2015; 3/2016; Updated procedure A; 1/2017; Updated proc. B & C; 1/2018

Moore County Health Department
Payment Agreement

In accordance with the policy of the Health Department, payment is due when service is rendered. However, we realize that there are times when an individual does not have the total amount of money owed to the clinic, therefore, this written agreement is established as a method of adopting a payment plan for those patients who have an outstanding balance.

Name _____ Date of Birth _____
SSN_____

Address:_____
I, _____, agree to establish a payment plan for my account and to the stipulations herein stated:

_____ My account balance is $_____

_____ I will pay the amount of $_____on my bill

_____ Monthly_____ Weekly_____ Bi-weekly_____

_____ I understand that the Moore County Health Department can not operate efficiently without adhering to the agreement as stated above. I further state that my options were explained to me and I fully understand.

_____ I understand that I am responsible for any balance left owing as of today and future charges shall apply to this agreement. If my insurance company should not pay the bill in full, it will be based on my sliding fee scale status.

This is a binding agreement by signatures of both parties. The agreement will be filed in the patient's financial information section of the medical record as a permanent document until bill is paid, in full.

Failure to comply with this agreement will greatly affect the overall services of the Health Department operation.

Signature of Patient_____
Signature of Witness_____
Date_____

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DATE OF DEPOSIT _____

List below the total amount of cash, checks and credit card payments received from each cash drawer.

Biller 1 $100.00 **Biller 2 $100.00**

DRAWER 1 MONEY RECEIVED	DRAWER 2 MONEY RECEIVED	TOTALS
CASH PAYMENTS F/P _____ M/H _____ IMM/Only _____ O/Svs_____ (Preg. Test/Tb/FT/AH) Copies_____	**CASH PAYMENTS** F/P _____ M/H _____ IMM/Only _____ O/Svs_____ (Preg. Test/Tb/FT/AH) Copies_____	**CASH PAYMENTS** F/P _____ M/H _____ IMM/Only _____ O/Svs_____ (Preg. Test/Tb/FT/AH) Copies_____ Total _____
CHECKS RECEIVED F/P _____ M/H _____ IMM/Only _____ O/Svs_____ (Preg. Test/Tb/FT/AH) Copies_____	**CHECKS RECEIVED** F/P _____ M/H _____ IMM/Only _____ O/Svs_____ (Preg. Test/Tb/FT/AH) Copies_____	**CHECKS RECEIVED** F/P _____ M/H _____ IMM/Only _____ O/Svs _____ (Preg. Test/Tb/FT/AH) Copies_____ Total _____
CREDIT CARD PAYMENTS F/P _____ M/H _____ IMM/Only _____ O/Svs_____ (Preg. Test/Tb/FT/AH) Copies_____	**CREDIT CARD PAYMENTS** F/P _____ M/H _____ IMM/Only _____ O/Svs_____ (Preg. Test/Tb/FT/AH) Copies_____	**CREDIT CARD PAYMENTS** F/P _____ M/H _____ IMM/Only _____ O/Svs _____ (Preg. Test/Tb/FT/AH) Copies_____ Total _____

List the total of all cash money, checks and credit card payments received for each program listed below.

CASH PAYMENTS **CHECK PAYMENTS** **CREDIT CARD PAYMENTS**

TOTAL $_____ **TOTAL $_____** **TOTAL $_____**

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HEALTH DEPARTMENT
DEPOSIT SHEET
DATE_____

Budget Code	**Charge Code**		
10024071-35021	390575	Immunization (Fees Only)	$ _____
10024071-35035	390010	Maternal Health (Fees Only)	$ _____
10024071-35037	390030	Family Planning (Fees Only)	$ _____
10024071-35049	390072	Other Services-(Flat Rate Fees) (Preg. Test/TB/FT/AH Fees)	$ _____
10024071-35036	390020	Child Health (Fees Only)	$ _____
10024071-35049	390060	Orthopedic (Fees Only) Includes Neuromuscular	$ _____
1003961-52600	390155	Clinical Office Supplies Expense	$ _____
10039025-53200	390150	Admin Telephone Expense	$ _____

CHECK TOTAL $ _____
CASH TOTAL $ _____
OFC SUP. AND PHONE TOTAL $ _____
TOTAL $ _____

Signature: _____

Date: _____

Received: _____

Date: _____

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HEALTH DEPARTMENT
CREDIT CARD DEPOSIT SHEET
DATE_____

Budget Code	**Charge Code**		
10024071-35021	390575	Immunization (Fees Only)	$ _____
10024071-35035	390010	Maternal Health (Fees Only)	$ _____
10024071-35037	390030	Family Planning (Fees Only)	$ _____
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		TOTAL	$ _____
		OFC. SUP. AND PHONE TOTAL	$ _____

Signature: _____

Date: _____

Received: _____

Date: _____

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