

GEORGIA FARMWORKER HEALTH PROGRAM (GFHP)

Policies and Procedures Manual



MIGRANT

HEALTH

GEORGIA FARMWORKER HEALTH PROGRAM
STATE OFFICE OF RURAL HEALTH (SORH)
GEORGIA DEPARTMENT OF COMMUNITY HEALTH (DCH)

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Preface

The State Office of Rural Health (SORH) under the auspices of the Georgia Department of Community Health (DCH) takes its responsibility to improve upon health care and health outcomes in rural Georgia very seriously. It seeks to work with and strengthen existing networks and is dedicated to engaging others in forming a broader health care system to satisfy the expanding needs of Georgia's rural communities. As such, SORH is uniquely positioned to understand the needs of the community it serves. It has, as part of its primary goal, the pursuit and direction of resources to address those needs. Among its efforts is the Georgia Farmworker Health Program (GFHP).

GFHP was established in 1990 within the Department of Human Resources' Office of Primary Care. In January 2000, the Program was transferred to the Office of Rural Health Services within DCH. The new Office of Rural Health Services was subsequently moved from Atlanta to Cordele, Georgia.

The U.S. Public Health Service is a federal agency in the Federal Security Agency, under the U.S. Department of Health and Human Services, established by the Public Health Service Act (42 U.S.C.S. 201 *et. seq.*, 2008) and administered by the Public Health Service Administration. Among other things, the Act allows for the Public Health Service Administration to assign personnel to a state along with supportive salary funding, for the promulgation of regulations necessary to the administration of the Service and for the Secretary of the Public Health Service to determine that a public health emergency exists and make appropriate response including the use of grants from a Treasury fund, the Public Health Emergency Fund (42 U.S.C.S. Sections 215, 216 and 247d). GFHP, as a statewide migrant health center program, receives federal funding under Section 330G of the Public Health Service Act (codified at 42 U.S.C.S. Section 254b).

The Program's federal funding is obtained from the Bureau of Primary Health Care (BPHC) within the U.S. Department of Health and Human Services' Health Resources and Services Administration. The Bureau administers federal funds distributed in accordance with the Migrant Health Program. The Migrant Health Program (MHP) provides grants to community non-profit organizations for a variety of culturally and linguistically competent medical and support services to seasonal farmworkers and their families.

In addition to their contract funds, providers may also obtain direct funding or donations from other sources, such as community groups, medical institutions, and local medical care providers. The providers also obtain funds from fees charges the farm workers for the services provided to them. The fees are assessed using a sliding scale based on income and federal poverty guidelines. The sites may also establish and charge a minimum flat fee for services; however, services cannot be denied to

patients who are unable to pay the minimum fee. The income generated from these fees is retained by the providers and may be carries over to the following grant year.

Georgia supplements federal dollars received for GFHP with state funds. It has assigned the management of GFHP to SORH. This places considerable fiduciary responsibility upon SORH in its management of GFHP to adhere in the strictest sense to all funding and reporting requirements. It is imperative that GFHP remain in compliance with all applicable federal and state regulations. Both federal and state prohibitions exist concerning the provision of federal and state public benefits or assistance to non qualified aliens.

The decision to deny federal, state and local public benefits to aliens not qualified to receive them was made by Congress and found in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“Welfare Reform Act”). United States Attorney General Order No. 2353-2001 states that the Welfare Reform Act, among other things, vests in the Attorney General the authority to specify certain types of community programs, services or assistance for which all aliens remain eligible (66 Fed Reg 3613). Under this Act, aliens who are not “qualified aliens” are generally ineligible for federal, state and local public benefits. However there are a number of specified exceptions to those restrictions. Included in the list of statutory exceptions is a provision authorizing the Attorney General to identify programs, services and assistance to which the Act’s limitations on alien eligibility do not apply. Pursuant to the Act, the Attorney General **may exempt only** those types of programs, services and assistance that **meet a three-prong test** set forth by Congress **by satisfying all** of the following three criteria: (1) deliver in-kind services at a community level, including through public or private non-profit agencies; (2) does not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient’s income or resources; and (3) are necessary for the protection of life or safety.

While the Welfare Reform Act authorizes exemptions for “programs, services or assistance” that meet the three-prong test, the Attorney General has no authority to provide a blanket exemption for all programs authorized by a single statute. This is because one or more of those programs may fail to meet all of the requirements imposed by the statute. Agencies and service providers must assess a program individually to determine whether it meets the three-prong test. Attorney General Order No. 2353-2001 specifically states that any state or federally funded program that is required as a condition of their funding to employ sliding scales, or to otherwise limit the access to services according to a client’s income or ability to pay would not qualify for exemption under the Attorney General’s Order. However where community-level health programs serve all eligible clients regardless of their ability to pay and do not administer any type of sliding scale fee schedule or other income test, they are covered by the Attorney General’s Order. Specifically, services for migrant farmers must meet the requirements of the three-prong test in order to be exempt under the Order.

Attorney General Order No. 2353-2001 opines that service providers and other interested parties should not assume that verification of citizenship or immigration status is required when its program or service is not exempted by the Order. Parties are advised to refer to benefit-granting agencies’ interpretations of the term “federal public benefit” as used in the Act in order to determine whether their program is a federal public benefit and therefore subject to the alienage restrictions of the Act. The Order offers the example that the Department of Health and Human Services (HHS)

notice of interpretation of federal public benefit. HHS advises that HHS programs not listed in the notice, such as Community Health Centers, and programs under the Ryan White Comprehensive AIDS Emergency (CARE) Act of 1990, as amended by the Ryan White CARE Act Amendments of 1996 and 2000 (codified under Title XXVII of the Public Health Services Act) and the Older Americans Act of 1965 (42 U.S.C. Section 3011 *et seq.*), do not meet the statutory definition of “federal public benefit” and therefore do not have to verify the citizenship or immigration status of applicants or recipients.

The Georgia Security and Immigration Compliance Act of 2006 (Senate Bill 529 of the 2006 Georgia General Assembly, enacted as Act 45; 2006 Ga. ALS 457; 2006 Ga. Act 457; 2005 Ga. SB 529; Ga. Comp. R. & Regs. r. 300-10-1-.01(2007)) requires that every agency or a political subdivision of this state shall verify the lawful presence in the United States of any natural person eighteen years of age or older who has applied for state or local public benefits, as defined in 8 U.S.C. Section 1621, or for federal public benefits, as defined in 8 U.S.C. Section 1611, that is administered by an agency or political subdivision of the this state. (Georgia Security and Immigration Compliance Act which amended O.C.G.A. Section 50-31-6.) The Act states further that it shall not apply to, and lawful presence in the United States shall not be required where, among other things, (1) for any purpose for which lawful presence in the United States is not required by law, ordinance or regulation; (2) for assistance for health care items and services that are necessary for the treatment of an emergency medical condition, as defined in 42 U.S.C. Section 1396b(v)(3), of the alien involved and are not related to an organ transplant procedure; (3) for public health assistance for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether of not such symptoms are caused by a communicable disease; (4) for prenatal care; (5) for programs, services or assistance such as soup kitchens, crisis counseling and intervention, and short-term shelter specified by the United States Attorney General, in the United States Attorney General’s sole and non reviewable discretion after consultation with appropriate federal agencies and departments, which:

- (A) deliver in-kind services at the community level, including through public or private nonprofit agencies;
- (B) do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient’s income or resources; and
- (C) Are medically necessary for the protection of life or safety.

Items A, B and C under number 5 above are the same criteria as that used by the Attorney General in the three-prong test exemption under the Welfare Reform Act (Attorney General Order No. 2353-2001).

Additionally, Attorney General Order No. 2353-2001 stresses that deference is given to the determination, if one has been made, by the benefit granting agency as to whether the program is a federal public benefit. Agencies and service providers should also note that Section 432(d) of the Welfare Reform Act which provides that nonprofit charitable organizations are not required to verify the immigration status of applicants for Federal, State, or local public benefits, may be applicable to their programs. (See Department of Justice, Verification of Eligibility for Public Benefits, 63 FR 41662, 41664 (1998)) (to be codified at 8 C.F. R. pt. 104).

Regulations applicable to federal grants for migrant health services are found at 42 C.F.R. Part 56. Attention is called to the requirements of title VI of the Civil Rights Act of 1964 (78 Stat. 252, 42 U.S.C. 2000d *et seq.*) and in particular section 601 of the Act which provides, among other things, that no person in the United States shall on the grounds of national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial participation (42 C.F.R. Section 56.110). A regulation implementing such title VI, which applies to grants for migrant health services, has been issued by the Secretary of Health and Human Services with the approval of the President (45 C.F.R. Part 80). Additionally, Appendix A, Part I of the Civil Rights Act (45 C.F.R. Part 80) lists categories of federal financial assistance to which the Act applies and specifically includes migratory workers health services (section 310, Public Health Service Act, 42 U.S.C. 242h) at number 81, and project grants for services for migratory agricultural workers at number 133 (45 C.F.R. Part 80, Appendix A, Part 1, 81, 133).¹ Also Appendix A, Part 2 of the Civil Rights Act is applicable to continuing assistance to state administered programs for grants to States for establishing and maintaining adequate public health services (section 314d Public Health Service Act, 42 U.S.C. Section 246d) (45 C.F.R. Part 80, Appendix A, Part 2, 21). Regulations for grants for migrant health services are applicable to all grants authorized by section 319 of the Public Health Service Act located at 42 U.S.C. 247d (42 C.F.R. Section 56.101). Federal regulations at 42 U.S.C.S. Section 247d apply to public health emergencies allowing the Secretary to take such action as may be appropriate to respond to the public health emergency.

GFHP is administered by the Director of Migrant, Homeless and Special Programs within the Office of Rural Health Services. In addition to the Director, the Program has four part-time positions: a program consultant, a field data consultant, and two administrative personnel. Program staff are responsible for administering the contracts with the providers, maintaining a database of program activities, and providing technical assistance to the project sites.

Under the SORH, the mission of the GFHP is to improve the quality of health of Georgia's migrant and seasonal farmworkers and their families by providing cost effective, culturally appropriate primary health care. This manual serves as the official policy and procedure manual for the GFHP. Every requirement stipulated in this manual must be met for program managers to remain a part of the program which supplies these essential services.

¹ 42 U.S.C.S. Section 242h was transferred and now appears as 42 U.S.C.S. Section 247d.

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I. MISSION

The mission of the GFHP is to improve the quality of life of Georgia's migrant and seasonal farmworkers and their families by providing cost-effective, culturally appropriate, preventive and primary health care services, and by arranging for other levels of health care through collaboration and advocacy.

II. PROGRAM ELIGIBILITY

Any MSFW, as defined below, is eligible for the program. MSFWs must have agriculture, as defined below, as their **principal employment**. Citizenship or legal status is not a requirement for eligibility for this program. NOTE: MSFWs with third party payment sources, such as Medicaid, are eligible for the program as well. See Section V, Financial Systems, for third party billing information.

Eligibility for the Georgia Farmworker Health Program is determined during the registration process; therefore, it is very important that registration information be accurately completed. The recommended sequence of questions to determine employment eligibility is located on the Georgia Farmworker Health Program Registration Form, in **Appendix B**.

A. Definitions:

MIGRANT FARMWORKER: A worker whose principal employment is in agriculture on a seasonal basis and who establishes a temporary abode for the purposes of such employment. Migrant farmworkers are usually hired laborers who are paid hourly and daily wages, and who have been so employed during the past twenty-four months. Dependent family members are included in this definition. Former migrant farmworkers who, because of age or disability, can no longer meet the above requirements are also included.

SEASONAL FARMWORKER: As above, except that the seasonal worker does not establish a temporary abode and does not travel from job to job. Seasonal workers are employed in farming only during parts of the year.

AGRICULTURE: The farming of land in all its branches: cultivation, tillage, growing, harvesting, and preparation and processing for market or storage that occurs on the farm. This definition also includes Christmas tree farming, pine seedling planting, pine straw collection and nursery workers. This definition does not include raising livestock, harvesting lumber, and preparation and processing that does not occur on the farm.

B. Income Requirements/Limits:

Income status must be determined and verified annually. The income verification can be accomplished by review of a current pay stub or by attestation letter from the employer after the initial registration. If the person obtaining the income information has a valid reason to believe that the income is incorrect, the reason for doubt must be documented. Patients are expected to

pay full charges if their income can not be verified at the time of their second clinic visit. They do not qualify for a sliding fee discount until income is verified.

Income is defined as the total annual cash receipts before taxes from all sources with certain exceptions. Income includes money, wages and salaries before deductions, net receipts from non-farm self-employment (receipts from a person's own unincorporated business, professional enterprise or partnership, after deductions for business expenses); net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter or sharecropper after deductions for farm operating expenses); regular payments from social security; railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including Temporary Aid to Needy Families (TANF) the successor to Aid to Families with Dependant Children (AFDC), Supplemental Security Income (SSI), Emergency Assistance payments, and non-federally funded general assistance or general relief money payments); and training stipends, alimony, child support, military allotments or other regular support from an absent family member or someone not living in the home; private pensions, government employee pensions, including military retirement pay, regular insurance or annuity payments, college or university grants, fellowships, and assistantships; dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

Income does not include capital gains; assets drawn down as withdrawals from a bank, sale of property, a house or a car; tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments or compensation for injury; non-cash benefits such as employer paid or union insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, imputed value of rent from owner-occupied, non-farm or farm housing, and such federal non-cash benefit programs as Medicare, Medicaid, Food Stamps, School Lunch or housing assistance.

C. Definition of Family

In determining family size, a family is a group of two or more persons related by birth, marriage or adoption who live together; all such related persons are considered members of one family. Married children and their families must be registered separately even if the married children are living with their parents. If two families live together, they must be registered separately. The federal poverty guidelines are applied separately to each family and/or unrelated individuals.

Family unit size of one is a family unit of one who is an unrelated individual 15 years or older, who is not living with relatives. This person may be the only person living in a housing unit or may be living in housing in which others live, but to whom the individual is not related by birth, marriage or adoption.

A pregnant woman is counted as two persons in determining family size.

The current **Poverty Income Guidelines** for income and payment determination can be found at <http://aspe.hhs.gov/poverty/>. Reviewers should visit the Web site periodically to ensure that the guidelines have not changed.

III. PROGRAM MANAGEMENT

Federal regulations, content of the GFHP grant application and strategic plan will guide program design and implementation. The state office's role will be to direct policy development and implementation, program development and implementation, monitoring and evaluation, data collection and reporting, funding requests, a state advisory council, and public information efforts. Local projects will be responsible for developing a visible program for MSFWs, for providing direct services, documenting services and costs, publicizing the program, linking with other agencies involved with MSFWs, and establishing and staffing local advisory councils.

A. Clinical Information Systems

The problem-oriented record system will be utilized. This means patients' records will be developed and maintained in accordance with their respective life cycle and by cause for visits. The record will include presenting problem, history, physical examination findings, diagnoses, problem list, treatment plan, medications, treatments, lab and x-ray reports, counseling and education consultation reports and plans for follow up and/or referral as appropriate to the patient's presenting conditions.

Each patient will have a plan of care based on a medically approved protocol. Problems should be prioritized with a date and plan for each problem. Assessment, planning and follow up will reflect the patient's respective life cycle and relative disease prevention and health promotion activities. Sensitivity to culture, language, educational level, environment and transitory status of the migrant must be integrated throughout.

With each patient encounter, the nurse or nurse practitioner either of whom must be licensed in the state of Georgia will be responsible for coordinating any needed follow up care. Medical and dental authorization forms (voucher forms) are located in Appendix E and F. These forms will be sent to physicians, dentists, and other health providers or agencies, with a section to be completed and returned to the issuing clinic indicating action taken and follow-up needed. The patient record will be routinely reviewed to determine which problems remain unresolved in order to review and reprioritize health care needs with the patient. A system to provide a check-and-balance mechanism to assure appointments will be kept or some other system suitable for this purpose and appropriate follow ups will be maintained.

Patient data will be entered into the GFHP Database system. Name, address, birth date, sex, race/ethnicity, language, occupation, income, family size, appropriate ICD-9 and CPT service codes, clinics attended, provider and provider type must be included. These data will be used to prepare state and federal reports as well as to serve as a resource for the clinical outcomes quality management program. For pregnant women, data on estimated and actual delivery dates,

prenatal care, infant birth weight, postpartum care for mother and child and information on WIC enrollment will also be entered into the GFHP Database.

B. Quality Assurance

A clinical outcomes baseline has been established for all GFHP sites and will serve as the focal point of respective continuous quality improvement efforts. This clinical outcomes baseline will be used to establish targets and measure improvement for life cycles. All will have and will refer to their respective baseline and follow-up reports located in the copy of the Quality Assurance (QA) / Continuous Quality Improvement (CQI) Plan. The clinical outcomes portion of this implementation plan will contain the respective clinical outcomes audit summaries, comparisons with the averages for all GFHP, improvement recommendations and targets set by the staff.

Continued implementation of the QA program will include periodic chart audits and establishment of standards of care. Projects will be required to participate in chart audits and other quality assurance activities of the GFHP.

Projects will be responsible for the quality management assessment of both the services provided on site as well as services provided at other sites within their area. Refer to the QA/ CQI plan for guidance.

IV. COMPONENTS OF THE HEALTH SYSTEM

A. Primary Health Care

Federal guidelines specify that migrant farmworkers have access to primary health care as defined to include:

- **physician services and, where appropriate, services of physician assistants and nurse clinicians who have agreed to accept program fees**
- **diagnostic lab and x-ray**
- **appropriate pharmacy services to complete treatment**
- **preventive health and dental services**
- **emergency dental care**
- **appropriate transportation services**
- **case management**
- **outreach, including health education**
- **interpreter services, as appropriate**

B. Staffing

The GFHP will utilize physicians, physicians assistants (PA), nurse practitioners (NP) or nurses, (all in good standing and licensed to practice in the state of Georgia), bilingual outreach and

clerical staff workers who will implement the above components, with referral to outside physicians as needed. Project staff will facilitate access to existing health department resources. In projects which support nurse practitioners, the NP will provide direct medical care. The expanded role registered nurse can provide blood pressure monitoring, family planning, and immunizations rather than referring the patient to a physician.

C. Selection of Providers

All physicians and dentists participating in the GFHP must be board-certified or board-eligible with admitting privileges at a local hospital. Any physician or dentist selected for the program must be willing to accept all referrals. Generally the program will only utilize physicians or dentists who accept Medicaid patients or who agree to bill Medicaid for a Medicaid patient. The maximum paid by the GFHP is the Medicaid rate regardless of the patient's Medicaid eligibility. However, if the physician or dentist charges less than this rate, the program will pay according to his or her charges. The physicians, dentists or other providers cannot bill a patient for the difference between the customary charge and Medicaid, insurance or Migrant Program payment. For all clients who are not Medicaid members or Medicaid eligible, the same billing practices will be applied.

In negotiating arrangements with physicians or dentists, GFHP sites must inform providers that generally patients will be referred for an evaluation and minor tests. If additional tests and treatment are indicated, the provider will contact the project site for authorization to proceed. Project sites may contract with physicians on a monthly basis to precept the mid-level providers.

Authorization forms (Appendix E and F) for additional test and treatment approval will be used prior to those services being rendered. Also included is a Medical/Dental Billing Checklist to assure that the provider has submitted required information on the patient and services. These forms will be completed by the issuing site prior to any services being rendered and each time a service of this type is required.

1. Health Departments as Providers of Service

Health Departments are expected to provide their usual services to MSFWs at no charge to the GFHP. Program funds cannot be used to pay for existing services, that is, services that ordinarily would be paid by health departments. Services provided by health departments in this case will be available to MSFWs at no cost to the program. However, sites can contract with health departments for services, which are not ordinarily provided such as x-ray service.

In areas where the local migrant health center is connected to the health district, MSFWs will be allowed to access the program through any county health department in the target area. While migrant health staff will generally establish eligibility and enroll MSFWs, health department staff must be trained by migrant program staff in registration procedures to facilitate this process in the event migrant health staff are not available.

2. Community Health Centers (CHC)

Health departments will be encouraged to link with CHC for referral physicians. CHC are federally supported to serve low-income persons on a sliding fee scale. CHC physicians can also serve as preceptors to the GFHP mid-level providers.

D. Use of Benefit Funds

1. Benefit funds may be used for the following **ONLY*****:

- Primary care physician office visits (internists, family practice physicians)
- Minor surgical procedures conducted in physician's office with prior approval
- Necessary diagnostic lab and x-ray
- Prescriptions when needed to complete treatment (generic drugs are desirable whenever possible and according to formulary)
- Transportation for patients who would otherwise lack access
- Preventive dental care and emergency care to relieve pain or infection for adults and children, i.e., gross caries, infections, inflamed gums, toothache
- Vision care if related to illness excluding glasses
- Outpatient hospital care
- Specialty care as based upon an approved Medical or Dental Authorization Form

*** The Migrant Program will only pay for those procedures/services within the above categories which Medicaid allows.

2. Use of Hospitals

Federal regulations forbid the use of grant funds for inpatient hospitalization. GFHP staff will provide follow up for the patient, but will not fund or otherwise support inpatient hospitalizations through use of any GFHP funds or services funded by GFHP.

Use of the hospital emergency room for non-emergency care should be strongly discouraged. Because benefit funds are extremely limited, the program will only pay for emergency room care for true emergencies on an exception basis with the cost not to exceed \$50. The hospital should treat MSFWs needing emergency care as they would any other indigent patient.

3. Benefit funds may not be used for home health care, restorative dental work or inpatient hospital care. The migrant health program can assist patients to obtain these services, but will rely on other sources of funding for payment (e.g., Medicaid, Children's Medical Services).
4. MSFWs must be enrolled in the GFHP program and be referred by the mid-level provider or other designated staff before the program can authorize payment. Payment will not be approved for a service received prior to authorization.

E. Gatekeeping Function

Each project will design a method of gatekeeping for referring patients to outside providers and create a policy and or procedures to document the approach. Once designed, a copy will be sent to SORH for review, approval, and to keep on file. Any changes will be sent to SORH prior to use. At minimum, gatekeeping functions will refer to or include these conditions: Generally, the mid-level provider will provide primary health care. Whenever care is needed from a physician, pharmacist or dentist, project staff will authorize the specific service needed, giving the patient an authorization form to take to the referral provider. The form will clearly state the services requested from the provider with an approximate amount the program will pay. The provider will contact the project if charges will exceed this and prior to rendering the associated service(s).

Persons with third-party payment sources will be referred to providers, but without an authorization form. Persons with third-party payment sources will pay for services that the third-party allows. The program can provide follow-up to these patients at no cost to the patient or under usual program requirements and costs.

The gatekeeping function can also be assigned to a nurse in a participating county. All documentation should be sent to the GFHP. Regardless of assignment, nurses must note in the record why the patient was referred to an outside provider.

F. After-Hours Coverage and Clinics

Due to the long hours that MSFWs work, provisions to provide care during non-traditional hours (such as evenings and weekends) is critical to assure access to services for this population. Federal regulations stipulate that programs will provide hours of operation to assure services are available and accessible at times meeting the needs of the population including evenings and weekends.

GFHP sites will open and remain open 5 days per week from Monday through Friday for a minimum of 36 hours per week and a minimum of 4 hours on Saturday or Sunday. The weekend hours of services can also be accomplished through the use of subcontractors within the assigned scope of service area if those subcontractors at minimum meet the provider participation requirements. Information on how patients may access health care services after hours must be established in writing and posted in public locations including the exterior of clinic sites. Phone messages will be offered in both English and Spanish and will refer callers to after hours care locations that are convenient and remind callers of any restrictions associated with care location referrals.

G. Prescribed Drugs

Whenever possible, GFHP will obtain drugs at low or no cost from health departments and physicians. Projects will identify pharmacists willing to accept Medicaid rates or lower for prescribed drugs. The nurse practitioner or provider will give the patient a pharmacy authorization form. Each patient will be asked to pay the program a minimum amount of five

dollars per prescription filled onsite, and a maximum of \$15 or half of Medicaid rate, whichever is less, per prescription filled offsite.

The migrant program will only authorize payment for a particular brand of drugs when the physician or dentist specifies that a particular brand is necessary for medical reasons. Otherwise the provider should specify a generic substitute. If a physician or dentist prescribes a drug and brand without saying “brand necessary,” the migrant farmworker will pay the pharmacist at the generic/Medicaid rate for that drug.

Pharmacists will bill the Migrant Program the Medicaid rate or lower. Use of drugs will be explained to patients in their native language, whenever possible.

H. Dental Component

All Medicaid children and adults will be referred to dentists accepting Medicaid payment. Preventive dental care will be provided, including fluoride supplementation where fluoridated water is lacking, sealant treatment, and dental education, particularly to prevent baby bottle mouth syndrome. MSFWs not eligible for Medicaid or insurance will only receive dental care related to alleviating conditions associated with an emergency.

Migrant health staff will provide dental health education for adults and children. The importance of dental health will be stressed to pregnant women. Children will be examined to determine presence of baby bottle mouth syndrome. Referrals will be made to dentists as appropriate. Where possible, patients will receive dental kits of toothbrushes, paste and floss with instructions for use from the program. In some health districts, a district dentist may be available to provide dental care to MSFWs. This resource should be used first and at no cost to the program. GFHP must ensure that participating dentists understand that they must receive approval for providing any treatment beyond that stated on the authorization form. An authorization for Dental Care is located in Appendix F.

I. Transportation

Project sites with no transportation assets may use program funds to pay for transportation to enable a migrant patient to obtain health services. Funds will be used sparingly. Medicaid policies and rates will apply. All attempts must be made to obtain “free” transportation before utilizing program funds for this purpose. The least expensive mode of travel must be secured. Only mileage will be paid to and from a doctor’s office from the driver’s home to pick up and visit sites and back to the driver’s home regardless of the number of passengers. Transportation requests are to be approved in advance by the migrant health program staff. No payment will be made for the following: driver waiting time; person escorting a patient to health care; meals for the patient, driver or other family members.

V. FINANCIAL SYSTEMS

The SORH for the GFHP will monitor and evaluate budgets and expenditures on a monthly basis. Cost reports will be submitted as scheduled in the Grant-in-Aid Master Agreement or the Grant Agreement. If there is a change in the budget from the project's plan, local projects are required to submit a budget revision and explanation of changes to the SORH for approval prior to expending any funds or making any changes to existing budget expenses.

All sites are **required** to submit supporting documentation of all expenses including copies of paid invoices and receipts. This means that each and every invoice must contain an itemized listing of the and expenses associated with the invoice, the grant number and refer to any SORH/DCH approved grant condition changes which relate to the services rendered. The invoice and its supporting documentation will be reviewed by the SORH/DCH to ensure adherence to the grant agreement terms and payment will be made accordingly. All travel expenses must adhere to the State of Georgia Travel Regulations policy found at <http://www.sao.georgia.gov>. Invoices for each month will be submitted for payment no later than thirty (30) days after services are provided to:

Department of Community Health
Contracts/ Grants Payable
P.O. Box 38401
Atlanta, GA 30334

Copies of check stubs are not acceptable.

B. Registration

Before receiving services a MSFW must be registered for the program. Project staff may register persons/families during visits to camps or when MSFWs present at project sites. If a MSFW presents at a participating health department, but not one staffed by the migrant program health department personnel trained in the registration process can enroll the person or family. If a MSFW presents at a health department where personnel are not trained in the registration process, the health department staff are to make a referral to the closest migrant clinic or contact a clinic for guidance. All local public health departments must have current migrant clinic contact information for their areas. A copy of the registration form can be found in **Appendix B**.

Verification of income status or agricultural work status may be requested annually during the registration process either by a current paycheck stub or verification letter from their employer. Patients are expected to pay full charges if their income cannot be verified at the time of their second visit. Clinics should require documentation during specified time periods as a quality assurance check.

C. Registration Cards

Each program participant will be issued a GFHP Registration card a copy of which is found at **Appendix C**. This will serve to identify MSFWs to other sites in Georgia so that the eligibility process is not repeated. Each project site will use the six-digit unit identification code of the GFHP which is 048270 followed by a letter representing the specific site that completed the initial registration. Each site will have an identification letter assigned by Health Resources and Services Administration (HRSA). Unit identification code and site identifier letter for the GFHP Sites will be as follows:

- 048270 – A Ellenton Farmworker Health Program
- 048270 – D Migrant Farmworkers Clinic, LLC
- 048270 – I East Georgia HealthCare Center
- 048270 – J Ellaville Primary Medicine Center
- 048270 – L South Central Primary Care Center
- 048270 – F Decatur County Health Department

The date of enrollment into the GFHP will also be listed on the registration card. Registration into the GFHP is valid only for one year. **A new registration card will be issued on an annual basis beginning on January 01 of the current year and to expire on December 31 of the current year.**

When a MSFW registers for the program, project staff will determine if she or he has been seen by another GFHP. If so, the existing ID number and family ID number will be used.

VII. REGISTRATION DATABASE ENTRY PROCEDURES

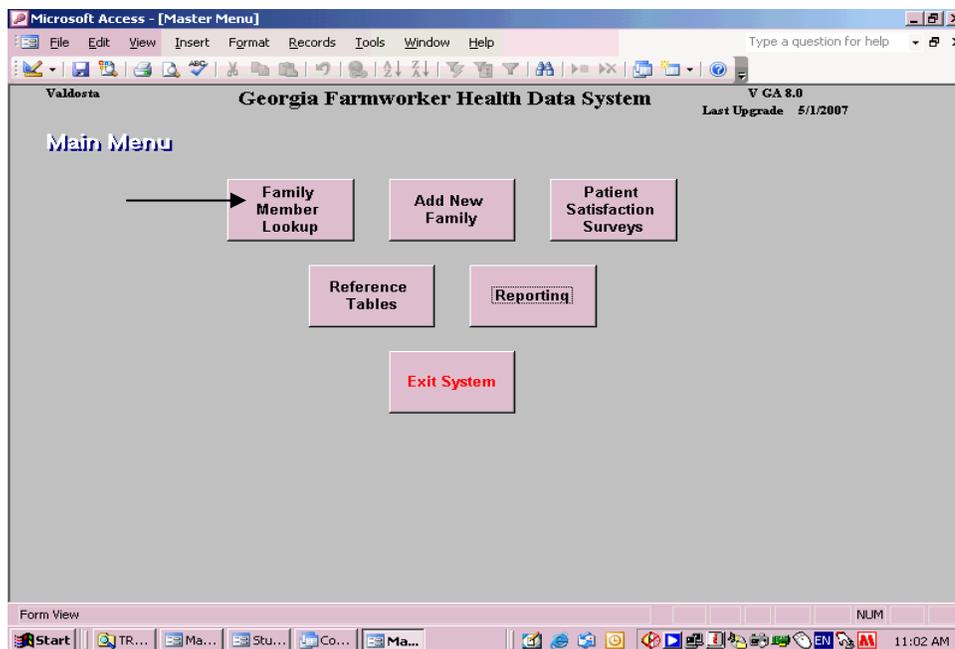
Every GFHP will have a migrant health database system. User and encounter data will be collected on services provided to MSFWs and input into and updated in the GFHP's database system. Only records on MSFWs who have been registered and determined to be eligible for program services will be entered into the migrant health database system. Patient data must include household income information, name, address, zip code, birth date, sex, race/ethnicity, language, occupation, income, and family size. These data will be used to prepare state and federal reports as well as to serve as a resource for the clinical outcomes quality management program reports. For pregnant women, data on estimated and actual delivery dates, prenatal care, and infant birth weights, postpartum care for mother and child and information on WIC enrollment will be entered and updated. Data will be transmitted monthly, by e-mail, modem or disk, to the SORH or their designated representative.

How to use the Database System:

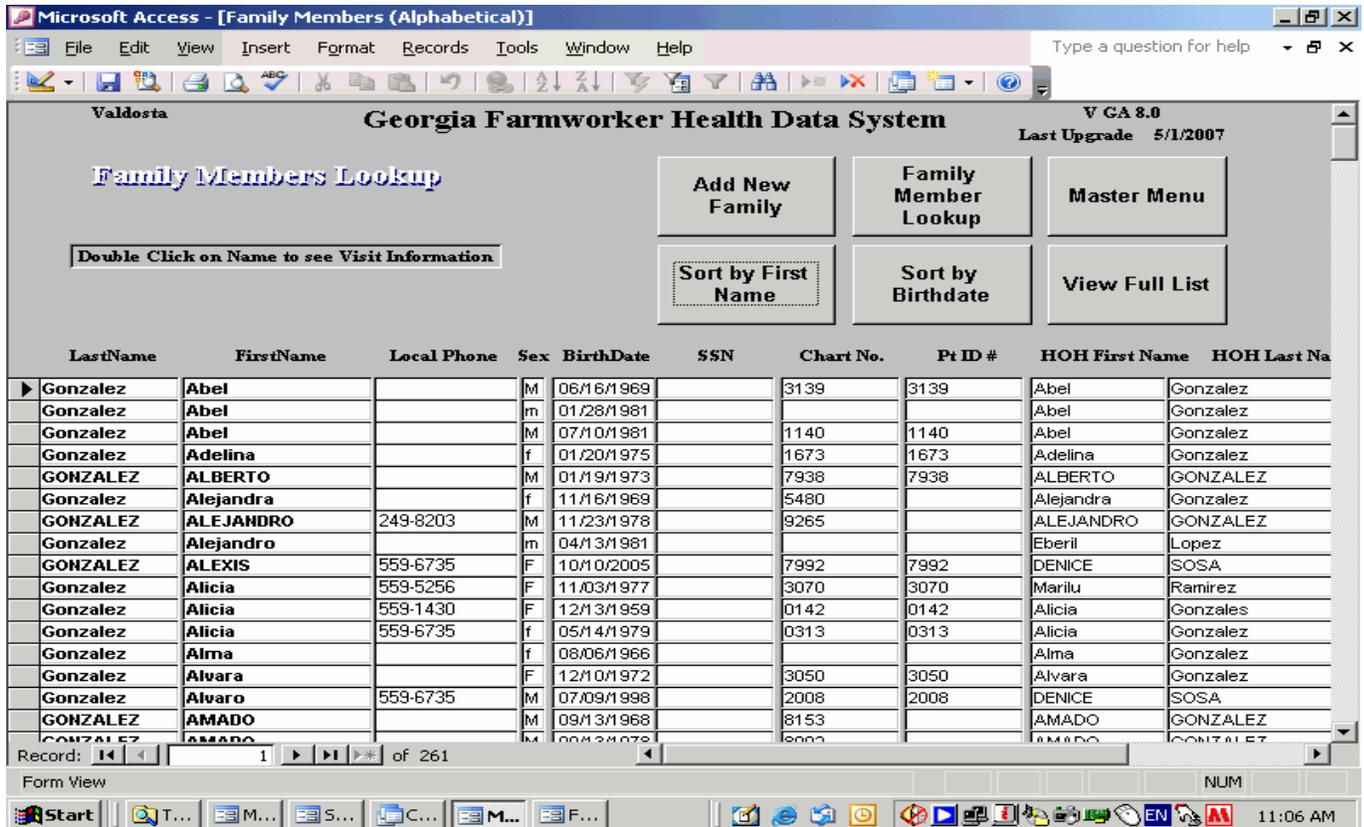
Opening GFHP Access Program

The following information will assist GFHP sites in using the database system.

1. Click the GFHP icon on desktop.
2. The Master Menu screen will appear.
3. Click on the FAMILY MEMBER LOOKUP button to begin



4. A screen to search by last name will appear. Enter the last name of the patient.



Search for Person or Family

1. To **find** a family/person:
 - a. click on the FIND BY LAST NAME or FIND BY BIRTHDAY button, and then scroll down to find the person desired. OR
 - b. click on any column, e.g., Birth Date, Chart No, Pt ID#, then click EDIT on top bar, scroll down to FIND. Enter desired data. If there are more than one person listed with the same birthday click FIND again. OR you may access this type of FIND by clicking on the desired column and then <CTRL> + F.

2. Once the black arrow on the far left is resting on the person desired, double click the person's last name to view their encounter data.

3. To **add** a NEW family/person that is not in the database click ADD NEW FAMILY.

Data Encounter Screens for Registration

A. Head of Household

Name: Enter name of the Head of Household. Do NOT enter children 18 and under as head of household.

Registration Date: Date that this person/family registered in the program (automatic, never change)

Family Id: Computer generated. Do not change!

Local Address: The current living address

County: The county in which the person resides

Local City: The city where the person resides

State: Field will default to GA

Zip: The zip of the address where the person resides

Migrant, Seasonal, Other, Community:

Mig = Migrant, an individual whose principal employment is in agriculture on a seasonal basis and who establishes a temporary home for the purpose of such employment.

Sea = Season, an individual whose principal employment is in agriculture on a seasonal basis, and who does not establish a temporary home for purposes of employment.

Other = This does **not** apply to us in Georgia. Do not use.

Community = Use this coding to mark a family who is **not** in farm work and who cannot be registered in the GFHP, but who uses the services of the clinic. This option exists primarily for the Ellenton Site.

Local Phone: Enter if they have one

The screenshot shows a Microsoft Access database window titled "Georgia Farmworker Health Data System". The form is titled "Family Information" and includes several sections: "Head of Household Information", "Program Eligibility Information", and "Family Address Detail Information". The "Head of Household Information" section contains fields for First Name, Middle Name, Last Name, Reg Date (8/13/2007), Family ID (9663), Local Street Address, County, Local City, State (GA), Zip, Migrant, Seasonal, Other, Community (MSOC) (M), and Local Phone. The "Program Eligibility Information" section contains fields for Farm Income, Other Income, Income Date (08/13/2007), Number in Family, Poverty Level, Last Year Farmwork, and Country of Origin. A red button labeled "Please Check Program Eligibility" is visible. The "Family Address Detail Information" section is currently empty. The form is displayed in a "Form View" and includes a record navigation bar at the bottom.

It is very important that the zip code of the current place of residence for the client is entered when registering MSFWs. If a zip code is unknown, use the zip code of the site that is registering the MSFW.

The PROGRAM ELIGIBILITY INFORMATION **must** be filled in each year when the client registers. The program does not allow the assumption that ALL who are registered

are automatically eligible. **Please Check Program Eligibility:** This RED line will appear if the family/person is not registered for the current year. All clients are to be registered annually if eligible.

1. Farm income: More than 50 percent of one's income during the previous year must come from farm work. The total income of the FAMILY will be reported here.
2. Other Income: Any income earned from non-agricultural services.
3. Income Date: This is the date that the income will be assessed. This date must be entered to complete the registration of the MSFW.
4. Number in Family: List the number in family even though they may not all be present at the time of registration with the farmworker.
5. Poverty Level: Choose the correct poverty level using the Federal Guidelines which are listed in the Program and which must be updated each year. To update the Poverty Level click the Fed Pov Levels button on the Main Menu. For annual update: go to <http://aspe.hhs.gov/poverty/>. When registering MSFWs, this information will be auto populated from the entered income and number in the family. **IT IS IMPORTANT THAT THE POVERTY LEVEL SECTION BE UPDATED EVERY YEAR.** This information is important for UDS reporting purposes.
6. Last Yr Farmwork: Enter the year only. This must be entered in order for the FAMILY to become eligible. Only when this is entered will the RED notice stating ineligibility on the FAMILY INFORMATION screen disappear. **Farmworkers must have participated in farmwork within the last two years to meet the minimum requirements for eligibility.**
7. Country: This entry is optional. It is requesting the country of origin of the Farmworker, e.g. Mexico, El Salvador, etc.
8. Press the Confirm Additions button to save changes.

B. Family Member Information

Once the Head of Household information has been completed, the Head of Household will automatically appear on the first line of FAMILY MEMBER INFORMATION. However, his/ her SEX must be entered, his /her RELATIONSHIP IN THE FAMILY, his/her BIRTHDAY, his/her SOCIAL SECURITY NUMBER if there is one, the PT ID NO if the site uses special numbers, his/her RACE/ETHNICITY (this must be entered, the default is Hispanic), and finally does he/she need an interpreter.

If there are other members of the family to be entered, click on the next blank line and begin entering.

Family members will be registered with a family Head of Household where they are automatically associated as a Family Group. Keeping a family together under Head of Household avoids duplicate data entry associated with addresses, and family income. If all patients are registered as individual families, this will result in the loss of the family association in the data model and will require entering the redundant family level information again for each family member. TABLE 4 in the UDS reports shows the number of users based on FAMILY INCOME as a percent of the federal poverty level. That means that when

the UDS TABLE 4 runs it will produce a lower count of users because many will have NULL values in the poverty level field.

VIII. PATIENT ENCOUNTERS

A medical encounter is a face-to-face contact between a user and a provider of health care services who exercises independent judgment in the provision of health services to the individual patient. For a health service to be defined as a medical encounter, the provision of the health service must be recorded in the patient’s record and performed by an LPN or higher. Therefore a chart must be made for any type of patients that receives a medical encounter, even those patients seen in the fields.

Outreach and enabling encounters consist primarily of case management and health education. The encounter will be face-to-face, and the encounter will be documented in the patient’s chart and entered into the GFHP Database with the corresponding CPT or the ICD9 Code associated with the specific education provided. Services such as transportation and interpretation provided without documentation in the patient’s chart will not be considered encounters. They may be, however, recorded in the database and will appear as enabling encounter activity.

For each on-site patient encounter, the following procedures will take place.

A. Patient Sign-In

Patients will sign in at the receptionist’s desk when they first arrive. A confidential sign-in sheet will be used. The sign-in sheet will be such that a permanent and consecutive record of all patients’ signatures for who have come in for services is maintained and retained for the term of the grant and three years after the close of the grant.

At the end of each office day, the sign-in sheet will be placed in a folder, locked in a cabinet restricted from public access, and kept as a permanent record. The sign-in sheet will serve as part of service documentation for the office, as a part of internal control, and for audit and review purposes. This sheet will be used in the end of day reconciliation of “patients seen” to “patients/program charges” for services.

The number of the encounter form, which will be sequential, will be issued for the patient’s visit and will be entered next to the patient’s name on the sign-in sheet.

Confidential Patient Sign-In System Date _____

Patient Name	Name of Healthcare Professional	Arrival Time	Any Insurance or Address Changes Since Last Visit?	Your Number
<i>Please Print Neatly and Press Firmly.</i>				
Patient: Please remove this ticket. You will be called by either your name or by this number.				
		9:55	NO	12
				13
				14
				15

Encounter forms should be pre-numbered for internal control purposes. The number of each encounter form issued to a patient should be entered next to the patient's name on the sign-in sheet. The original encounter forms must be kept as a permanent record. A copy of each encounter form should be given to the patient, along with a cash receipt for any fees collected.

IX. PROGRAM INCOME, BILLING AND COLLECTIONS

PROGRAM INCOME

Program income includes general program income (inclusive of patient fees as described in the sections below), proceeds from the sale of assets acquired with funds; royalties from copyrights on publications developed under, or patents and inventions conceived or first actually reduced to practice under, a grant-supported and interest and investment income. All program income generated must be reported on the monthly and annual cost reports. The program income must be spent in the current or immediately following fiscal year and will only be used to support, enhance or maintain the site's GFHP in accordance with the grant terms and specifications. Documentation of expenditures of program income must be provided to the SORH and reported on the monthly and annual cost reports.

The guidelines which govern the programs allow for the billing and collection of payment within specific guidelines. The objectives of this program feature are as follows:

Objectives

- To ensure encounters, procedures and referral services are recorded in an accurate and timely manner in accordance with program and grant criteria
- To ensure uniform nominal flat fees are charged to MSFW patients as permitted
- To ensure all and only services provided result in an accurate and timely recognition of revenue as permitted by program requirements, charges will be assessed only as allowed and will be applied in accordance with the sliding fee scale
- To ensure the sliding fee scale discount is applied accurately to full charges when appropriate
- To ensure sliding fee scale discounts, bad debts and other revenue adjustments are recorded in an accurate and timely manner
- To ensure voucher services are monitored and treated in accordance with contract guidelines

A. Charges for Services

A “**Nominal Flat Fee Schedule**” has been established to offset the costs of providing services. This “**Nominal Flat Fee Schedule**” is universal at all GFHP project sites and it defines the flat fees that project sites can charge if a family's income is at or below the federal poverty level. If a client's income exceeds the poverty level guidelines it is expected that the client fees will be

based upon full charges. Full charges may not be below the current Medicaid rates or the **minimum flat fee or nominal** amounts.

Nominal Flat Fee Schedule – on-site services:

Initial medical appt:	\$25.00
F/U appt – acute	No Charge
F/U appt – chronic	\$25.00
Rx – filled on site	\$5.00
Lab work – on site	No Charge

Nominal Flat Fee Schedule – Off-site or voucher services – Lower of ½ Medicaid Rate or,

Rx – filled off site	\$15.00* (Must use generic meds if available. Only
Lab work – Voucher	\$15.00 prescriptions equal to \$50 or greater can
X-Ray – Voucher	\$15.00 be vouchered out)*
Provider referral – Voucher	\$15.00

If a patient’s income is above the Federal Poverty Guidelines, charges associated with a voucher request are to be based upon the sliding fee scale percentages applied to Medicaid rates.

The GFHP requires that fees paid to outside providers coincide with Medicaid rates for allowable services. An “allowable service” is defined as any service reimbursed by Medicaid. Other services (e.g., transportation, etc.) may have a related fee. Note that there can be several Medicaid rates for each procedure code. Project sites will be required to use the procedure code with the least expensive Medicaid rate.

B. Sliding Fee Scale

The **patient charge** is the amount requested from the patient. The patient will be charged either the Nominal Flat Fee or a percentage of the clinic’s “full charges” based on a sliding fee scale. The sliding fee percentage is determined by comparing the family’s income to Federal Poverty Guidelines. The following table represents the percentage of the total fees to be charged according to the federal poverty guidelines. **This table will be updated annually and will be used consistently for each patient or case.**

2007 Poverty Guidelines and Sliding Fee Scale Table

Annual Income

Full Charge %	Minimum Fees	20%		40%		60%		80%		100%
% Poverty Level	100% or less	101% to 125%		126% to 150%		151% to 175%		176% to 200%		over 200%
Family Size		From	To	From	To	From	To	From	To	Over
1	10,210 or less	10,211	12,763	12,764	15,315	15,316	17,868	17,869	20,420	20,420
2	13,200 or less	13,201	16,500	16,501	19,800	19,801	23,100	23,101	26,400	26,400
3	16,600 or less	16,601	20,750	20,751	24,900	24,901	29,050	29,051	33,200	33,200
4	20,000 or less	20,001	25,000	25,001	30,000	30,001	35,000	35,001	40,000	40,000
5	23,400 or less	23,401	29,250	29,251	35,100	35,101	40,950	40,951	46,800	46,800

sliding fee scale is developed using a family’s income and the Federal Poverty Level. If a family’s income is over 200 percent of the federal poverty level, the patient will be charged the total of all fees or “full charges.” If a family’s income is at or below the federal poverty level, the patient will be charged only the **Nominal Flat Fee**. If a family’s income is between 100 percent and 200 percent of the federal poverty level, the patient will be charged a percentage of the “full charges.”

The following provides the percentages of charges by income percentage to poverty level.

20% of full charges - 101% to 125% of poverty level

40% of full charges - 126% to 150% of poverty level

60% of full charges - 151% to 175% of poverty level

80% of full charges - 176% to 200% of poverty level

100% of full charges - over 200% of poverty level

The following table represents an **EXAMPLE** of a Sliding Fee Scale that incorporates the GFHP Nominal Flat Fees and the 2006 Federal Poverty Levels. For update on poverty levels go to <http://aspe.hhs.gov/poverty/>. NOTE: Federal Poverty Levels must be reviewed and modified as updated every year.

Sliding Fee Schedule

The Minimum Payment must be used by all clinic sites for patients at or below Federal Poverty Levels. Each clinic may set their own "Full Charges". However the percentage of full charge to be paid (**Patient Charge**) must be determined from the "Full Charge %" in the "Poverty Guidelines and Sliding Fee Scale Table".

EXAMPLE

VISITS

CPT Code	EXAMPLE Full Charges (1)	2006 Medicaid Rate (2)	Patient's Minimum Payment	Percentage of Clinic Full Charges (Each clinic may determine "Full Charges") (See note 3)					
				20%	40%	60%	80%	100%	
NEW VISITS									
99201	\$ 60.00	\$ 35.19	\$ 25.00	\$ 25.00	\$ 25.00	\$ 36.00	\$ 48.00	\$ 60.00	\$ 60.00
99202	\$ 75.00	\$ 54.57	\$ 25.00	\$ 25.00	\$ 30.00	\$ 45.00	\$ 60.00	\$ 75.00	\$ 75.00
99203	\$ 90.00	\$ 76.53	\$ 25.00	\$ 25.00	\$ 36.00	\$ 54.00	\$ 72.00	\$ 90.00	\$ 90.00
99204	\$ 105.00	\$ 110.51	\$ 25.00	\$ 25.00	\$ 42.00	\$ 63.00	\$ 84.00	\$ 105.00	\$ 105.00
99205	\$ 120.00	\$ 137.12	\$ 25.00	\$ 25.00	\$ 48.00	\$ 72.00	\$ 96.00	\$ 120.00	\$ 120.00
ESTABLISHED									
99211	\$ 40.00	\$ 17.46	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00	\$ 32.00	\$ 40.00	\$ 40.00
99212	\$ 50.00	\$ 29.67	\$ 25.00	\$ 25.00	\$ 25.00	\$ 30.00	\$ 40.00	\$ 50.00	\$ 50.00
99213	\$ 60.00	\$ 40.70	\$ 25.00	\$ 25.00	\$ 25.00	\$ 36.00	\$ 48.00	\$ 60.00	\$ 60.00
99214	\$ 70.00	\$ 62.71	\$ 25.00	\$ 25.00	\$ 28.00	\$ 42.00	\$ 56.00	\$ 70.00	\$ 70.00
99215	\$ 80.00	\$ 93.46	\$ 25.00	\$ 25.00	\$ 32.00	\$ 48.00	\$ 64.00	\$ 80.00	\$ 80.00

- (1) To be determined by each clinic
- (2) Full charges should not be less than the 2005 Medicaid Rates.
- (3) Regardless of full charge %, fee cannot be less than nominal payment amount.

OTHER SERVICES

	Patient's Minimum Payment	Percentage of Clinic Full Charges (Each clinic may determine "Full Charges") (See note 3)				
		20%	40%	60%	80%	100%
Lab on-site (per test not to exceed \$15)	N/C	Full charges to be determined by clinic.				
Prescriptions filled on-site/injections (per drug)	\$ 5.00	Full charges to be determined by clinic.				

- (3) Regardless of full charge %, fee cannot be less than nominal payment amount.

Vouchered Services (Full charges are based on Medicaid rates)

Xray (each xray)	See note (4)	\$ 15.00	Charges are set at the Medicaid rate for service.
Lab (total of all tests)	See note (4)	\$ 15.00	Charges are set at the Medicaid rate for service.
Provider Referral (per visit)	See note (4)	\$ 15.00	Charges are set at the Medicaid rate for service.

- (4) Patient will pay the lower of 1/2 Medicaid rate or nominal fee for vouchered services.
Clinic will pay vouchered provider at the Medicaid rate (or usual and customary fee if less than Medicaid rate) less any monies the vouchered provider may have directly collected from the patient.

The “full charges” will be reported on the **GFHP Monthly and Quarterly Cost Reports**, Appendix G. These fees will apply to all patients, regardless of payer.

The difference between the total of “Full Charges” and the amount of “Patient Charges” is the **sliding fee adjustment**.

Migrant Health Program Quarterly Cost Report		District:	Reporting Period: From	To	Prepared by:	Page 1 of 2
REVENUE FOR SERVICES RENDERED:						
	Beginning A/R Balance	Full Charges	Payments Received	Sliding Fee Adjustments	Contractual Adjustments	Ending A/R Balance
1	Medicare					
2	Medicaid					
3	Other Third Parties					
4	Patients					
5	Total Services Revenue (sum of lines 1-4)					
OTHER REVENUE SOURCES:						
6	Migrant Pgm Grant-In-Aid		Payments Received			
7						
8						
9						
10	Total Other Revenue (lines 6-9)					
VALUE OF DONATED VALUE						
11			Value Received			
12	Net Donated Cost, from p.2, 1.24					
Total Revenue, Grants, & Donated Value (5+10+11+12)						

(Cost Report, Section 1) Appendix G

C. Collections and Deposit Procedures

Patient collections are the funds received from the patient. Every effort will be made to collect the amount charged on the day services are rendered. However, health services cannot be denied to patients who are unable to pay on the date service is needed or rendered.

All collections from patients will be taken by a designated “cashier.” Each site will have a designated cashier and a backup. Each cashier will have a background check conducted prior to the assignment to ensure that there is nothing in this person’s background that would make them unsuitable to handle and record the receipt of cash. A pre-numbered receipt book will be used for recording payments. (A separate pre-numbered receipt book will be kept for the GFHP patients if the clinic sees patients who are not GFHP.) A receipt will be written for all collections received on-site or through mail. Patients will be given one copy, while a remaining copy will be kept in the receipt book for end of day reconciliation purposes. Collections will be received and receipts written by the designated cashier or the cashier’s backup. **The cashier will be required to run the daily receipts report at the end of each day. The cashier’s supervisor will verify the cash intake and the deposit slips against the daily receipts report.**

1. All cash taken will be immediately secured in a locked cash drawer. All checks will be endorsed (stamped) as they are collected from the patient.
2. During the day, someone will be responsible for the GFHP Database entry of the day's encounters. (See Section X, **Encounter Database Entry Procedures**, of this manual.)
3. At the end of each day, the "cashier" will count the collections and summarize these for preparation of the daily deposit ticket. The Receipt Book and Deposit Slip will be given to the Office Manager (or comparable position) for verification against the Encounters and Daily Receipts Reports.
4. All bank deposits will be made daily at the end of the business day. **GFHP funds will have a separate deposit slip from other funds being deposited.** If a deposit cannot be made, all collections will be locked in a safe place by the Office Manager. A copy of the bank's deposit receipt and the daily deposit ticket will be attached to the Daily Cash Receipts Report. **MONIES COLLECTED CANNOT NOT BE USED AS A PETTY CASH FUND.** If petty cash is needed for small office expenses, a separate fund should be established and handled in accordance with the "Petty Cash Procedures" in **Section XVIII.**
5. Bank reconciliations will be prepared monthly by the Office Manager. A comparison of bank deposits slips for the migrant program to the bank statement will be made and compared to the Monthly Cash Receipts Report. Any discrepancies will be investigated immediately and any major problems reported to appropriate supervisory personnel and the state office immediately but no later than the next business day after the discovery. Major problems will be defined as any dollar discrepancy greater than \$50 or any missing records for reconciliation purposes that cannot be accounted for within 24 business hours.

D. Bad Debts

The difference between the amount of the patient charge and the amount collected should be written off of the books in accordance with the project's Financial and Billing Policies and Procedures. These uncollected charges are also called **bad debt** (See also Cost Report, Section 1). All project sites are expected to request payment for any services rendered that still have remaining charges attached for prior services. Health care services will not be withheld from those patients with bad debt balances. A record of bad debts will be maintained for the current calendar year. At the end of the calendar year, sites will provide the SORH Program Director with a report of the bad debt write offs.¹

Example: *Anywhere Migrant Project Site*

¹ Review this section carefully. The federal policy concerning write offs for bad debt may be eliminated as a result of proposed 2008 White House legislation.

Nominal Flat Fee: \$25.00

Example 1

Patient X comes in for a visit. His family income is \$15,000 per year, and he has four people in his family. Therefore, he falls into the 0 percent pay category on the sliding fee scale. He receives services and his total of all fees is \$60.00. Therefore you request \$25.00 as the Nominal Flat Fee. The patient only has \$6.00. The following is a financial breakdown of this visit:

Full Charges (Total of all fees):	\$60.00
Sliding Fee Adjustments:	\$35.00
Charges to patient:	\$25.00
Payments Received (Collections):	\$ 6.00
Bad Debt (Written Off):	\$ 19.00

Example 2

Patient Y comes in for a visit. Her family income is \$15,000, and there are 2 people in the family. Therefore, she falls into the 20 percent pay category on the sliding fee scale. She receives services and her total cost for the office visit is \$60.00. She also receives an over the counter medication for \$5.00. Although 20 percent of \$60.00 is \$12.00, the patient must pay no less than the Nominal Flat fee of \$25.00. The patient pays \$30.00. The following is a financial breakdown of this visit:

Full Charges (Total of all fees):	\$60.00
Sliding Fee Adjustments:	\$35.00
Charges to patient:	\$25.00 for Office visit \$ 5.00 for medication
Payments Received (Collections):	\$30.00
Bad Debt (Written off):	\$ 0.00

There is no bad debt to be written off. The patient paid charges in full

Those items in bold in the above examples correspond with the wording from the Quarterly Cost Reports.

Encounters and Billing for

Abel Gonzalez

Set Date

Add New
EncounterCase
Mgt/Refer

Peri Hx

Edit Dx

Ed

TransDate:	Svc Date:	Pay Date	CPT Code	Fee Charged	Slide Adj.	Bad Debt	Fee Pd	Receipt #	Referral No.	Provider
10/24/2002	10/15/2002		81003				\$0.00			1054
10/24/2002	10/15/2002		99201				\$0.00			1054
10/24/2002	10/15/2002		00009				\$0.00			72
10/24/2002	10/15/2002		85025				\$0.00			1054

X. ENCOUNTER and BILLING DATABASE ENTRY PROCEDURES

Please note the following:

- Below the ENCOUNTERS AND BILLING FOR section; there must always be a name listed that was chosen from the FAMILY MEMBER INFORMATION section before data can be entered. If an error message is received when trying to enter data, it is because a particular family member was not chosen.
- The SET DATE button is for convenience. If you have a large number of data encounters to be entered on the same date, this will make the date default
- ADD NEW ENC - this button must be clicked in order to enter a new encounter
- CASE MGT/REFERRAL - See explanation in Registration Section of manual
- PERI HX - See explanation in Registration Section of manual
- EDIT Dx - Button will allow editing of ICD Dx codes not already in the computer file. To add a new code, click the ADD RECORD button at the top. Enter the Code number and the correct description of the code as given in the manuals. Existing codes may also be deleted or edited. After entry, you can return immediately to this screen
- EDIT CPT - This button is for adding a CPT code that is not already in the computer file. If a new CPT code needs to be added, contact program director to ensure that all sites use the same code. After entry, you can return immediately to this screen. If the Medicaid payment needs to be entered, it has to be done from the CPT Code button on the Master Menu page. **Medicaid rates change each year around the month of May. For the latest rates go to www.ghp.georgia.gov/wps/portal and click Provider Information and then Provider Manuals. These rates should also be updated or imported into the GFHP database every year**

Patient encounter data manually entered on the encounter forms (charges, adjustments and payments) will be entered into the GFHP Database system DAILY. When invoiced by an outside provider, voucher services will also be entered as patient encounters. Staff will enter the voucher service date, invoice amount and client payments per instructions below.

The following information will be entered into the database system for EACH on-site or voucher encounter.

Click on the Add new encounter box to add a new encounter for the patient

Service Date - Date Service was rendered e.g. 01/01/2006. If a payment is received on a different date than the service date, user will look up the encounter to which the payment applies. This may be different from the current date. Enter the payment amount in the same row as the service date to which it applies.

Pay Date - Enter the date the payment was received. If the “Pay Date” is AFTER the “Service Date” look up the encounter to which the payment applies and post the payment in the same row as the service date. **If there is already an entry in the “Fee Paid” field, then you must enter another encounter with the same service date in order to post the payment.**

CPT Code - Enter the CPT code by number. Only one CPT code can be entered per encounter. If there are more CPT codes to enter, they must be entered under another encounter, using the same date. All CPT codes listed must be already listed in the CPT Code database. Clicking the **EDIT CPT** button will provide a screen of listed CPT codes with their description. New CPT codes may be added here when instructed to do so by the Program Director. However, the Medicaid Rate must be entered. This editing must be done from the Main Menu screen and by clicking on **CPT Codes** button.

Fee Charged - Type in the “full charge” for the service provided. The full charge is the amount that will be reduced by the sliding fee percentage.

Slide Adj. - Type in the \$ amount of the full charge that will be written off due to the sliding fee adjustment.

Bad Debt - Type in the amount of the fee owed by the patient (after the Slide Adjustment) that is not paid by the patient. (See Bad Debt report section.) If the patient is going to come in at a later date to pay on the bill, do not enter a bad debt amount.

Fee Paid - Enter the amount that is paid to the clinic by the patient for services rendered at the clinic site. This may be a payment for the current visit or for a prior visit.

Receipt # - Enter the number of the receipt given to the patient. A copy of this receipt should remain in the receipt book.

Referral No. - Enter a “0” if this is an on-site service; enter “1” if this is a service that will be performed off-site through the “voucher” program.

Provider - Type in the provider’s number, or look up the provider on the pull down list. Please avoid generic provider numbers, if possible, so that all providers may see a report of their activity.

Provider type - Type in the provider type letters or look up the provider type on the pull down list. The provider type is defaulted to the provider. It **MUST** be changed if the provider is functioning under another provider type. Choosing the correct provider type is essential to obtaining a true UDS report. **All encounter reporting is generated by the Provider Type.**

Invoice Amount - USED FOR VOUCHER SERVICES ONLY - Enter the amount of charges billed to the Clinic by off-site (voucher) providers.

Client Paid - USED FOR VOUCHER SERVICES ONLY - Enter the amount paid by the patient directly to the off-site provider for voucher services.

Medicaid Rate - Once the CPT code has been entered, the Medicaid Rate will automatically default, unless there is no amount listed for that CPT code. This is used in REPORTS to determine the amounts due to the providers for referred patients with vouchers.

Diag. 1 - Enter the primary diagnostic code or look it up in the pull down list. **No diagnostic code should be entered for the provider type of HE, which are health education encounters.**

Diag. 2 - Enter the second diagnostic code if one is given.

Diag. 3 - Enter the third diagnostic code if one is given. If there are more diagnostic codes, then a new encounter has to be entered listing them under the same date. These can be added to a CPT code, for example, translation or another code that does not have a corresponding ICD-9 code. Almost all needed ICD-9 codes are listed in the database. For health education encounters, no diagnostic codes will be entered.

Paid Status - Enter paid or pending. Pending is the default for all encounters

Service Location - Please select the service location of the encounter

County - Enter the county of the service location

PRESS THE CONFIRM ADDITIONS BUTTON TO SAVE ENTRIES.

Perinatal Encounters

Encounters and Billing for											
Abel Gonzalez											
	TransDate:	Svc Date:	Pay Date	CPT Code	Fee Charged	Slide Adj.	Bad Debt	Fee Pd	Receipt #	Referral No.	Provider
	10/24/2002	10/15/2002		81003							
	10/24/2002	10/15/2002		99201				\$0.00			1054
	10/24/2002	10/15/2002		00009				\$0.00			72
	10/24/2002	10/15/2002		85025				\$0.00			1054

The Perinatal Encounter input screen is accessed by clicking the “Peri Hx” button in the Encounter and Billing For section of the Family Information Screen.

For UDS reporting all pregnancies are to be reported. However, because clients are referred to other providers for continued follow up of the pre and post delivery, the information entered will be minimal. Answer all that is possible. If there was a miscarriage, stillbirth or twins, this data is to be entered at the bottom of the screen “Extra Pregnancy Data.” The general data report of all “Extra Pregnancy Data” may be obtained by clicking on the button “Extra Preg Data” on the Main Menu. Follow up, with expectant mothers, will be crucial to UDS reporting.

Programs will contact mothers after delivery to obtain the birth weight information of their babies, ensure newborn visit within four weeks of birth, and to schedule their eight week post partum checkup. Each project will develop its own process for ensuring this follow-up contact takes place.

XI. AUTHORIZING AND TRACKING SYSTEM REFERRALS (VOUCHERS)

A. GateKeeping

Each project will design a method of gatekeeping for referring patients to outside providers. This method will be submitted to SORH as a part of the project’s policies and procedures. Generally, the nurse practitioner will provide primary health care. Whenever care is needed

from a physician, pharmacist or dentist, project staff will authorize the specific service needed, giving the patient an authorization form (**Appendix E and F**) to take to the referral provider. The form will clearly state the services requested from the provider with an approximate amount the program will pay. The provider will contact the project site if charges exceed the authorized amount. Patients are required to pay the nominal charge of \$15 for referrals or voucher services.

Persons with third-party payment sources will be referred to providers, but without an authorization form. The program can provide follow-up to these patients.

Health providers (physicians, dentists, pharmacists) will be paid either the Medicaid Rate or the provider's usual and customary fee for services, if lower than the Medicaid Rate. **As a guideline the maximum amount of Federal and State funding authorized per MSFW is \$250 per year per user.** If a patient's accumulated medical expenses exceed the threshold listed contact the SORH for guidance.

Providers must bill the GFHP by ICD-9 or CPT code. Physicians and dentists requesting payment must state patient's name, diagnosis, treatment, prescriptions ordered, instructions to patient, follow-up, and date of service on the authorization form.

REFERRING PROGRAM GEORGIA FARMWORKER HEALTH PROGRAM Service: _____
 Authorization for Medical Care Patient Information Form # _____

LOCATION _____ Date of Referral _____

Name (Last, First, MI) _____
 Date of Birth _____ ID# _____
 Local Address _____
 Homebase Address _____
 Referred to (Name, address, city, state, zip) _____
 County Code _____

Reason for referral (include diagnosis, length of time patient has been seen for this problem, etc.) _____

Estimate of program payment _____ Patient's % of payment _____

Office Use Only

This authorization is void if patient qualifies for Medicaid, insurance, or other third party payment.
 Authorized by _____ Phone _____

Provider Information

Date	Place	Procedure Code	Medical Procedure	Diagnosis Code	Charges	Type of Service
Total Charges					Patient Payments	Balance Due

Was laboratory work performed outside your office?
 Yes No charge _____

Narrative report: Please describe treatment, follow-up, prescriptions ordered, when, where patient was hospitalized, instructions to patient.

Physician's Signature _____
 Date _____

Please return a copy of this authorization form for payment to: _____

REFERRING PROGRAM GEORGIA FARMWORKER HEALTH PROGRAM
 Authorization for Dental Care Patient Information Form # _____

LOCATION _____ Date of Service _____

Name (Last, First, MI) _____
 Date of Birth _____ ID# _____
 Local Address _____
 Homebase Address _____
 Referred to (Name, address, city, state, zip) _____

Office Use Only Estimate of program payment _____

This authorization is void if patient qualifies for Medicaid, insurance, or other third party payment.
 Authorized by _____ Phone _____

Provider Information

NO Enumeration and Treatment Record - List in Order from Table No. 1 through Table No. 33

TABLE NUMBER	DESCRIPTION OF SERVICE	DATE SERVICE RENDERED	PROVISION NUMBER	FEE	FOR DENT USE ONLY
TOTAL CHARGES				AMOUNT PAID	BALANCE DUE

Is follow-up needed? yes no; for what _____
 Return appointment? yes no; when needed? _____
 Does patient need transportation to the next appointment? yes no

Physician's Signature _____
 Date _____

Please return a copy of this authorization form for payment to: _____

Appendix E

Appendix F

The gatekeeping function can also be assigned to a nurse in a participating county. All documentation will be sent to the migrant project. Nurses must note in the record why the patient was referred to an outside provider.

If a non-insured, non-Medicaid patient is eligible because of income and family size to pay a percentage of the provider's charges, program staff will determine this percentage. Project staff should note it on the authorization form when the patient comes in for a referral, and send the authorization form to the provider via the patient. The amount due from the patient will be the appropriate percentage of what the GFHP will pay the provider for the service, not a percentage of the usual and customary charge. If a patient is in the 0 percent pay category on the sliding fee schedule, project staff should also note on the authorization form that the patient should be asked by the provider's office to pay the Nominal Flat Fee. If the provider collects any money from the patient, this must be noted on the authorization form that is returned to the local project office.

Participating physicians and dentists will bill third-party payment sources directly. Any arrangements for applicable co-payments or deductibles must be negotiated between the provider and patient. The GFHP will only pay for those persons not covered by a third party. Regarding injuries, the physicians and dentists must determine if they are work-related and whether or not the farmer carries worker's compensation. If the farmworker is covered by worker's compensation, the physician should bill the worker's compensation insurance. If a farmworker is not covered by worker's compensation, the patient should be treated as any other farmworker without a third-party payer. Physicians and dentists are requested to send copies of all bills submitted to any other party payer to the project site.

The GFHP will assist migrants in establishing eligibility for Medicaid/Medicare. The program will authorize services for a patient who is applying for Medicaid or Medicare. If the patient is found ineligible, the program will pay the referral provider. If the patient becomes eligible after payment is made, the referral provider will bill Medicaid or Medicare and refund the GFHP.

Referral providers will not be paid for care provided to MSFW patients who are not enrolled in the GFHP and who have not been given a referral for service by GFHP staff. Providers should strongly encourage migrants to register with the program before seeking medical care.

Referral providers must be informed that GFHP funds are funds of last resort and that the physician must bill insurance, including workers compensation, or Medicaid first.

Example: Somewhere Migrant Project Site

Example 1

Patient W comes in for a medical problem. A nurse completes the referral authorization form, and notes the following: her family income is below the federal poverty level (therefore, she falls into the 0 percent pay category on the sliding fee scale), the provider should request \$25.00 as the Nominal Flat Fee for her clinic visit and \$15.00 for her referral. The patient goes to the referral provider and receives services. The provider plans to bill GFHP for \$60.00

(Medicaid rate). The patient only has \$2.00. The following is a financial breakdown of this visit:

<i>Full Charges (for office visit):</i>	<i>\$60.00</i>
<i>Sliding Fee Adjustments:</i>	<i>\$35.00</i>
<i>Charges to patient:</i>	<i>\$25.00 office visit</i>
	<i>\$15.00 for voucher</i>
<i>Full Charges for Voucher</i>	<i>\$60.00</i>
<i>Payments to provider from patient:</i>	<i>\$ 2.00</i>
<i>GFHP payment to provider:</i>	<i>\$58.00</i>
<i>Patient still owes</i>	<i>\$38.00 for OV & voucher</i>

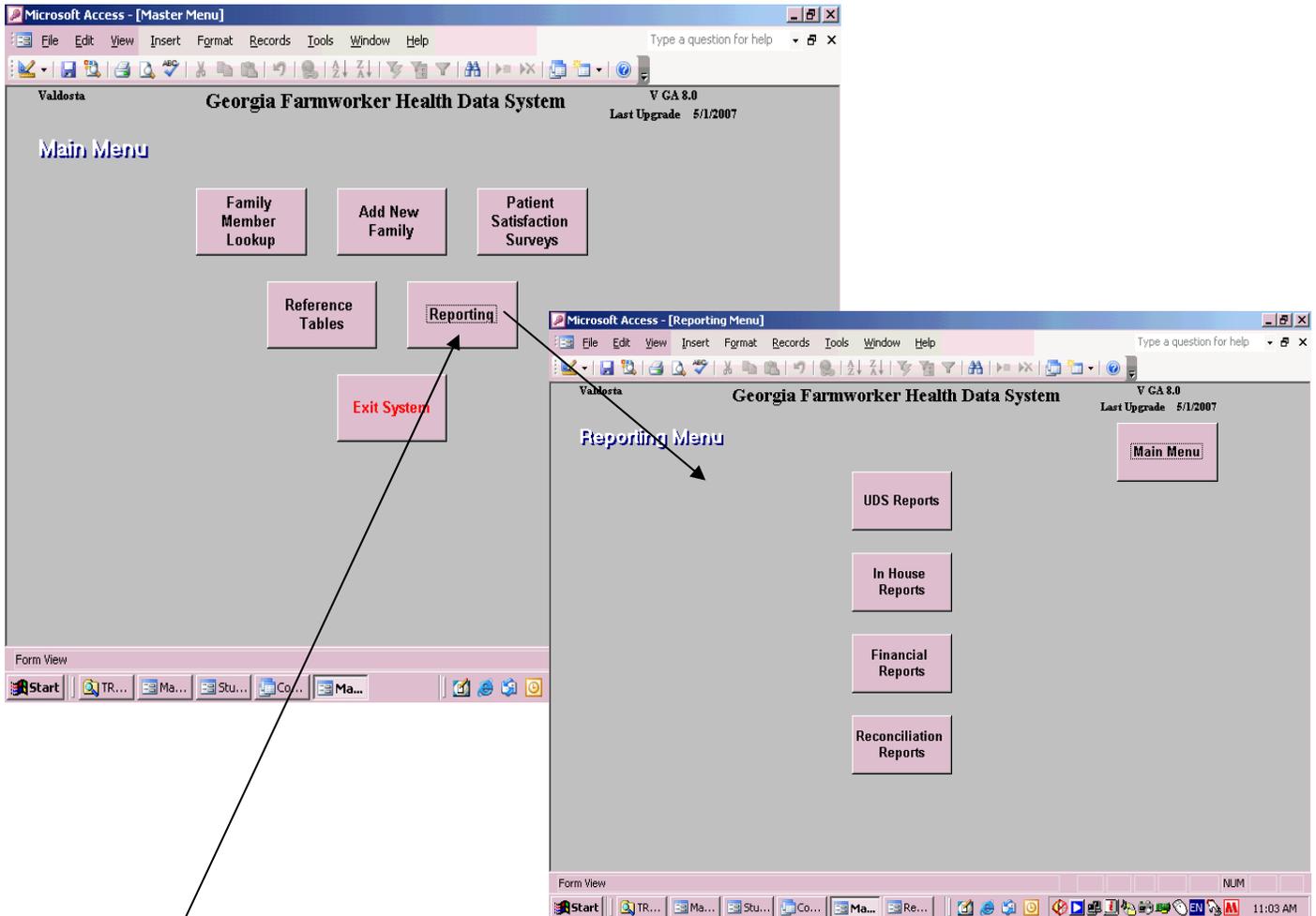
Example 2

Patient Z comes in for a medical problem. A nurse completes the referral authorization form, and notes the following: his family income is 155 percent of the federal poverty level (therefore, he falls into the 60 percent pay category on the sliding fee scale), the provider should request 60 percent of the GFHP reimbursable rate. The patient goes to the referral provider and receives services. The provider plans to bill GFHP for \$65.00 (Medicaid rate) . The patient only has \$5.00. The following is a financial breakdown of this visit:

<i>Full Charges (for office visit):</i>	<i>\$60.00</i>
<i>Sliding Fee Adjustments:</i>	<i>\$24.00</i>
<i>Charges to patient:</i>	<i>\$36.00 for office visit</i>
	<i>\$15.00 for voucher</i>
<i>Full Charge for Voucher</i>	<i>\$65.00</i>
<i>Payments to provider from patient:</i>	<i>\$ 5.00</i>
<i>GFHP payment to provider:</i>	<i>\$60.00</i>
<i>Patient still owes</i>	<i>\$46.00 for OV & voucher</i>

XII. GFHP Reporting

This next section references various reports for GFHP. To access the reports in the database, the user must click the **REPORTING** button on the main menu. The Reporting Menu houses all necessary reports for GFHP.



Click the Reporting Button to access the reporting menu where all reports for GFHP are housed.

VOUCHER DATABASE ENTRY PROCEDURES

Local projects should reimburse providers the difference of the total fees for services based on the **Sliding Fee Scale or Medicaid Rates** rendered and the amount paid by the patient. The **“Service Date”**, **“Invoice Amount”** and the amount paid by the patient to the outside provider, **“Client Paid,”** should be entered into the GFHP Database as an encounter. There should be a **“1”** entered into the **“Referral No.”** column, along with appropriate information concerning the **“CPT Code,” “Provider”** and **“Provider Type.”** (See Section X, **Encounter Database Entry Procedures**, of this manual).

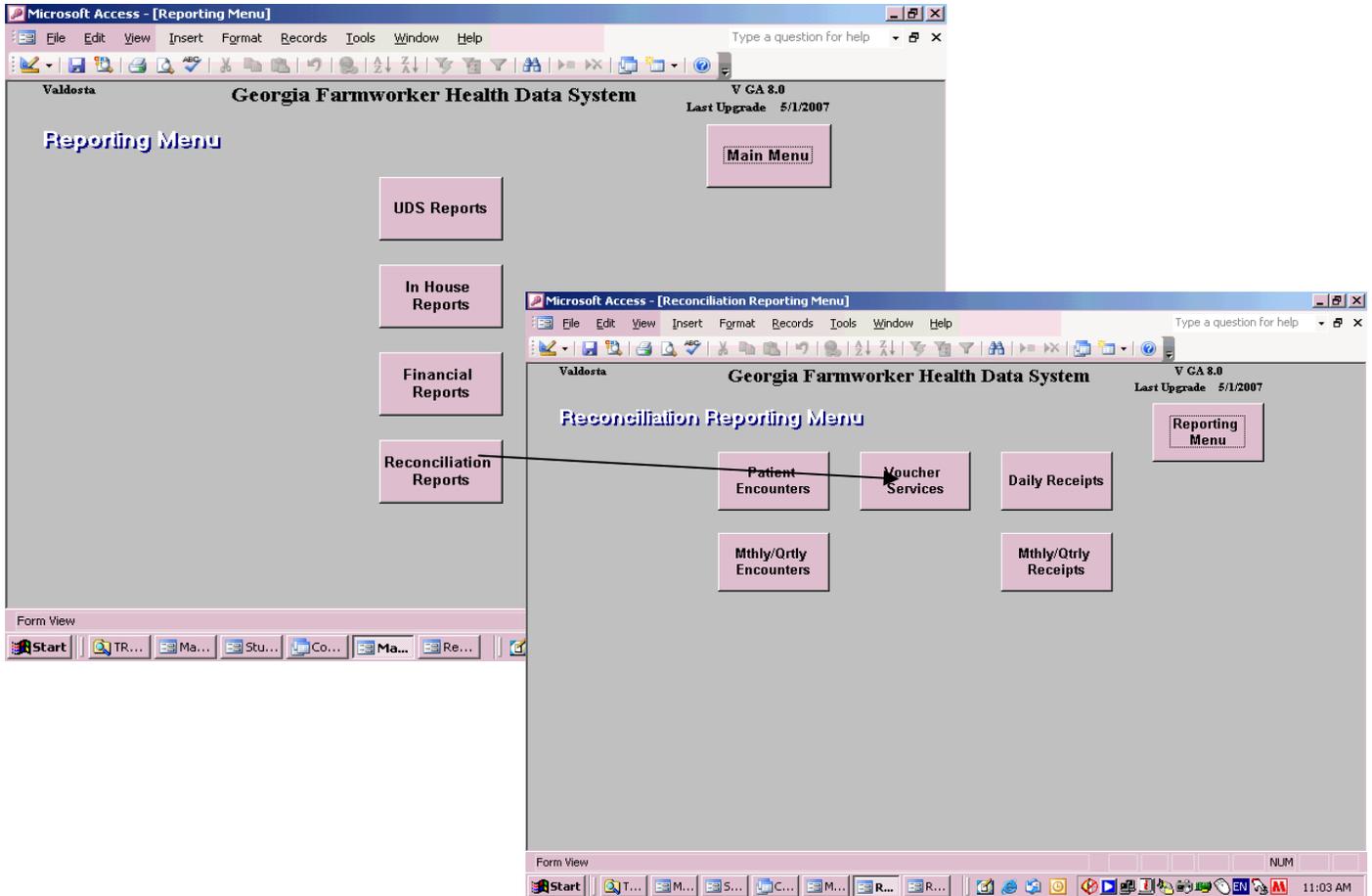
A. Voucher Tracking

The voucher program allows payment of **up to \$250 per year** for farmworkers for services rendered by a specialist which includes but not limited to, medical, dental, and mental health services. Voucher services are not to exceed \$200 per year. Therefore it is important to enter all voucher service information into the GFHP Database. There is a reporting function in the database to allow clinics to monitor and track the spend-down of the \$200 allowance. The spend-down is based upon the amount of funds GFHP will pay to the referral providers.

As previously discussed (See Section **Patient Encounter and Voucher Database Entry Procedures**) each encounter defaults to a **Paid Status** of **“Pending.”** Pending status will be changed for Voucher services only. Once an outside provider has been paid, the following action should be taken. Click the button **“Change Payment Status”** on the Main Menu. Enter the provider’s name and the date of the desired month. The listing of the entries plus the total amount to be paid should be listed at the bottom of the screen. This should coincide with the billing sent by the provider. If so, then click, **“Post as Paid.”** Close the window.

B. Voucher Reporting

On the Reporting Menu of the GFHP Database, the voucher report can be found under the reconciliation button. When selecting this report, you will be asked to enter a date range.



Once the date range has been entered, a report will be produced that provides information for each patient that has utilized voucher services during the period. The report will also indicate the remaining balance left for the patient toward the \$200 limit.

Georgia Farm Worker Health Program
Voucher Services by Patient
 For Service Dates Between 1/01/2005 and 01/31/2006

<i>Last</i>	<i>First</i>	<i>M</i>	<i>Service Date</i>	<i>Provider</i>	<i>Medicaid</i>	<i>Client Pay</i>	<i>Invoice Amt</i>	<i>Remaining</i>
MOUSE	MICKEY		12/2/2005	AGUEVO, ARTH	\$73.91	\$0.00	\$55.00	\$145.00
								\$145.00
SMITH	ROSALYN		1/6/2005	AllCare Pharmacy		\$15.00	\$22.28	\$177.72
								\$177.72
Aigner	Sue		1/4/2006	ACREE, DR. DA	\$8.48	\$5.00	\$8.48	\$191.52
								\$191.52

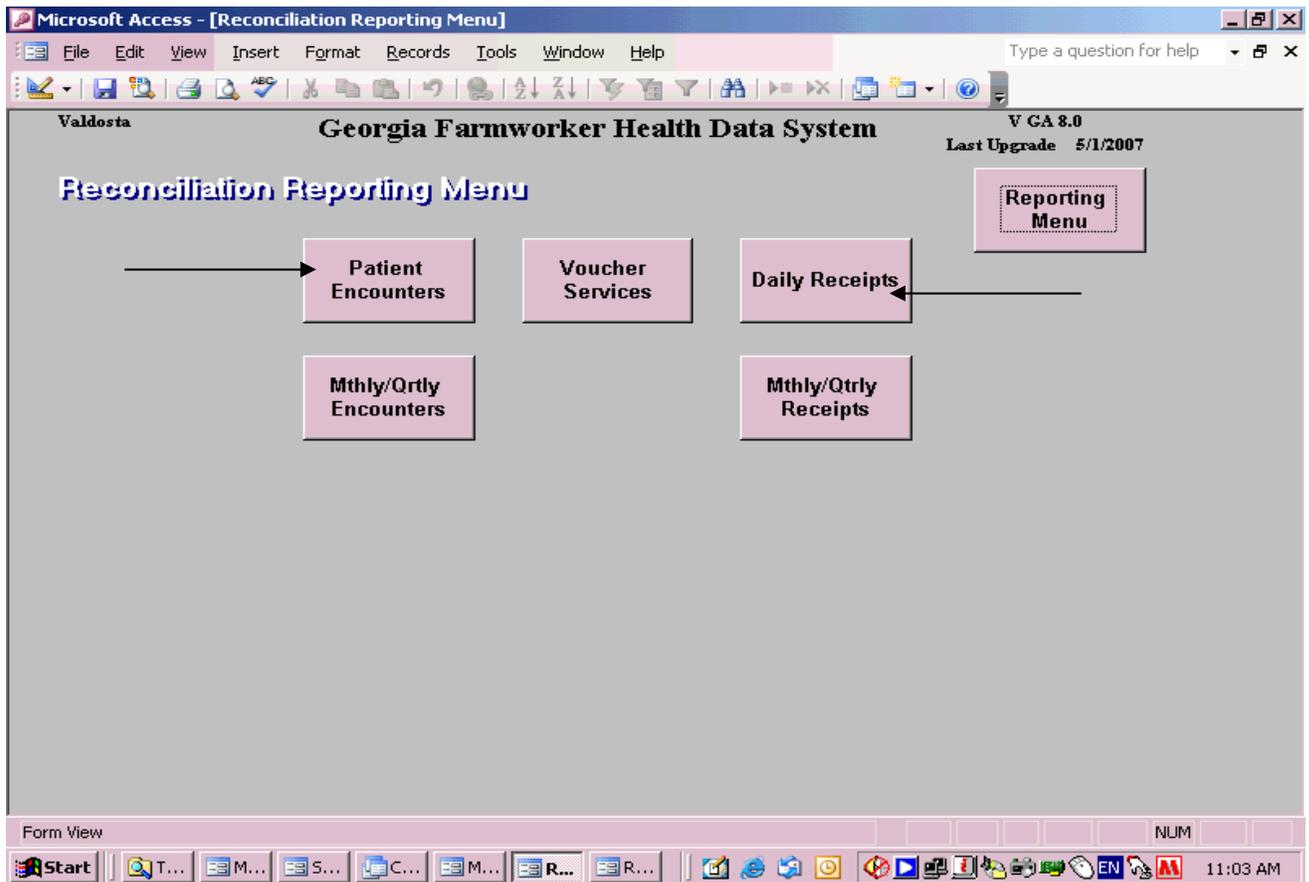
XIII. DAILY RECONCILIATION PROCESS

Objectives

- To provide strong internal controls over the handling of cash and posting of patient collections
- To ensure monies collected from patients and through the mail are properly recorded and deposited

In order to insure controls over income and receipts, as well as to insure accurate reporting, the following procedures should be followed at the end of each day.

The GFHP Database System will produce the following reports to assist in the Daily Reconciliation Process.



Patient Encounters Report - Indicates all services rendered by Service Date

Daily Receipts Report - Indicates all payments received by Payment Date



PATIENT ENCOUNTERS

Valdosta

For services from 12/2/2005 to 12/2/2005

					<i>Clinic Charge</i>	<i>Slide Adj</i>	<i>Fee Paid</i>	<i>Bad Debt</i>	<i>Account Balance</i>	<i>Receipt#</i>
<i>Service Date:</i>		12/2/2005								
2012	DUCK	DONALD	85025	CBC-lab	\$10.00	\$5.00	\$5.00	\$0.00	\$0.00	1234
2012	DUCK	DONALD	99211	Office Visit-Brief, Estab. Pt.	\$50.00	\$25.00	\$20.00	\$5.00	\$0.00	1234
2012					\$80.00	\$30.00	\$25.00	\$5.00	\$0.00	
2013	DUCK	DAISY	99211	Office Visit-Brief, Estab. Pt.	\$20.00	\$0.00	\$20.00	\$0.00	\$0.00	1235
2013					\$20.00	\$0.00	\$20.00	\$0.00	\$0.00	
<i>ServiceDate:</i>		12/2/2005			\$80.00	\$30.00	\$45.00	\$5.00	\$0.00	
For services from 12/2/2005 to 12/2/2005					\$80.00	\$30.00	\$45.00	\$5.00	\$0.00	

Both of these reports are accessed from the GFHP Database Reconciliation Reporting Menu.

A. Patient Encounters Report

The Patient Encounters Report will list all patient encounters entered into the database system for a particular date of service. Prior to generating the report, there will be a computer prompt for the user to enter the date range of services to be included on the report. The information on the report is taken from the encounter data entered by clinic staff into the GFHP Database.

The report lists the following:

Patient Name and Number

CPT and Description - This will indicate the specific services rendered to the patient.

Clinic Charge - Total charges for the day. This is “Full Charges” prior to any sliding fee adjustments.

Slide Adjustment - This amount represents the \$ amount of charges written-off from “Full Charges” based on the Clinic’s Sliding Fee Scale.

Fee Paid - This amount represents all monies collected for services rendered on the date range selected. If monies were collected for a prior service date, these amounts will not appear on this report.

Bad Debt - This amount is the bad debts written-off related to a particular service.

Account Balance - The report computes any balances remaining on the patient’s account for the services rendered on the selected service dates.

Receipt # - This should correspond with the MSFW patient receipt book copy.

B. Patient Encounter Report Reconciliation Procedures

1. Gather all GFHP Encounter Forms for the date of service.
2. Sort the encounter forms in numerical order. Identify and locate any missing forms.
3. Compare the information on the encounter form to the Patient Encounter Report. Place a check mark by each encounter on the Patient Encounter Report to indicate that the manual form information agrees with the data entered into the GFHP Database.
4. Batch all encounter forms together and staple a copy of the Patient Encounter Report to the front of the batch.
5. File the batch by date of service.

C. Daily Receipts Report

This report is generated based upon a payment date range. This report will indicate all payments posted for a particular date. Note that the service date indicated may be different than the payment date. This will be due to instances whereby the patient may not pay at time of service, but rather pays at a later date.

 <p style="text-align: center;"><i>Georgia Farm Worker Health Program</i> Daily Client Payment Report Valdosta Georgia For payments from 01/03/2006 to 01/03/2006</p>							
<i>Region</i>	<i>Family ID</i>	<i>Last Name</i>	<i>First Name</i>	<i>Service Date</i>	<i>Payment Date</i>	<i>Fee Paid</i>	<i>Receipt #</i>
<i>Valdosta</i>							
	1647	DUCK	DONALD	12/2/2005	1/3/2006	\$5.00	1234
	1647	DUCK	DONALD	1/3/2006	1/3/2006	\$20.00	1234
						Receipt #	1234
						\$25.00	
	1647	DUCK	DAISY	1/3/2006	1/3/2006	\$20.00	1235
						Receipt #	1235
						\$20.00	
	1648	MOUSE	MICKEY	1/3/2006	1/3/2006	\$15.00	1236
						Receipt #	1236
						\$15.00	
Daily Total					1/3/2006	\$60.00	
Grand Total						\$60.00	

D. Daily Receipts Report Reconciliation Procedures

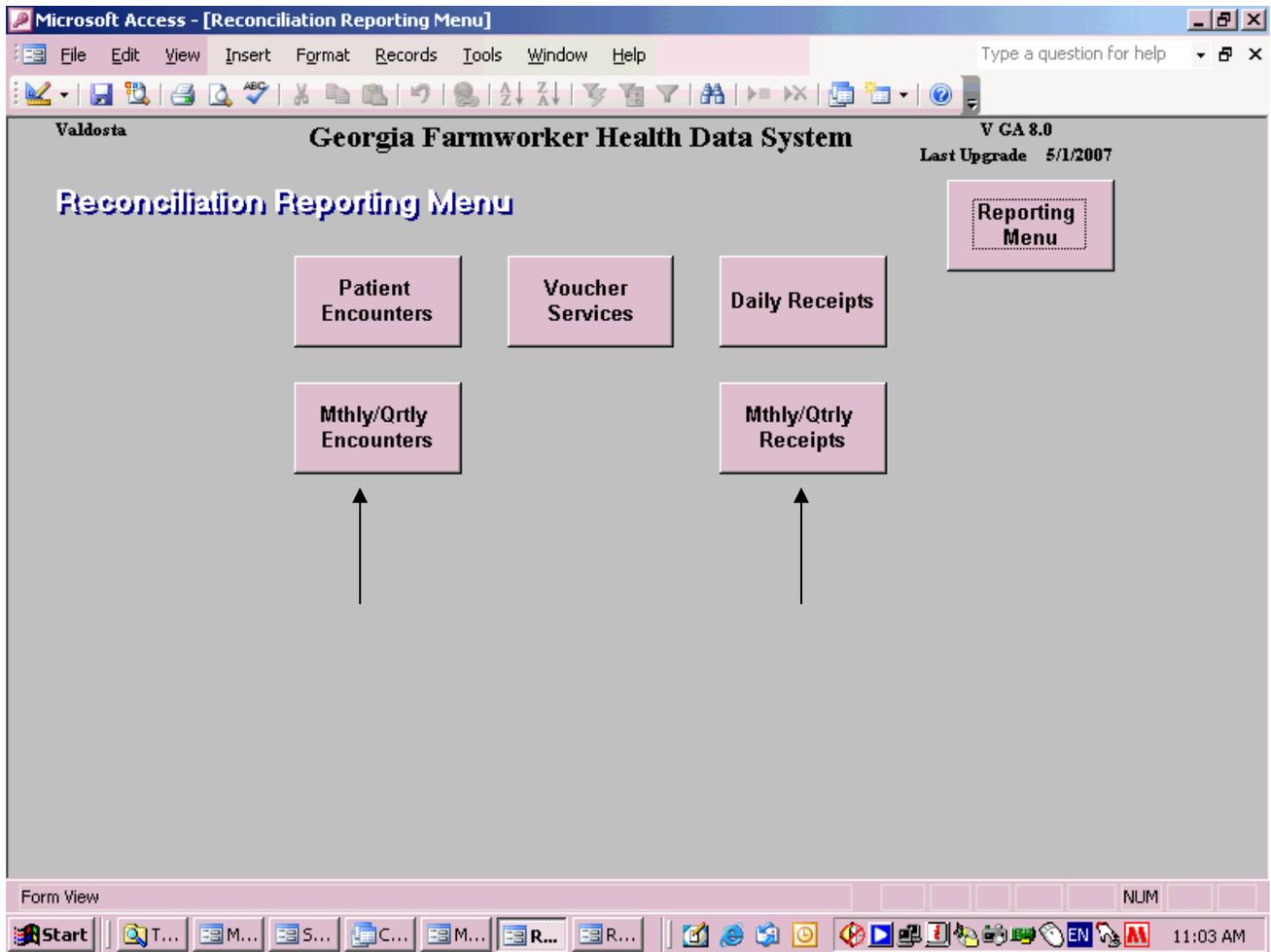
1. Obtain the MSFW receipt book.
2. Compare the information in the receipt book to the Daily Receipts Report. Place a check mark by each receipt number on the Daily Receipts Report to indicate that the receipt book information agrees with the data entered into the GFHP Database.
3. Account for any missing receipts or differences in amounts and note on the report.
4. A copy of this report should be given to the person who will be preparing the daily deposit.
5. The Daily Deposit ticket should match the grand total on the Daily Receipts Report.
6. A validated copy of the deposit ticket should be stapled to the front of the Daily Receipts Report.
7. The report and deposit ticket should be filed along with the batch of daily encounter forms.

The Daily Reconciliation Processes should be performed by someone other than the person who collects cash or enters the information into the GFHP database system.

The Daily Reconciliation Reports are subject to audit by the contracting agency.

XIV. MONTHLY AND QUARTERLY RECONCILIATION PROCESS

At the end of each month and quarter, the Monthly/Quarterly Encounters Report and Monthly/Quarterly Receipts Report should be generated using the applicable beginning and ending dates. Information generated by these reports will be used in completing the Migrant Health Program Cost Reports and should be submitted monthly to the Program Director.



A. Monthly/Quarterly Encounters Report:

Clinic Charge - Report total in “Full Charges” column of cost report.

Slide Adjustment - Report total in “Sliding Fee Adjustments” column of cost report.

Bad Debt - Report total in “Bad Debt” column of cost report.

		Clinic Charge	Slide Adj	Fee Paid	Bad Debt	Account Balance	Receipts
ServiceDate:	7/4/2005	\$149.75	\$26.57	\$15.00	\$108.00	\$0.00	
ServiceDate:	7/25/2005	\$89.00	\$0.00	\$10.05	\$78.95	\$0.00	
ServiceDate:	8/12/2005	\$330.00	\$51.84	\$40.00	\$238.16	\$0.00	
ServiceDate:	8/24/2005	\$25.00	\$1.25	\$0.00	\$23.75	\$0.00	
ServiceDate:	8/26/2005	\$90.00	\$2.58	\$10.00	\$67.02	\$0.00	
ServiceDate:	9/12/2005	\$300.00	\$25.69	\$0.00	\$274.31	\$0.00	
ServiceDate:	9/30/2005	\$350.00	\$5.21	\$100.00	\$244.79	\$0.00	
For services from 07/01/2005 to 09/30/2005		\$1,523.75	115.54	\$175.05	1,038.06	\$0.00	

Friday, January 06, 2006 Page 1 of 1

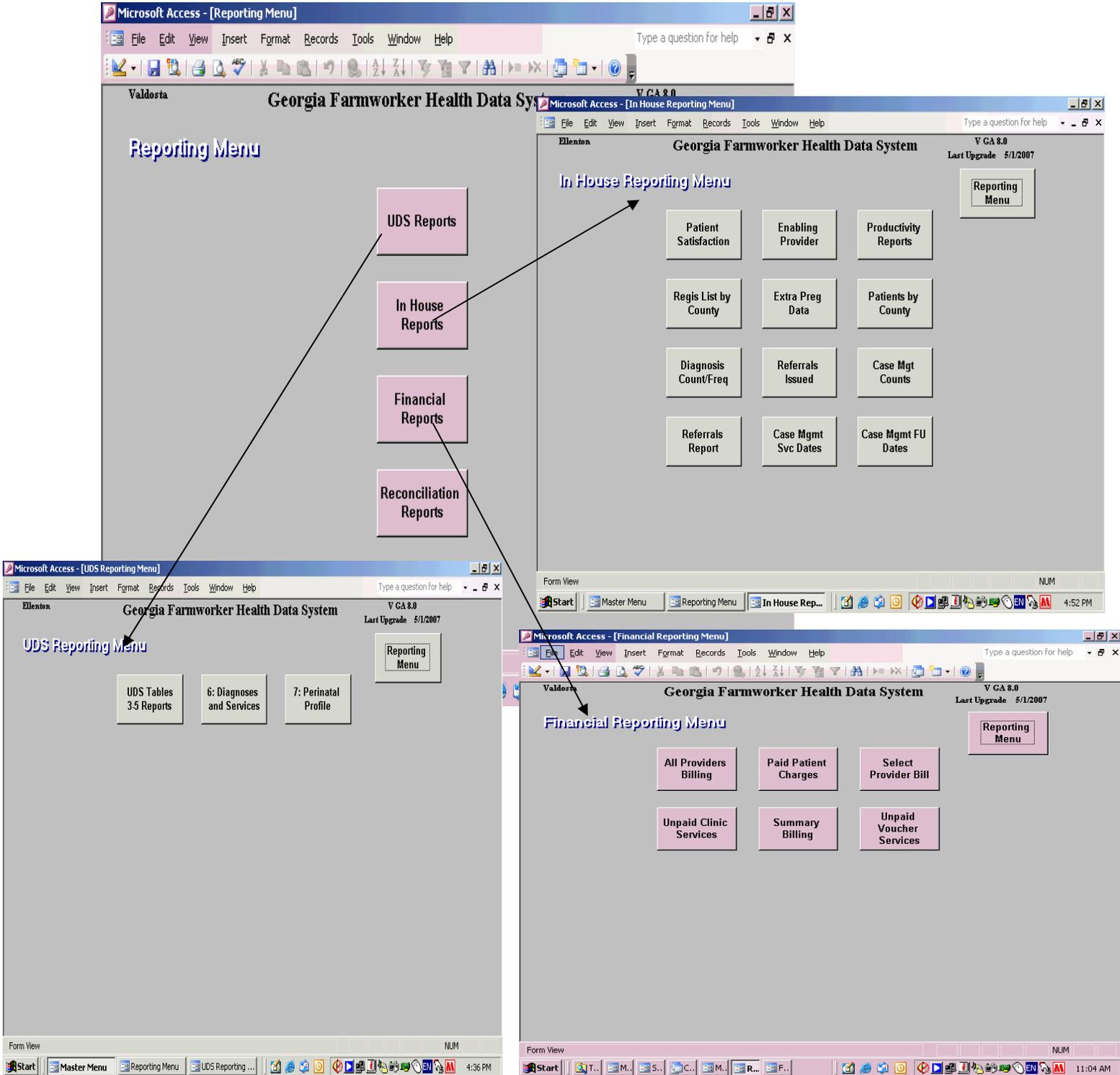
B. Monthly/Quarterly Receipts Report:

Fee Paid - Report quarterly total in the “Payments Received” column of the Quarterly Cost Report.

<i>Georgia Farm Worker Health Program</i>		
<i>Monthly / Quarterly Client Payment Report</i>		
Valdosta Georgia		
For payments from 07/01/2005 to 09/30/2005		
<i>Region</i>		
<i>Valdosta</i>		
	<i>Daily Total</i>	<i>7/4/2005</i> \$12.00
	<i>Daily Total</i>	<i>7/25/2005</i> \$10.00
	<i>Daily Total</i>	<i>8/12/2005</i> \$20.00
	<i>Daily Total</i>	<i>8/26/2005</i> \$10.00
	<i>Daily Total</i>	<i>9/1/2005</i> \$10.00
	<i>Daily Total</i>	<i>9/30/2005</i> \$400.00
	<i>Grand Total</i>	<i>\$492.00</i>

A copy of both reports should be submitted with the Migrant Health Program Cost Report.

XV. Other Reports



The Reporting Menu gives a list of possible reports that can be run. The first set will generate the UDS Table reports. The second set will generate a variety of IN HOUSE reports, and the third will generate various FINANCIAL Reports.

“**All Providers Billing**” gives a total of each providers’ charges for services rendered, the amount the client paid, and the Medicaid Rate for each client within a selected time frame.

“**Summary Billing**” gives a summary total of the Medicaid Rate charged for services rendered, the amount the client paid and the fee charged by the provider for each provider only within a selected time frame.

“**Paid Patient Charges**” will give a list of all patients who have charges over a selected amount for a selected time frame.

“**Selected Provider Bill**” will give a print out of all the patients that a selected provider has seen within a selected time frame. This will also show a total of the charges made by the provider, the Medicaid Rate and the amount due.

The final section of reports “Reconciliation Reporting” are used for daily, monthly and quarterly internal control purposes. Sections XIII and XIV of this manual provide detailed information concerning the generation and use of these reports.

XVI. COST REPORTING

Program income should be reported on the Migrant Health Program Cost Report(s) **Appendix G**. Additionally, the value of donated or volunteer time contributed to the migrant program income should be recorded and documented if the project is claiming the encounter. Monthly, Quarterly and Annual Cost reports should be submitted appropriately.

REVENUE FOR SERVICES RENDERED:								
	Beginning A/R Balance	Full Charges	Payments Received	Sliding Fee Adjustmnts	Contractual Adjustmnts	Bad Debt	Ending A/R Balance	Change in Balance
1 Medicare								
2 Medicaid								
3 Other Third Parties								
4 Patients								
5 Total Services Revenue (sum of lines 1-4)								

OTHER REVENUE SOURCES:		Payments Received
6 Migrant Pgm Grant-In-Aid		
7		
8		
9		
10 Total Other Revenue (lines 6-9)		

VALUE OF DONATED VALUE		Value Received
11		
12 Net Donated Cost, frm p. 2, l. 25		
Total Revenue, Grants, & Donated Value (5+10+11+12)		

Microsoft Excel - Copy of Jan 05 - Dec 05 Programic Rpt revised form

File Edit View Insert Format Tools Data Window Help Adobe PDF

Type a question for help

Arial 10 B I U

Reply with Changes... Egd Review...

A	B	C	D	E	F	G	H	I	
1	MIGRANT HEALTH PROGRAM								
2	MONTHLY COST REPORT					From:		To:	
3									
4		F.T.E.	Salary	Fringe Benefits	Travel	Equipment	Building Rent	Contracted Services	
5	Personnel:								
6	Medical								
7	1	Enter Medical Staff							
8	2	Enter Medical Staff							
9	3	Enter Medical Staff							
10	4	Enter Medical Staff							
11	5	Total Medical Staff	-	-	-			-	
12	Enabling								
13	6	Enter Enabling Staff							
14	7	Enter Enabling Staff							
15	8	Enter Enabling Staff							
16	9	Total Enabling Staff	-	-	-			-	
17	Administrative								
18	10	Enter Administrative Staff							
19	11	Enter Administrative Staff							
20	12	Total Admin Staff	0.00	-	-			0.00	
21	All Other (non-personnel) Direct Service Costs:								
22	Medical								

Page 1 Page 2

Ready CAPS NUM

Start Inbo... GFH... oper... Micr... 11:13 AM

Cost Reports and other financial reports should be submitted as scheduled in the grant-in-aid Master Agreement or Grant Agreement.

Expenditures reported on page two of the cost report MUST be supported by accurate supporting documentation. Copies of invoices and corresponding paid checks should be available for audit. All expenditures should be in compliance with budget requests submitted and approved by the contractor.

XVII. CASE MANAGEMENT AND REFERRALS

This part of the GFHP can be used for:

- Tracking studies
- Educational outreach
- Listing F/U appointments and tracking them
- Listing referrals
- Tracking needs for transportation or translation
- Printing the CM report to obtain lists of F/U, etc.

Please Note: Case Management activity is always to be entered as an encounter. This information is requested in the UDS report. However, do NOT use this screen to report UDS activity. This is strictly for IN HOUSE reporting. The main qualifications/activities for CM as accepted by UDS include:

- Assessment of the client's needs and personal support systems,
- Development of a comprehensive, individualized service plan
- Coordination of services required to implement the plan
- Client monitoring to assess the efficacy of the plan, and
- Periodic re-evaluation and adaptation of the plan as necessary.

Utilize the Plan/Notes section of this screen to note which type of services were referred out, specifically with dental services including code for treatment (for example: sealants, fluoride treatments, extractions, prophylaxis, etc.)

XVIII. PETTY CASH PROCEDURES

Clinic sites may choose to establish petty cash funds. Daily patient monies collected should not be used for this purpose. The following procedures should be used in handling petty cash.

1. A designated individual (petty cash custodian) should be responsible for maintaining the petty cash fund.
2. The petty cash fund should be for an established fixed dollar amount, no more than \$100.
3. The petty cash fund custodian should sign a receipt for the fund.
4. All petty cash funds should be kept in a locked box in a locked drawer or file cabinet. Only the petty cash custodian should have a key to the petty cash box.
5. Disbursements of \$25 or less may be made from the petty cash fund at any one time. Exceptions must be in writing and approved by the Office Manager.
6. The custodian of the petty cash fund must obtain a receipt or other supporting documentation from each payee. The receipts are placed in the petty cash box to replace the currency which has been paid out.
7. Monthly, or more frequently if need (but not more than weekly), the petty cash fund will be replenished for expenses paid out as listed on the receipts. Requests for reimbursement will be entered on the Petty Cash Reimbursement and Summary Sheet and submitted to the Accounting Clerk. No funds will be advanced without a proper Petty Cash Reimbursement form being prepared. It is recommended that if fifty percent or more of the fund has been spent, a reimbursement summary be prepared.
8. A check is prepared and attached to the Petty Cash Reimbursement and Summary Sheet and the expenses charges to the cost categories indicated on this form. The Reimbursement Form and Summary Sheet should be filed in the paid bills files. If the amount claimed to be reimbursed to petty cash does not match the amount of receipts verifying the use of funds, the custodian will be required to make up the difference.
9. Loans will not be made from petty cash funds. Checks will not be cashed from petty cash funds.
10. During the last month of the grant or grant program year, all petty cash and/or receipts will be submitted to the Office Manager for close-out.

PETTY CASH FUND REIMBURSEMENT AND SUMMARY FORM	
DATE _____	
PETTY CASH FUND - BEGINNING BALANCE	\$100.00
EXPENDITURES (must be supported by approved receipt):	
Purpose	Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
	Total Spent \$ _____
PETTY CASH FUND - REMAINING BALANCE	\$ _____
REPLENISHMENT REQUEST	\$ _____
PREPARED BY: _____	
APPROVED: _____	
DATE: _____	

XIX. REPORTING AND DATA COLLECTION

A. Data Collection

User and encounter data will be collected on services provided to MSFWs utilizing the GFHP's Database System. Only records on MSFWs who have been registered and determined to be eligible for program services should be entered into the migrant health data system. Patient data must include household income information, name, address, birth date, sex, race/ethnicity, language, occupation, payment source, services received by ICD-9 and CPT service codes, provider, provider type and service date. Data should be transmitted monthly by CD to the Program Specialist at the SORH by the 10th of each month.

Please refer to the Director of Migrant Health for more detailed information on the database. Copies of these guidelines may be obtained from the Director of Migrant Health or the Program Operations Specialist.

B. Encounters

An encounter is a face-to-face contact between a user and a provider of health care services who exercises independent judgment in the provision of health services to the individual patient. For a health service to be defined as an encounter, the provision of the health service must be recorded in the patient's record. The Georgia Farmworker Health Program Clinic Encounter Form is included in Appendix D.

Criteria for encounters, as defined in the Bureau of Primary Health Care, Uniform Data System, User's Manual, are given below:

To meet the encounter criterion for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample is not credited with a separate encounter. A nurse utilizing standing orders or protocols, that monitor patients' physiological signs, provide medication renewal, etc., without the patient also seeing the physician during the same visit is credited with a medical encounter.

Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling/dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may be accompanied by services performed by medical, dental, or other health providers that do constitute encounters.

The patient record does not have to be a full and complete health record in order to meet the encounter criteria even if a patient receives only one, or minimal, services and is not likely to return to the health center. For example, if a patient not normally eligible for services receives services on an emergency basis and these services are documented, the encounter criteria are met even though a complete health record is not created. Provision of HIV counseling and testing

meets the encounter criteria so long as services are documented. The same is true for services, such as employment physicals, sports physicals, etc., which are rendered to persons who do not regularly use the center. However, the services rendered must be documented.

A patient may have more than one encounter with the health center per day. The number of encounters per site per day is limited as follows:

- One medical encounter (physician, nurse practitioner, physician’s assistant, certified nurse midwife, or nurse);
- One dental encounter (dentist or hygienist); and
- One other health encounter for each type of other health provider (family planning of HIV counselor, nutritionist, psychologist, podiatrist, speech therapist, etc.).

A provider may be credited with not more than one encounter with a given patient during that patient’s visit to the center in a single day, regardless of the type or number of services provided. If a student provider sees patients in conjunction with a non-student provider, only one encounter, credited to the non-student provider, is counted.

An encounter may take place in the health center or at any other location in which supported activities are carried out. Examples of other locations include mobile vans, hospitals, patients’ homes, schools, homeless shelters, and extended care facilities.

When a provider renders services to several patients simultaneously, the provider can be credited with an encounter for each person if the provision of services is noted in each person’s health record. Examples of “group encounters” include: family therapy or counseling sessions and group mental health counseling during which several people receive services and the services are noted in each person’s health record. Patient education or health education classes (e.g., smoking cessation) are not credited as medical encounters. These would be enabling encounters only.

The encounter criteria are not met in the following circumstances.

- When a provider participates in a community meeting or group session that is not designed to provide health services. Examples of such activities include information sessions for prospective users, health presentations to community groups (high school classes, PTA, etc.), and information presentations about available health services at the center
- When the only health services provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program (e.g., a health fair)
- When a provider is primarily conducting outreach and/or public education sessions, not providing direct services

Further encounter definitions from the manual are given below:

Physician Encounter (Medical): An encounter between a physician and a user.

Nurse Practitioner/Physician’s Assistant Encounter (Medical): An encounter between a NP or PA Encounter – An encounter between a NP or PA and a user in which the practitioner acts as an independent provider.

Nurse Encounter (Medical) - An encounter between an R.N. or L.P.N. and a user in which the nurse acts as an independent provider of medical services. The service may be provided under standing orders of a physician, under specific instructions from a previous visit or under the general supervision of a physician or mid-level practitioner who has no direct contact with the patient during the visit.

Dental Services Encounter (Dental) - An encounter between a dentist or dental hygienist and a user for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.

Case Management Encounter (Enabling) - An encounter between a case manager and a user during which services are provided that assist patients in the management of their health and social needs, including patient assessments, home visits, the establishment of treatment plans and the maintenance of referral, tracking and follow-up systems.

Education Encounter (Enabling) - An encounter between an education provider and a user in which the services rendered are of an educational nature relating to health matters and appropriate use of health services (e.g., family planning, HIV, nutrition, parenting and specific diseases). Classes are not generally counted as educational encounters unless the site maintains signed attendance rosters of all participating users.

Outreach Encounters (Enabling) - Outreach encounters consist primarily of **case management and education**. The encounter must be face-to-face, and the encounter must be documented in the patient’s chart and entered into the database with the corresponding CPT code or the ICD9 Code associated with the specific education provided. Services such as transportation and interpretation provided without counseling are not medical encounters. They may, however, be recorded in the database and will appear as enabling encounter activity.

XX. STATE AND LOCAL ADVISORY COUNCILS

Each GFHP site is to have a Migrant Advisory Board and the program as a whole has an Advisory Council. Each board is to have “meaningful input into the program design, implementation and evaluation.” Additionally, GFHP has established a QA/CQI Committee to assure accessibility, quality and cost effectiveness of primary care services available to migrant and seasonal farmworkers in Georgia. For additional information concerning this committee see Attachment 1, page 17.

A. Role of Advisory Council:

1. Recruit and refer MSFWs to the program.
2. Publicize the program.
3. Provide feedback on program services.
4. Identify gaps in service and assist in filling gaps.
5. Share resources between agencies represented on the council and locate other resources.
6. Collectively seek solutions to problems experienced by MSFWs.
7. Assist in obtaining ongoing funding and in seeking new funding.
8. Advocate for changes in federal or state legislation or funding.
9. Assist in recruiting staff.
10. Provide expertise in areas of social services, data processing, quality assurance, environmental standards, etc.
11. Evaluate, monitor and promote continuous improvement in the health services delivered to MSFWs.

B. Role of Migrant Health Staff:

1. Select council members
2. Orient members to goals of Georgia Farmworkers Health Program.
3. Orient members to role of council.
4. Provide council with quarterly reports on progress made in carrying out objectives.
5. Involve members in quality assurance and evaluation activities.
6. Pay for expenses of MSFWs of council when necessary.
7. Inform council of legislation and appropriations affecting MSFWs.
8. Provide staffing support, call meetings, prepare agenda and minutes.
9. Forward copies of advisory council minutes to SORH.

C. Suggested Council Members:

1. Growers
2. Migrant and Seasonal Farm Workers (comprise 50% of the council)
3. Migrant Education Groups
4. DFCS, WIC, Food Stamps representatives
5. Farm Worker Legal Service
6. Faith Based Organizations
7. College/University staff
8. Area Health Education Centers (AHEC)
9. Georgia Extension Service
10. Department of Labor
11. Department of Agriculture
12. Other community agencies
13. Nursing and medical representatives from the local community

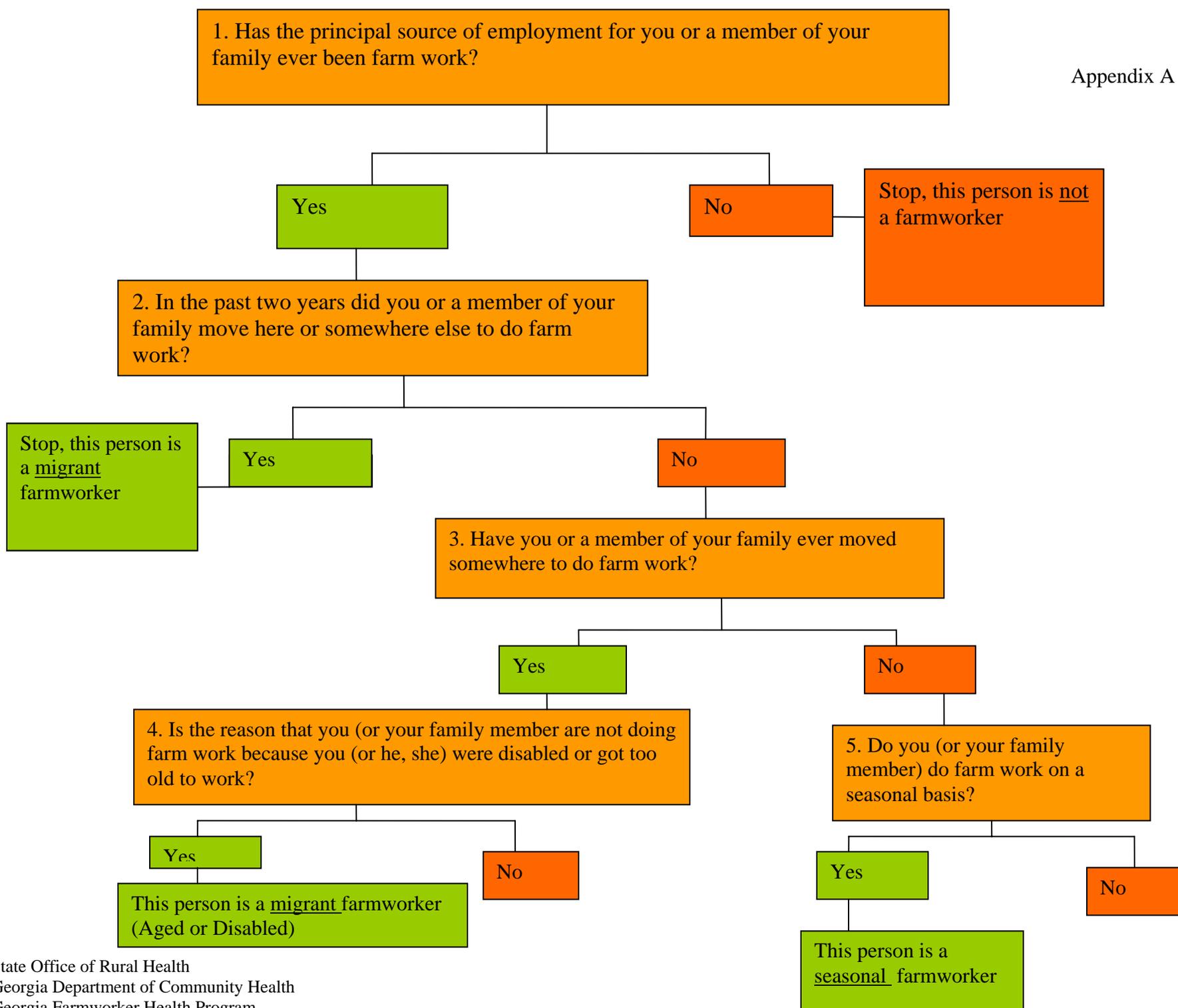
D. Suggested Meeting Schedule:

1. A meeting before the season begins to inform agencies, MSFWs and growers of plans, clinic operations, services, fees, need for resources and to ask for assistance in recruiting program participants.
2. Two meetings during the season to coordinate resources and identify problems. MSFWs participating in the program should be asked to attend these meetings.
3. A meeting after the season to evaluate program, recommend changes for next year, develop strategies for resolving problems and advocate for funding.

E. Migrant Health Center

The governing board of the center must meet the following requirements:

- (a) Size: The board must consist of at least 9 but not more than 25 members except that this provision may be waived by the Secretary for good cause shown.
- (b) Composition:
 1. A majority of the board members must be migratory and seasonal agricultural workers and members of their families who are or will be served by the center and who, as a group, represent the individuals being or to be served in the terms of demographic factors, such as race, ethnicity and sex.
 2. No more than two-thirds of the remaining members of the board may be individuals who derive more than ten percent of their annual income from the healthcare industry.



Appendix B

Registration Form

Instructions For Registration Form

This form must be completed yearly on all individuals or families accessing health care through the Georgia Farmworker Health Program or through the Health Departments. If a family is registered with another project in Georgia, you may obtain a copy of the registration form verify the information checking the update box on the registration form or the project may complete a new registration using the original ID number. Or you may fill out a new registration form to obtain current information but retain the original ID number. Only one form needs to be completed per family, but document in each family member's chart where this form may be found.

1. New Register/Update: Check the appropriate box. New register for first time registrants, and update for updated or requalification information.
2. Camp/Farm: Refers to the camp where the registrant lives or Enrollment Site.
3. Date: Record the date of the registration.
4. Family ID Number: Is given out when the family is registered into the program, even if a medical service has not been provided. Then as each family member receives a service, that person receives his own ID number, derived from the family ID. This number should be noted on the registration form in the ID number column. For example, if the head of household's number is AB0000101, write only the last 2 or 3 digits in each person's ID number column, (i.e.: 02,03,04)
5. ID Number: See instructions under Family ID Number. The Data Entry Person will place this ID number for each member of the Household in the column marked **Pt ID No** that is found in the individual family member section. Please note that this number is NOT the automatic generated ID number given. Do NOT change that number when entering data.
6. Name (Last, First, Middle): List the names of the family members. List only those members living with migrant/seasonal farmworkers, not those living at a home base. See definition of family in Section II. Register married children and their families separately even if the married children are living with their parents. If two families are living together, register them separately. A minor child (under age 18) who is accompanying the family may be registered with the family.
7. D.O.B.: Record the date of birth of each family member.
8. Gender: Choose Male (M) or Female (F).
9. Social Security Number: Record the social security number if it is known/available.
10. Race: Choose one of the following: Hispanic and Latinos (H); White (W); Black (B); Asian (A); American Indian / Alaskan Native (AM); Haitian (HA); Jamaican (J); Unknown (U);
11. Occupation: Choose one of the following for each family member by asking the eligibility questions on the front of the registration form: Migrant (M) or Seasonal (S).
12. Speaks English: Choose Yes (Y) or No (N).

Appendix B

13. Medicaid Number: Record the Medicaid number if it is known/available.
14. Address and Telephone Number: Record all information that is known.
15. Income Data: In determining family size, other dependent members not residing with the family can be counted in the total family size. However, in determining income, the income of all adult members of the family must be counted, including persons age 18 and above. Annual income may be determined for proceeding 12 months, or previous calendar year. The purpose is to determine amount of cost participation. Income must be determined annually.
16. Certification: Use the eligibility question to verify that the migrant/seasonal farmworker qualifies to receive services from the GFHP. Ask him/her to sign and date the certification, reading it to the MSFW in Spanish. The MSFW must validate their eligibility every year. If the form is used a second year, update all relevant sections and ask the MSFW to sign the certification section on the line provided.
17. Completed By: One must sign and date a registration form when filling it out.
18. Once the registration form has been completed, give the family member the program identification card with the family ID number. The first family member needing medical care will bring this card to the project indicating that the family has been registered. The patient can then be assigned an individual number and a medical record can be opened for that person. Each family member receiving health services will receive his own card.
19. Do not assign new ID numbers to transferring households or patients. However, a new household could materialize if a member moves. In this instance the household number could change for an individual. Always check so that there are not duplications.
20. Numbering System: First letter designates local project, second letter indicates county issuing card, and remaining five digits are the individual's identification number. Projects should assign letters for participating counties.

A=Ellenton D= Lake Park I=Reidsville J=Ellaville L=Pearson

F=Bainbridge

Registration Card

Georgia Farmworker Health Program

*Department of Community Health
State Office of Rural Health*

502 South Seventh Street • Cordele, Georgia 31015

Patient Name: _____

DOB: _____

Allergies: _____

H2A: _____ Migrant: _____ Seasonal: _____

GFHP Registration Date: _____

****This is not an insurance card and does not authorize payment****

Clinic/Project Sites:

- Ellenton Clinic - 185 North Baker Street, P.O. Box 312
Ellenton, GA 31747 Phone (229) 324-2845
- Georgia Farmworker Clinic - 224 Culpepper Road, P.O. Box 889
Lake Park, GA 31636 Phone (229) 559-9933
- East Georgia Healthcare - 222 South Main Street
Reidsville, GA 30453 Phone (912) 557-3300
- Ellaville Primary Medicine Center - 103 Broad Street
Ellaville, GA 31806 Phone (229) 937-5321
- Nicholls Family Clinic - 804 North Liberty Street
Nicholls, GA 31554 Phone (912) 345-0059
- Decatur Counth Health Department - 928 West Street
Bainbridge, GA 39818 Phone (229) 248-3055

Encounter Forms

Instructions for Using the GFHP Encounter Form

Most of the information on this form is designed to support data entry in Access. GFHP staff should use the form, but referral physicians may use other encounter forms. If another form is used, it should be reviewed to ensure that it captures the same data as the GFHP form. The following are some general comments on using the Encounter Form, both for Medical Encounters as well as for Enabling Encounters. For instructions on entering this data into the GFHP data base program, please refer to the GFHP Access Computer Program Manual.

- Encounter Type: Access will use the data, which is entered to calculate the number and type of encounters, but the encounter type boxes may also be checked as a backup method for counting encounters
- All items printed in **BOLD** are of special importance for the Study and Funding
- Tracking Codes: These codes may be marked on the form at the discretion of the clinician seeing the MSFW patient. This data is entered in the Migrant Health detail screen in a patient's record where it is intended to aid clinicians and project staff in flagging the records of patients with chronic conditions. This data would be entered under the Case Management Screen on the Encounter/Billing Data Entry Screen
- Patient and Service date: Information on patients including name, patient ID number, provider name, provider type, and service date is required data. This data must be entered into Access. An appropriate provider type should be selected from the GFHP list provided. A given provider may function in several capacities during the same health visit if he or she is providing case management or health education in addition to medical services
- Payment Source: Mark the payment source with the appropriate code if Medicaid, Medicare, Indigent Care Trust Fund (ICTF), or private health insurance covers the patient. If the patient is not eligible for or covered by these payment sources, circle GAFHP funding. The self-pay category should be used for patients who pay for the services they receive. The fee collected is to be entered in the blank space provided. The Data Entry Person will enter this in the appropriate column "Client Paid" when entering the Medical Encounter into the GFHP Access Database
- WIC: If the service rendered to the MSFW is a WIC service, check this box listed in the CPT Code Section
- Medical Services and Diagnoses: In the Medical Services and Diagnoses sections check all services (procedures) and diagnoses that were provided and circle the primary ones. If a service (CPT) or diagnostic (ICD-9) code is not listed on the form, the provider should describe it in detail so that the data entry staff can either find the appropriate code in the CPT or ICD-9 reference books or call the GFHP Field Data Consultant to request assistance

- If a Health Ed Encounter has taken place by a Medical Provider, there is to be a corresponding diagnostic code (usually a Screening ICD-9) also entered. The Provider Type of the Medical provider must be HE. It may be assumed that the Medical Provider listed on the Medical Encounter side of the Encounter Form is also the HE Provider Type/Provider
- The Enabling Services Encounter Form may be used by the non-medical providers (Enabling Providers) offering Health Ed, Interpretation, and Transportation without reference to a Medical Provider and his/her activity on the opposite page. The general Client-Provider data requested at the top of the page is to be filled out. An Enabling Provider may circle more than one Provider Type as long as the necessary CPT codes are also checked below
- It is possible that the Interpreting Provider may change as the patient moves from one section to the other for Medical or Enabling services. Each Interpreting Provider may be counted provided that he/she has turned in an Enabling Encounter Form with the necessary data entry having been filled in and checked. The Enabling Encounter Form may be a separate sheet from the one used by the Medical provider
- Case Management – All referrals to medical providers are Case Management. If the referral concerns items of our study, the correct item is to be checked, otherwise check “referrals.” If Case Management is done by a medical provider without a referral, and it is not part of the Study, then check “General Case management.” Always remember that the Provider Type for the Medical Provider MUST be entered as CM
- Prenatal Data – Every pregnant woman being seen by the Medical provider must have this section completed. Every mother returning with her newborn baby must have this section completed. Every newborn receiving services that are listed on the Medical Encounter Form separate from its mother must have this baby Medical Data listed in HER RECORD. For easy reference, please provide the mother’s name and birthday
- DO NOT enter children into the database as Head of Household. Every infant and child must be registered in the database under a parent

Georgia Farmworker Health Program

Revised 03/17/2008

CLINIC MEDICAL ENCOUNTER FORM

Patient Name _____ Provider Name _____ Type: FPP NP NUR
(Circle One of the Provider Types)

Patient DOB _____ ID: _____ Service Site _____ Date _____

Payment Source: Circle One: Medicaid Medicare Indigent Care Private Insur GAFHP Self-Pay : \$ _____

MEDICAL PROCEDURES		Audiometry	<input type="checkbox"/> 92551	HIV-1 Test	<input type="checkbox"/> 86701	Immunizations
		Case Management	<input type="checkbox"/> 99361	Lead Screening	<input type="checkbox"/> 83655	DPT <input type="checkbox"/> 90701
		Ear Lavage	<input type="checkbox"/> 69210	Lipid Panel	<input type="checkbox"/> 80061	DT <input type="checkbox"/> 90702
			<input type="checkbox"/> _____	PAP Smear	<input type="checkbox"/> 88150	Hep.B, Pediatric <input type="checkbox"/> 90744
				PPD Skin Test	<input type="checkbox"/> 86580	Hib <input type="checkbox"/> 90647
				RPR, Serology	<input type="checkbox"/> 86592	MMR <input type="checkbox"/> 90707
				SGOT Assay	<input type="checkbox"/> 84450	OPV <input type="checkbox"/> 90712
				Smear, gram stain	<input type="checkbox"/> 87025	IPV <input type="checkbox"/> 90713
				Throat Culture	<input type="checkbox"/> 87081	Tetanus <input type="checkbox"/> 90703
				Thyroid Panel	<input type="checkbox"/> 80092	Hep B Adult <input type="checkbox"/> 90746
				Urine Culture	<input type="checkbox"/> 87056	DpaT <input type="checkbox"/> 90702
				Urine Routine	<input type="checkbox"/> 81000	Varicella <input type="checkbox"/> 90716
				UrinePregnancy Test	<input type="checkbox"/> 81025	Influenza <input type="checkbox"/> 90659
				Urinalysis, auto	<input type="checkbox"/> 81003	Td <input type="checkbox"/> 90718
				Urinalysis, non-auto	<input type="checkbox"/> 81002	Prevnar <input type="checkbox"/> 90669
				Wet Mount	<input type="checkbox"/> 87210	Pneumococcal <input type="checkbox"/> 90732
				WICNutrition Couns	<input type="checkbox"/> 99401	_____ <input type="checkbox"/> _____
				WIC Services	<input type="checkbox"/> 00002	_____ <input type="checkbox"/> _____
				_____	<input type="checkbox"/> _____	_____ <input type="checkbox"/> _____

DIAGNOSES		Dizziness	<input type="checkbox"/> 780.4	Otitis externa, inf.	<input type="checkbox"/> 380.10	Thrush	<input type="checkbox"/> 112.00
		Drug Addiction	<input type="checkbox"/> 304.9	Otitis media, acute	<input type="checkbox"/> 382.0	Tinea Pedis	<input type="checkbox"/> 110.4
		Dysuria	<input type="checkbox"/> 788.1	Otitis media, serous	<input type="checkbox"/> 381.1	Tobacco Depend	<input type="checkbox"/> 305.1
		Elevated BP/no HTN	<input type="checkbox"/> 796.2	Chr		Tonsillitis	<input type="checkbox"/> 463
		Exposure to heat/cold	<input type="checkbox"/> 991.0	PAP, non-spec.abnor	<input type="checkbox"/> 795.00	Tuberculosis	<input type="checkbox"/> 010.0
		Fatigue	<input type="checkbox"/> 780.79	Pelvic infl.dis (PID)	<input type="checkbox"/> 614.9	Urinary Tract	<input type="checkbox"/> 599.0
		Fever(Pyrexia)	<input type="checkbox"/> 780.6	Pelvic pain, female	<input type="checkbox"/> 625.9	Infection	
		Gastritis, acute	<input type="checkbox"/> 535.0	Pharyngitis	<input type="checkbox"/> 462	Urethritis, unspec	<input type="checkbox"/> 597.80
		Gastritis, atrophic	<input type="checkbox"/> 535.1	Pneumonia	<input type="checkbox"/> 486.00	Upper Resp.	<input type="checkbox"/> 465.9
		Gastroenteritis	<input type="checkbox"/> 558	Pesticide poisoning	<input type="checkbox"/> 989.4	Infection	
		Gonorrhea	<input type="checkbox"/> 098.0	PPD Positive (non-TB)	<input type="checkbox"/> 795.5	Venereal Disease,	<input type="checkbox"/> 099.9
		Headache	<input type="checkbox"/> 784.0	Pterygium	<input type="checkbox"/> 372.4	unspec	
		Head lice	<input type="checkbox"/> 132.0	Rash	<input type="checkbox"/> 782.10	Vulvovaginitis	<input type="checkbox"/> 616.1
		Heat exhaustion	<input type="checkbox"/> 992.3	Rhinitis Allergic	<input type="checkbox"/> 477	_____	<input type="checkbox"/> _____
		Hemorrhoids	<input type="checkbox"/> 455.6	Scabies	<input type="checkbox"/> 133.0	_____	<input type="checkbox"/> _____
		Herpes, genital	<input type="checkbox"/> 054.10	Sebaceous Cyst	<input type="checkbox"/> 706.2	_____	<input type="checkbox"/> _____
		Herpes, simples	<input type="checkbox"/> 054.9	Sinusitis	<input type="checkbox"/> 461.9	_____	<input type="checkbox"/> _____
		Herpes, zoster	<input type="checkbox"/> 053.9	Sprain/strain ankle	<input type="checkbox"/> 845.00	Other	
		HIV symptomatic	<input type="checkbox"/> 042	Sprain/strain knee	<input type="checkbox"/> 844.9	_____	<input type="checkbox"/> _____
		Hives	<input type="checkbox"/> 708.9	Sprain/strain shoulder	<input type="checkbox"/> 840.9	_____	<input type="checkbox"/> _____
		Hypertension	<input type="checkbox"/> 401.9	Stomatitis	<input type="checkbox"/> 528.0	_____	<input type="checkbox"/> _____
		Impetigo	<input type="checkbox"/> 684.0	Strep Throat	<input type="checkbox"/> 034.00	_____	<input type="checkbox"/> _____
		Influenza	<input type="checkbox"/> 487.1	Syphilis	<input type="checkbox"/> 909.0	_____	<input type="checkbox"/> _____
		Ingrown Toenail	<input type="checkbox"/> 703.0	Tendonitis	<input type="checkbox"/> 726.90	_____	<input type="checkbox"/> _____
		Lice, head (pedicul)	<input type="checkbox"/> 132.0			_____	<input type="checkbox"/> _____
		Low Back Pain	<input type="checkbox"/> 724.2			_____	<input type="checkbox"/> _____
		Lumbar Sprain	<input type="checkbox"/> 847.2			_____	<input type="checkbox"/> _____
		Myalgia/Myositis	<input type="checkbox"/> 729.1			_____	<input type="checkbox"/> _____
		Nausea & Vomiting	<input type="checkbox"/> 787.0			_____	<input type="checkbox"/> _____
		Neck pain	<input type="checkbox"/> 723.1			_____	<input type="checkbox"/> _____
		Obesity	<input type="checkbox"/> 278.0			_____	<input type="checkbox"/> _____

Georgia Farmworker Health Program
MEDICAL SCREENING, PRENATAL & ENABLING SERVICES ENCOUNTER FORM

Revised 03/17/2008

Patient Name: _____ Enabling Provider: _____

Date of Birth: _____ Date of Service _____ Provider Type: **CM HE ITR TRANS**
(Circle One of the Provider Types)Service site: _____ *Items printed in **Bold** comprise studies and reports.

Screenings	Health Education	Case Management	Interpretation	Transportation
ICD-9 Codes	CPT Codes	CPT Codes	CPT Codes	CPT Codes
Alcohol Abuse <input type="checkbox"/> V79.1	Baby Bottle Educ <input type="checkbox"/> 00001	General Case <input type="checkbox"/> 99361	Interpretation <input type="checkbox"/> 00007	Transportation <input type="checkbox"/> 00006
Anemia <input type="checkbox"/> V78.1	Immuniz. Status <input type="checkbox"/> 00005	Management		
Anxiety <input type="checkbox"/> V79.5	Check/OK <input type="checkbox"/>	Referrals <input type="checkbox"/> 00008		
BMI <input type="checkbox"/> V77.8	General Health <input type="checkbox"/> 00009	CM Perinatal <input type="checkbox"/> 00018		Pharmacy
Cancer, Breast <input type="checkbox"/> V76.1	Education	CMAbnormal <input type="checkbox"/> 00019		Pharmacy <input type="checkbox"/> 00003
Cancer, Cervix <input type="checkbox"/> V76.2	Alcohol Abuse <input type="checkbox"/> 00024	BP		
Cancer, other <input type="checkbox"/> V76.49	Breast Cancer <input type="checkbox"/> 00010	CM CM Eye <input type="checkbox"/> 00020		
Cancer, Skin <input type="checkbox"/> V76.43	Cervical Canc. <input type="checkbox"/> 00022	Exam Ref	Dental	
LipoidDisorders <input type="checkbox"/> V77.91	Dental Health <input type="checkbox"/> 00016		CPT Codes	
Cardio Risk <input type="checkbox"/> V81.2	Depression <input type="checkbox"/> 00026		Dental Exam <input type="checkbox"/> D0120	Prenatal Data
Dental <input type="checkbox"/> V72.2	Diabetes <input type="checkbox"/> 00011		Limited Dental <input type="checkbox"/> D0140	
Depression <input type="checkbox"/> V79.0	Drug Abuse <input type="checkbox"/> 00017		Exam	Receiving Care Y N
Diabetes <input type="checkbox"/> V77.1	Family Plann <input type="checkbox"/> 00013		Comprehnsive	Initial Visit
Drug Abuse <input type="checkbox"/> V79.4	Hepatitis <input type="checkbox"/> 00028		Dental Exam <input type="checkbox"/> D0150	Trimester 1 2 3
Develp Screen <input type="checkbox"/> 96110	HIV <input type="checkbox"/> 00029		Dental X-ray <input type="checkbox"/> D0220	Date of Delivery:
Develp test <input type="checkbox"/> 96111	HTN <input type="checkbox"/> 00014		Prophylaxis <input type="checkbox"/> D1110	Birth Weight grams:
Ears/hearing <input type="checkbox"/> V72.1	Lung Cancer <input type="checkbox"/> 00027		Adult	
Ears/vision <input type="checkbox"/> V72.0	Mental Health <input type="checkbox"/> 00015		Prophylaxis <input type="checkbox"/> D1120	Normal Y N
ContracepMgmt <input type="checkbox"/> V25	Nutrition <input type="checkbox"/> 00031		Fluoride child <input type="checkbox"/> D1203	Below Normal Y N
Contraceptive <input type="checkbox"/> V25.4	Occup. Haz. <input type="checkbox"/> 00021		Fluoride adult <input type="checkbox"/> D1204	PP Return w/8 wks Y N
Services	Pesticide Exp. <input type="checkbox"/> 00034		Sealant <input type="checkbox"/> 1351	First Newborn Serv Y N
Gyn Exam <input type="checkbox"/> V72.3	Prenatal <input type="checkbox"/> 00033		Ext. Surgical/ Erupted <input type="checkbox"/> D7210	Prenatal WIC User Y N
w/PAP	Prostate Cancer <input type="checkbox"/> 00025		Emergency <input type="checkbox"/> D9110	Baby WIC User Y N
Health Check <input type="checkbox"/> V20.0	Smoke Prev. <input type="checkbox"/> 00032		Services	Medicaid:
Infant Reg.	STD <input type="checkbox"/> 00012		Rehabilitative <input type="checkbox"/> _____	Appr'd, Recv'd,
Health Check <input type="checkbox"/> V20.2	Testicular Canc. <input type="checkbox"/> 00023		Services	Applied Y N
Child, reg	TB <input type="checkbox"/> 00030		Restorative <input type="checkbox"/> _____	Perinatal Followup Y N
Health Check, <input type="checkbox"/> V70.0			Services	Note:
Adult				List Mother's Name & DOB below so that this child's data will be attached to the Mother's Perinatal file:
Hepatitis <input type="checkbox"/> V78				_____
HIV <input type="checkbox"/> V99.2				_____
Hypertension <input type="checkbox"/> V81.1				_____
Nutrition <input type="checkbox"/> V65.3				_____
Occup. Haz. <input type="checkbox"/> V99.1				_____
PregnancyExam <input type="checkbox"/> V72.4				_____
Pregnancy <input type="checkbox"/> V22				_____
Pregnancy <input type="checkbox"/> V23				_____
High-risk				_____
STD <input type="checkbox"/> V74.5				_____
TB <input type="checkbox"/> V74.1				_____

Referral Forms

Instructions for Using GFHP Medical Referral Form

This Medical Referral GFHP Form is an authorization form for Medical Care. There are two sections: the top section is to be completed by the GFHP Clinic making the referral. The second section below “**Physician’s Office Use Only**” is to be completed by the Medical Provider receiving the referred patient.

- **GFHP Outreach Provider:** write in the patient’s full name, date of birth and local GFHP ID#. If the patient is seeing only a physician write in name and address of the Physician. If receiving a voucher for Pharmacy only, write in the name and address of the Pharmacy. If patient is to see both, please include the name and address of both. When an appointment has been obtained, it is to be written in the top left hand box
- **Financial payment:** this section is to be completed by the GFHP Outreach provider.
- **GFHP Medical Provider:** please give the reasons for the referral, including diagnosis and length of time with the problem
- The referral form must be signed by an authorized person of the GFHP Clinic
- **Physician’s Office:** please complete the requested information. The “Place” normally will be the Physician’s Office
- **Charges:** the Physician’s Office may charge the regular prices for medical procedures, and total them in the appropriate column. If the patient is to pay a certain percentage, the amount is to be noted in the appropriate column. A Balance Due may be given. When GFHP sends the Physician a statement of payments, the Physician’s Rate will be shown along side the Medicaid Rate and the Patient’s percentage Payment. Since GFHP reimburses only with the Medicaid Rate, whatever percentage that the patient may have been charge will be deducted from the Medicaid Rate instead of the Physician’s Rate. The Balance will be paid the Physician
- The Federal Government requires a narrative report of the treatment even if it is brief. The Pharmacy section serves as the Prescription of the Physician for the Pharmacy
- The Physician must sign and date the report. One copy is to be returned by the Physician’s Office for proper billing and payment at the end of the month

**GEORGIA FARMWORKER
HEALTH PROGRAM**

Importante
Su cita con Dr. _____
Es el _____ a las _____

Authorization for Medical Care

Patient Information

Name (Last, First) _____

Date of Birth _____

Local Address _____

Referred to: _____

Physician _____ and/or _____ Pharmacy

Name: _____

Address: _____

Reason for referral(include diagnosis, length of time patient has been seen for this problem, etc.)

Max GFHP Program will pay for this visit: \$ _____ or Patient's % of payment \$ _____

Authorized by: _____ Telephone _____

Physicians's Office Use Only:

Provider Information

Date	Place	CPT code	Name of Medical Procedure	Diagnosis Code	Charges	Type of Service

Was laboratory work performed outside your office? Yes No Charge: __

Patient Paid	Total Charge	Balance Due

Narrative Report

--	--

Physicians Signature

Date

Referral Forms

Instructions for Using the GFHP Dental Encounter Form

The Dental Referral GFHP Form is an authorization for dental care. The form is divided into two sections: Section 1 is to be completed by the GFHP Outreach Worker and section 2 by the Dentist's Office. Section 2 begins with the words: **Dentist Office Use Only**.

- **GFHP Outreach Worker:** is to complete the patient information giving the full name, birth date, GFHP local ID#, and address of the patient. After obtaining an appointment with a dentist, the health outreach worker (HOW) will write in the dentist's name and address. The date and time for the appointment is to be written in the box at the top left side of the referral form
- The Outreach Worker will also complete the financial payment section by either listing the maximum that the GFHP will pay for this particular visit, or what percentage of the total cost must be paid by the patient, leaving the rest for GFHP to pay
- The referral must be signed by an authorizing agent of GFHP
- **Dentist Office** – the dentist is to complete the necessary information requested on the form concerning the work done. Most dentists list only the Medicaid Rate for their fee. If so, then the charge listed will be paid by GFHP. If the patient paid a certain percentage, that payment is to be listed and deducted from the total payment due. If the charges given by the dentist are not Medicaid Rates then the GFHP statement of payment will show the dentist charge along side of the Medicaid Rate and the Patient payment. The Patient payment will be deducted from the Medicaid Rate, and the dentist will receive the balance due as payment
- Dentist must sign and date the Referral Form. A copy of this form is to be returned to the GFHP Clinic who authorized the referral for payment

**GEORGIA FARMWORKER
HEALTH PROGRAM**
Authorization for Dental Care

Importante

Su cita con el Dentista es:

El _____ a las _____

Patient Information

Date of Referral _____

Name (Last-First) _____

Date of Birth _____ ID# _____

Local Address _____

Home Base Address _____

Referred to (Name, Address, City, State, Zip):

Estimate of GFHP program payment: \$ _____ or Patient % of payment \$ _____

This authorization is void if patient qualifies for Medicaid, Insurance or other third party payment.

Authorized by _____ Telephone _____

Dentist Office Use Only:

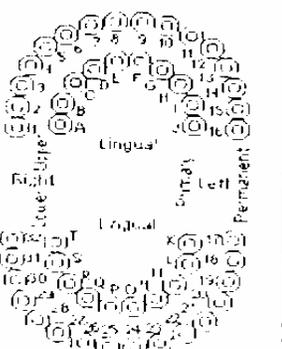
Provider Information

Examination and Treatment Record

List in Order from Tooth No. 1 through Tooth No. 32

Tooth	Surface Code	DESCRIPTION OF SERVICES Including X-rays, Prophylaxis, and materials used, Etc	Date of Service Performed	Procedure Number	Fee

Total Charge	Client Paid	Balance Due



Is follow-up needed? Yes No For What? _____

Return Appointment? Yes No When needed? _____

Does patient need transportation to the next appointment? Yes No

Physician's Signature

Date

MIGRANT HEALTH PROGRAM MONTHLY COST REPORT		Program:	Report Period:	From:	Prepared by:	Page 1 of 2			
				To:					
REVENUE FOR SERVICES RENDERED:									
		Beginning A/R Balance	Full Charges	Payments Received	Sliding Fee Adjustments	Contractual Adjustments	Bad Debt	Ending A/R Balance	Change in Balance
1	Medicare								
2	Medicaid								
3	Other Third Parties								
4	Patients								
5	Total Services Revenue (sum of lines 1-4)		-				0	0	0
OTHER REVENUE SOURCES:									
				Payments Received					
6	Migrant Program Grant								
7									
8									
9									
10	Total Other Revenue (lines 6-9)			-					
VALUE OF DONATED VALUE									
				Value Received					
11									
12	Net Donated Cost, p.2, 1.25								
	Total Revenue, Grants & Donated value (5+10+11+12)								

MIGRANT HEALTH PROGRAM MONTHLY COST REPORT		From: To:							Prepared by:		Page 2 of 2	
	F.T.E.	Salary	Fringe Benefits	Travel	Equipment	Building Rent	Contracted Services	Other Operating	Total Expenditures	Donated Value	Depreciation	
Personnel:												
Medical												
1	Enter Medical Staff								-			
2	Enter Medical Staff								-			
3	Enter Medical Staff											
4	Enter Medical Staff											
5	Total Medical Staff	-	-	-								
Enabling												
6	Enter Enabling Staff								-			
7	Enter Enabling Staff								-			
8	Enter Enabling Staff								-			
9	Enter Enabling Staff								-			
10	Enter Enabling Staff								-			
11	Total Enabling Staff	-	-	-								
Administrative												
12	Enter Administrative Staff								-			
13	Enter Administrative Staff								-			
14	Enter Administrative Staff								-			
15	Enter Administrative Staff								-			
16	Total Admin Staff	0.00	-	-					-			
All Other (non-personnel) Direct Service Costs:												
Medical												
17	Medical/ Other Direct								-			
18	Laboratory								-			
19	X-ray								-			
Total Medical Care Services												
20	Pharmacy								-			
21	Pharmaceuticals								-			
22	Dental								-			
23	Mental Health								-			
22	Substance Abuse								-			
23	Pharmacy								-			
24	Pharmaceuticals								-			
25	Total Other Clinical Services	0.00	0	0								
Enabling												
26	Patient Transportation								-			
27	Patient Education								-			
28	Translation/Interpretation								-			
29	Community Education								-			
30	Total Enabling Service Cost	0.00	0	0	0	0	0	-	-	0		
Administrative												
Overhead and Totals												
31	Facility								-			
32	Administration								-			
33									-			
34	Total Overhead Costs (sum of lines 31-34)	0.00	0	0	0.00	0.00	0	-	-	-	0	
		← Program Expenditures →							TOTAL	Non-Cash Costs		
TOTAL MEDICAL COSTS		0.00	-	-					-			
TOTAL ENABLING COST		0.00	-	-					-			
TOTAL ADMINISTRATIVE COST		0.00	-	-					-			

Attachment I

**Georgia Farmworker Health Program (GFHP)
State Office of Rural Health (SORH)
Georgia Department of Community Health (DCH)**

**Quality Assurance / Continuous Quality Improvement Plan
(QA/CQI)**

02 January 2008

Georgia Farmworker Health Program (GFHP)

QA/CQI Program Manual

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Georgia Farmworker Health Program (GFHP)

Chapter I

Purpose/Background

Purpose:

The purpose of the Quality Assurance/Continuous Quality Improvement (QA/CQI) Program Manual is to provide specific standards, measurement tools, and processes for improving the quality of healthcare provided to migrant and seasonal farmworkers (MSFWs). The GFHP QA plan will include four dimensions of quality, pertinent to health care delivery, along with identified indicators and/or data sources: (1) **Quality of service delivery** that will focus on provider credentialing, and patient satisfaction assessments; (2) **Quality of care** that will focus on peer reviews, utilization reviews, and patient medical records; (3) **Quality of work force and work environment** that will focus on personnel records, and administrative reviews; and (4) **Quality of health status measures/screenings** that will focus on clinical measures for each identified lifecycle.

Because of the unique differences among the GFHP project sites, this Manual should be used as a basis for standardization of the basic elements of a quality management program. It is not intended to replace existing contracting agencies' QA plans but to be used in conjunction with current agency protocols. The purpose for this approach is to enhance current QA programs by ensuring specific MSFW program requirements and/or elements are in place. The GFHP has been mandated to implement a uniform QA/CQI program in order to comply with federal regulations. This plan is a template for developing uniform procedures and protocols required of all GFHP project sites while maintaining flexibility to accommodate federal, state, county, district, and/or agency requirements.

Background:

The GFHP was created in 1990 to serve migrant and seasonal farmworkers and their dependents. The Program currently provides primary healthcare services in 21 rural Georgia counties through six project sites with an estimated labor force of over 75,000 MSFWs. The GFHP is a Federal/State-funded program designed to ensure the availability of and accessibility to essential primary healthcare services for people who have the most limited access and face the greatest barriers to care. Its purpose is to improve the general health status of Georgia migrant and seasonal farmworkers by providing (1) cost effective, culturally-appropriate primary healthcare services; (2) arranging for other levels of healthcare through collaboration and advocacy; (3) working collaboratively with local organizations and groups; and (4) finding alternative funding sources and equipping MSFWs with skills, through health education and outreach, to better understand their healthcare options in terms of health status and accessing care.

Georgia Farmworker Health Program

Chapter II

Provider Credentialing

In order to provide quality health care to eligible migrant and seasonal farmworkers, provider credentials and verification are required. All contract physicians, dentists, and mid-level providers must have a valid license to practice in Georgia. Institutional providers, such as the local hospital, federally-funded community health centers, or county health departments, have their own internal quality assurance programs required by regulatory agencies and may be willing to share their findings with the project. **Refer to BPHC Policy Information Notice 2001-16 and 2002-22 for policy guidance.**

Contracting agencies for the project sites will review provider credentials every two years. All contracting agencies provider credentialing policy must meet state and federal credentialing requirements. Primary Source Verification (Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner) is required. Examples of Primary Source Verification include direct correspondence, internet verification, and reports from credentials verification organizations (CVO's). Also, hospitals that meet JCAHO's "Principles for CVO's" are an acceptable method of primary source verification. Contractors shall make available, copies of practitioner credentialing documents for review by the Director, Migrant Health, Homeless, and Special Programs or is representative. Verification of credentialing is required on all providers including contract providers and/or participating community volunteer providers. A credentialing checklist is provided as a guide to ensure a complete credentialing review is performed prior to engaging a provider.

Georgia Farmworker Health Program

Credentialing Checklist

Provider Name: _____

Date of verification: _____

Expiration date of licenses: _____

Source of Verification	Date of verification	Comments
1. Primary Source Verification.		
a. Georgia Secretary of State Website Query.		
b. Credentialing verification letter from CVO.		
c. Credentialing verification letter from a JCAHO certified hospital.		
2. National Practitioner Data Bank (NPDB) Information Query		
3. Secondary source verification (if required)		
a. DEA registration (as applicable)		
b. Hospital admitting privileges		
c. Immunization status current		
d. Life support training current		

Comments:

Georgia Farmworker Health Program

Chapter III

Physician Preceptor Review

In order to promote accountability and improve patient care, a physician preceptor must conduct a clinical record review on **10 percent** of all mid-level providers medical record entries **Monthly**. Each GFHP project site that is staffed with a mid-level provider currently has a physician preceptor under contractual agreement or memorandum of understanding.

The physician preceptor is to conduct a clinical record review using the GFHP Physician Preceptor Review Checklist and forward a copy of their overall findings to the appropriate Program Coordinators. The Program Coordinators are to maintain a file of all Physician Preceptor Reviews for review by the Director, Migrant Health, Homeless, and Special Projects during site visits.

Rationale:

- a. Promotes accountability and improves quality of patient care;
- b. Provides information to assess knowledge and skills of protocols/standards for evaluation; and
- c. Stimulates personal and professional development

Review/Grading criteria for audit form:

Put a check in the box if criteria are present and satisfactory. Add the number of checks for each criterion and put in the # column. Convert the number of checks to percentages and put in the % column. Add the total percentages and divide by the total number of criteria reviewed to determine average compliance.

Georgia Farmworker Health Program

Physician Preceptor Review Checklist

Provider under review: _____

Date: _____

Reviewer: _____ Title: _____

Criteria for Review	1	2	3	4	5	#	%
1. Medical record identifier							
2. Legible and appropriate documentation format							
3. Documentation of appropriate:							
a. Past history and history relevant to current complaint							
b. Examination							
c. Lab and/or diagnostics							
d. Assessment and plan (to include education and follow-up)							
4. Problem list current							

Compliance Score: _____ (Compliance score goal is >90%)

Comments / recommendations:

Georgia Farmworker Health Program

Chapter IV

Utilization Review of Vouchers

All GFHP project sites utilize a voucher program to refer patients to outside providers for services not provided for on site. Generally, the nurse practitioner/mid-level provider will provide primary healthcare. When care is needed from a physician, dentist or pharmacist, project staff will complete a voucher authorization form. Because of the potential cost to the project site for services provided by an outside provider, it is necessary to conduct a utilization review of services being provided.

Patients and potential clients should be advised that the voucher program does not provide emergency care. Migrant and seasonal farmworkers should be provided with instructions on how to call for an ambulance, and directions to hospital emergency rooms in the area. This information is to be widely disseminated so that valuable time is not lost when a true medical emergency arises. Examples of medical emergencies include the following (not an all-inclusive list):

- Bleeding which cannot be stopped
- Difficulty breathing
- Convulsions
- Compound fractures
- Eye Injuries
- Fever of 104 degrees or more
- Heat Stroke
- Possible miscarriage or imminent delivery
- Vomiting blood
- Loss of consciousness
- Severe abdominal or chest pain

The program coordinator at each project site will perform concurrent utilization reviews through the process of issuing vouchers, approving vouchers for payment, and arranging follow-up care. **A utilization review will be conducted on all patients with more than two encounters per quarter for which vouchers were issued.** The following checklist is to be utilized to determine compliance with voucher policies.

Review/Grading criteria for audit form:

Put a check in the box if criteria is present and satisfactory. Add the number of checks for each criteria and put in the # column. Convert the number of checks to percentages and put in the % column. Add the total percentages and divide by the total number of criteria to determine average compliance score.

Georgia Farmworker Health Program

Utilization Review of Vouchers

Criteria for Review	1	2	3	4	5	#	%
Record identifier							
Patient is registered into the GFHP							
Appropriate signature on authorization							
Reason for referral documented							
Fee conforms to Medicaid rate							
Patients percentage of payment listed							
Amount paid to provider includes deductions for any client payment							
Provider completed requested services							
Narrative report provided by participating voucher physician / dentist.							
Services provided were consistent with services requested							
Payment made to participating voucher physician/dentist/pharmacist							
Pharmacist dispensed authorized drug							
Generic rate charged unless provider specified brand name							

Program Coordinators are to maintain a log of all Vouchers authorized and the appropriate utilization review forms associated with each voucher.

Compliance score: _____ (Compliance score goal is 100%)

Signature of Program Coordinator: _____ Date: _____

Georgia Farmworker Health Program

Chapter V

Medical Records Audit

The GFHP is committed to delivery of high quality, comprehensive health care, therefore, written medical records that are clear, legible, and well organized, are a necessary prerequisite for this process. A medical record is to be initiated on all new patients entering the system. All medical records are to be filed and maintained according to accepted ambulatory health care standards. All record entries will be in **BLACK or BLUE** ink.

The contractor has ownership of patient medical records and will maintain them in accordance with clinic policy. If requested, the contractor is responsible for providing migrant and seasonal farmworkers and their dependents with a copy of the medical record before they leave the area.

The contractor is responsible for maintaining the confidentiality of all medical records and complying with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

A medical record audit is to be conducted on 10 charts per month. The review will be based on medical record maintenance. A medical records review checklist form has been developed.

Georgia Farmworker Health Program

Medical Record Audit

Project Site: _____ Auditor: _____ Date: _____

	Chart 1	Chart 2	Chart 3	Chart 4	Chart 5	#	%
Medical record identifier							
Problem list updated and complete							
Signed patient consent							
Signed HIPAA acknowledgment							
Immunization status assessed							
Drug allergies listed							
Medication list current							
Health education documented							
Risky behaviors/habits noted							
Lab/X-ray tests and reports are present and signed by provider							
Appropriate signatures on forms							
Voucher forms placed in record (if applicable)							
Follow-up appointments listed/scheduled							
Patient registration forms on file and current.							

Put a check in the box if criteria are present and satisfactory. Add the number of checks for each criterion and put in the # column. Convert the number of checks to percentages and put in the % column. Add the total percentages and divide by the total number of criteria reviewed to determine average compliance score.

Compliance Score: _____ (Compliance score goal is >90%)

Comments:

Georgia Farmworker Health Program

Chapter VI

Patient Satisfaction Assessments

Patient satisfaction assessments are to be conducted on a semi-annual basis. Each project site is to distribute the patient satisfaction assessments to clients seeking health care at project sites. Additionally, health outreach workers are to be utilized to obtain surveys from farms and camps. These surveys play a valuable role in obtaining information from the MSFW population about needs and views of the health care services being provided. Project sites are to conduct assessments on all patient encounters during a one-week period on a semi-annual basis.

The information is used to assess the quality of care, as well as barriers to care experienced by farmworkers so that improvements may be made. The results of the surveys are to be maintained at the project sites. Evidence of review by the local advisory board shall also be maintained at the project site.

Each project site shall forward an overview of the patient satisfaction assessment to the Director, Migrant Health, Homeless, and Special Programs within 30 days of completion on a semi-annual basis.

A patient satisfaction assessment form has been developed and is attached. All surveys are to be published and provided in the appropriate languages of the MSFW population.

Georgia Farmworker Health Program

Patient Satisfaction Assessment

Dear Patient:

For us to serve you better, we ask for your opinion about our services, facilities and staff. Please answer the following questions about your experience with our services TODAY. If you need assistance in answering any question, our representatives will be glad to help you. Your answers will remain anonymous. Thank you for your feedback.

1. Where were you served today?

Work Home Clinic Mobile Clinic

2. If you were served at the clinic today, how did you arrive to the clinic?

Clinic transportation Your transportation Friend's transportation

3. Did you use an interpreter today?

Yes Somewhat No

4. Did you receive the services you were seeking today?

Yes Somewhat No

5. Did you understand the information you were given today?

Yes Somewhat No

6. Were all your questions answered by our staff today?

Yes Somewhat No

7. Was our staff friendly and respectful to you today?

Yes Somewhat No

8. Would you recommend our services to a friend?

Yes Maybe No

9. Do you have any suggestions for improving our services?

Georgia Farmworker Health Program

Patient Satisfaction Assessment

Estimado Paciente:

Para servirle mejor, deseamos saber su opinión acerca de nuestros servicios, clínicas y personal. Por favor responda las siguientes preguntas sobre los servicios que Usted recibió HOY. Si necesita ayuda para responder alguna pregunta, nuestros representantes estarán felices de ayudarlo. Sus respuestas se van a quedar anónimas. Gracias por ayudarnos.

1. En donde recibió Usted nuestros servicios hoy?

Trabajo Casa Clínica Clínica Mobil

2. Si Usted recibió servicios en la clínica hoy, cómo llegó a la clínica?

Transportación de la clínica Transportación suya Transportación de un amigo

3. Usó un interprete hoy?

Sí Algo No

4. Recibió los servicios que Usted estaba buscando hoy?

Sí Más o menos No

5. Entendió la información que le dieron hoy?

Sí Más o menos No

6. Fueron todas sus preguntas respondidas por nuestros empleados hoy?

Sí Más o menos No

7. Hoy estuvieron amigables y respetuosos nuestros empleados?

Sí Más o menos No

8. Recomendaría nuestros servicios a un amigo?

Sí Quizás No

9. Tiene Usted algunas sugerencias para mejorar nuestros servicios?

Georgia Farmworker Health Program

Chapter VII

Administration Audit

The GFHP uses contractual agreements between multiple health care agencies. In order to ensure that uniform health care services are provided to the MSFW population, the GFHP has developed basic policies that all project sites are to implement to ensure uniformity. It is the intent of the GFHP to enhance the project sites delivery of healthcare services to the MSFW population and not to replace existing procedures or policies.

All project sites are to maintain on site the following policies and/or procedures.

1. GFHP Policy and Procedures Manual
2. Financial tracking policy
3. GFHP QA/CQI Manual
4. Local QA plan
5. Clinical protocols
6. HIPAA Policy and Procedures
7. Contractual agreements and memorandum of understandings/memorandum of agreements related to the delivery of healthcare and dental services.
8. CLIA waivers for project sites with laboratory capability
9. All local policies relating to the delivery of healthcare services

In addition, each project site is to implement and maintain the following boards, policy and/or procedures:

Advisory Board:

- Meets on a quarterly basis
- Members will include MSFW representatives, community agencies, etc.
- Member names are displayed and available to the clients upon request
- Develop and forward minutes of all meetings to the Director, Migrant Health, Homeless and Special Programs

Patient “Bill of Rights”:

- Displayed in obvious areas (waiting rooms) and disseminated to center clients
- Published in appropriate languages

Sliding Fee Scale:

- Displayed in obvious areas (waiting rooms)
- Published in appropriate languages
- States that services will be provided regardless of patient’s inability to pay

Building safety checks (conducted by local Fire Marshall or agency Safety Officer):

- Fire Hazards
- Fire Extinguishers (inspected & tagged)
- Emergency exits identified
- Hazardous material storage

Hours of Operation:

- Accessible
- After hour access available
- **Weekend access available**
- After hour referral procedures available

Health education pamphlet:

- Available in appropriate languages
- Displayed in obvious areas (waiting rooms)

An administrative audit is to be conducted on an annual basis. The purpose of this audit is to make appropriate policies and procedures readily available for staff members; ensure a safe working environment for clients and staff; and provide a means to educate clients on their rights.

Project sites are to use the following audit form as a means to document compliance.

Georgia Farmworker Health Program

Administration Audit

	Available Yes – No – N/A	Comments
GFHP Policy and Procedures Manual		
Financial tracking policy		
GFHP QA/CQI Manual		
Local QA/CQI Plan		
Clinical protocols available		
HIPAA Policy and Procedures		
Contractual agreements MOU/MOAs on file		
CLIA waiver posted		
Local agency's policies for healthcare services		
Advisory Board established and functional		
Patient Bill of Rights displayed		
Sliding fee scale displayed		
Building safety checks conducted		
Hours of operation displayed		
Health education pamphlets in appropriate languages		

Georgia Farmworker Health Program

Chapter VIII

Quality Assurance / Continuous Quality Improvement Committee

The GFHP has instituted a QA/CQI Committee to assure accessibility, quality and cost effectiveness of primary care services available to migrant and seasonal farmworkers in Georgia. The GFHP QA/CQI Committee will be responsible for evaluating, monitoring, and promoting continuous improvements in the quality of health services provided to the migrant farmworkers by the various project sites.

The primary function of the GFHP QA/CQI Committee will be:

- A. Monitoring of identified issues in the QA/CQI Plan
- B. Review and make recommendations regarding quality assurance/improvement findings
- C. Identify quality improvement opportunities

The GFHP QA/CQI Committee will consist of:

- A. Director, Migrant Health, Homeless, Special Programs;
- B. Program coordinators from all project sites; and
- C. Mid-Level providers and Nursing representative from all project sites

Meetings will be held on a quarterly basis. The QA/CQI Committee will meet in concert with the quarterly GFHP meetings.

The GFHP will utilize the **FOCUS PDCA** approach for performance improvement. The approach is as follows:

- F** Find a process to improve
- O** Organize a team that knows the process
- C** Clarify the current knowledge of the process
- U** Understand the cause of the process variation
- S** Select the process improvement

- P** Plan the process to improve
- D** Do the improvement
- C** Check the study results
- A** Act to hold and sustain the improvement

Any staff member that discovers a process or policy that can be enhanced, streamlined or made more efficient is to complete the Quality Improvement Process Form and forward to the QA Committee for consideration and/or action.

Georgia Farmworker Health Program

Quality Improvement Process Form

Process or Policy identified for improvement:

Nature of the problem:

Recommended improvement action:

Date forwarded to the QA Committee: _____

Action/s taken by the QA Committee:

- 1. Process improvement team assigned _____
- 2. Disagree with recommendation _____
- 3. Recommendation implemented _____
- 4. Follow-up of process improvement scheduled _____
- 5. Improvement process completed _____

Comments:

Georgia Farmworker Health Program

Chapter IX

Schedule of Events

The following is a schedule of events and/or reports associated with the QA/CQI Plan. All Project Coordinators are to ensure that all aspects of the program are implemented and appropriate reports are forwarded to the Director, Migrant Health, Homeless, and Special Program.

Item/Topic	Number of checks / reviews	Periodicity
Provider Credentialing	All healthcare providers	Bi-annually
Physician Preceptor	10% of all mid-level provider record entries	Monthly
Utilization Review	All vouchers meeting identified standards	Concurrent
Medical Record Reviews	10 medical records	Monthly
Patient Satisfaction Assessments	All patient encounters during a one-week period.	Semi-annually
Administration	All identified topics	Annually

Georgia Farmworker Health Program (GFHP)
Glossary of Terms

ADFC: Aid to Families with Dependent Children. Presently called “Temporary Assistance to Needy Families (TANF).”

Administration Audit: Conducted on an annual basis by the GFHP Program Operations Specialist . The purpose of this audit is to make appropriate policies and procedures readily available for staff members; ensure a safe working environment for clients and staff; and provide a means to educate clients on their rights.

Advisory Council: Each GFHP site is to have a Migrant Advisory Board and the GFHP program as a whole has an Advisory Council. The Advisory Council evaluates, monitors and promotes continuous improvement in the health services delivered to migrant and seasonal farmworkers. Additional roles of the Advisory Council are listed on page 49 of the GFHP manual.

Agriculture: The farming of land in all its branches: cultivation, tillage, growing, harvesting, and preparation and processing for market or storage that occurs on the farm. This definition also includes Christmas tree farming, pine seedling planting, pine straw collection and nursery workers. This definition does not include raising livestock, harvesting lumber, and preparation and processing that does not occur on the farm.

Bad debts: Difference between the amount of patient charge and the amount collected.

Benefit funds: Federal and State funds associated with the Grant Program.

BPHC: The Bureau of Primary Health Care is the entity under which Community and Migrant Health Centers, and other programs are organized. BPHC is organized under the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services BPHC assesses the credentials of each licensed or certified health center to determine that they meet Health Center Standards. (GFHP: QA/CQI Program Manual, pg 3.)

BPHC Uniform Data System: System used to collect data from health care centers which helps to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations.

CHC: Community Health Centers are federally supported to serve low-income persons on a sliding-fee scale.

CPT: Current Procedural Terminology: CPT codes are five-character, all numeric configurations (e.g., 99215) used for medical coding. The CPT coding system is maintained by the American Medical Association.

CVO: Credentials verification organization.

Catchment area: Means the geographic area served by a project funded under the Public Health Service Act (42 U.S.C. 201 *et seq.*)

Credentialing: The process of assessing and confirming the qualifications of the practitioner.

Daily Receipts Report: Daily report of all monies collected. The cashier from each site is required to run this report at the end of each day to verify monies collected.

DCH- Department of Community Health which oversees the GFHP.

Department of Health and Human Services (DHHS):

Federal government department which oversees the Bureau of Primary Healthcare.

Director, Migrant Health, Homeless and Special Programs: Oversees the development and on-going management of the Georgia Farmworker Health Program in regards to development of policies and procedures, compliance with state and federally mandated regulations, and assurance program objectives are being met.

Encounter: face-to-face contact between a patient and a provider who exercises independent professional judgment in the provision of services to the patient. Services rendered must be documented in the patient's record to be included as an encounter.

Family: Group of two or more persons related by birth, marriage, or adoption who live together; such related groups are considered one family.

Gatekeeping: A method, designed by each project site, for referring patients to outside providers.

GFHP: Georgia Farmworker Health Program administered by the State Office of Rural Health (SORH) under the auspices of the Georgia Department of Community Health.

GFHP Database System: Data system that contains information for each participant that includes name, address, birth date, sex, race/ethnicity, language, occupation, income, family size, appropriate ICD-9 and CPT service codes, clinics attended, provider and provider Type.

GFHP Financial and Billing Policies and Procedures: Guidelines used to assess financial status which determines program eligibility; guidelines used to track all monetary collections and/or debts acquired for services rendered.

GFHP Registration Card: Each participant receives a registration card, issued annually during the registration process, which will serve to identify MSFWs to other GFHP sites. This will help to ensure the eligibility process is not repeated.

GFHP sites: Facility location which provides health care and health related services to the migrant and seasonal farmworker population and their families.

Grant-in-Aid Master Agreement: Also known as Grant Agreement

Health Departments: A division of a local or larger government responsible for the oversight and care of matters relating to public health.
www.case.edu/med/epidbio/mphp439/Dictionary.htm

Health professionals: Professionals (such as physicians, dentists, nurses, podiatrists, optometrists, and physicians' extenders) who are engaged in the delivery of health services and who meet all applicable Federal or state requirements to provide their professional services.

HIPAA: Health Insurance Portability and Accountability Act regulations. Each patient must acknowledge receipt of HIPAA privacy notice and remain permanent part of each patient's record.

HRSA: Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

ICD-9: International Classification of Diseases which is the official system of assigning codes to medical diagnoses.

JCAHO: Joint Commission on Accreditation of Healthcare Organizations is an independent, not-for-profit organization, that accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Licensed or Certified Health Care Practitioner: An individual required to be licensed, registered, or certified by the State, commonwealth or territory in which a Health Center is located. These individuals include, but are not limited to, physicians, dentists, registered nurses, and others required to be licensed, registered, or certified (e.g., laboratory technicians, social workers, medical assistants, licensed practical nurses, dental hygienists, nutritionists). The definition will vary dependent upon legal jurisdiction. "Licensed or certified health care practitioners" can be divided into two categories: a) licensed independent practitioners (LIPs) and b) other licensed or certified practitioners.

Licensed Independent Practitioner:

Physician, dentist, nurse practitioner, "individual permitted by law and the organization to provide care and services within the scope of the individual's license and consistent with individually granted clinical privileges.

Medical Record Audit: Audit of patient medical records conducted monthly on ten charts. Each site must provide current and completed Medical Record Audit *checklists* at the time of each quarterly QA/CQI Site Review.

Migrant Advisory Board: SORH designated board which provides support and advice to facilitate the achievement of the mission, goal and objectives of the migrant program.

Migratory agricultural worker: Individual whose principal place of employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes, for the purpose of such employment, a temporary place of abode.

Migrant Health Center: An entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides for migratory agricultural workers, seasonal agricultural workers, and the members of families of such workers, within its catchment area primary health services.

Nominal flat fee schedule: Defines the flat fees that project sites can charge if a family's income is at or below the federal poverty level.

Nonprofit: As applied to any private agency, institution or organization, means one which is a corporation or association, or is owned and operated by one or more corporations or associations, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

Other Licensed or Certified Health Care Practitioner: An individual who is licensed, registered, or certified but is not permitted by law to provide patient care services without direction or supervision. Examples include, but are not limited to, laboratory technicians, social workers, medical assistants, licensed practical nurses, dental hygienists.

Patient Encounter Report: The Patient Encounters Report is a list of all patient encounters entered into the database system for a particular date of service.

Patient Satisfaction Assessments: Survey conducted by each project site during a one-week period on a semi-annual basis. This information is used to assess the quality of care, as well as barriers to care experienced by farmworkers so that improvements may be made.

Physician: A licensed doctor of medicine or doctor of osteopathy.

Plan of care: The overall approach to the assessment, management, and outcome measurement given to each patient to address the specific healthcare needs based upon medically approved protocol.

Poverty Income Guidelines: guiding source used to determine sliding fee scale; changes annually.

Primary Health Care: Means preventive, diagnostic, treatment, consultant, referral, and other services rendered by physicians and, where feasible, by physicians' extenders, such as physicians' assistants, nurse clinicians, and nurse practitioners.

Primary Source Verification: Verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. Examples of Primary Source Verification include, but are not limited to, direct correspondence, internet verification and reports from CVOs. The Education Commission (ECFMG), the American Board of Medical Specialties, the American Oste—Database, or the American Medical Association (AMA) Master file can be used.

Principal employment: MSFW must have agriculture (see definition) as primary source of income.

Problem oriented record system: Patients' records kept and maintained in accordance with their respective life cycle and by cause for visits.

Program Income: Includes general program income, proceeds from the sale of assets acquired with funds; royalties from copyrights on publications developed under, or patents and inventions conceived or first actually reduced to practice under, a grant supported and interest and investment income.

Provider: Providers are individual health care professionals who deliver services to health center patients on behalf of the health center. They assume primary responsibility for assessing the patient and documenting services in the patient's record. Providers include only those individuals who exercise independent judgment as to the services rendered to the patient during an encounter. <http://bphc.hrsa.gov/policy/pin0801/definingscope.htm>

QA/CQI: Quality Assurance/Continuous Quality Improvement Committee:
Responsible for evaluating, monitoring and promoting continuous improvements in the quality of health services provided to the migrant farmworkers by the various project sites.

QA/CQI: Quality Assurance/Continuous Quality Improvement Plan Program Manual:
Provides specific standards, measurement tools, and processes for improving quality of healthcare provided to migrant and seasonal farmworkers (MSFWs).

Secondary Source Verification: Method of verifying credentials when primary sources are not available. Examples of secondary source verification methods include, but are not limited to, notarized copy of the credential, a photo-copy of the credential (when an original is not available to the Health Center staff).

Seasonal agricultural worker: Means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agriculture worker.

Sliding fee scale: Percentage determined by comparing the family's income to Federal Poverty Guidelines.

Sliding fee schedule: A schedule of fees or payments for the provision of services consistent with locally prevailing rates or charges and designed to cover its reasonable cost of operation. A schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay. Poverty Guidelines and Sliding Fee Scale Table located in Manual.

SORH: State Office of Rural Health operates under the auspices of the Georgia Department of Community Health.

State of Georgia Travel Regulation Policy: Regulations found at <http://www.sao.georgia.gov>.

SSI: Social Security Income. A federal program that provides monthly benefits for persons age 65 years or older and persons who are disabled.

Third party payment source: Other payment sources such as: private insurance, Medicare, Medicaid, or S-CHIP(State Child Health Insurance Program).

User: Any person receiving health care and/or health related services from any of the GFHP sites.

Utilization Review: Review of services being vouchered out by a GFHP site. This is necessary due to the potential cost to the project site for services provided by an outside provider.

Voucher: A form used to refer patients to outside providers requiring services not provided for by a GFHP site.