

**Section I: Board Adopted Policies**

**Policy A: Compliance with Public Health Laws/Regulations**

Reviewed By: Board of Health

Approved By: Board of Health, Health Director

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**Policy I.A.**

It shall be the policy of the Orange County Board of Health and Health Department to ensure that its workforce consults and follows federal, state, and local laws and regulations and the current recommendations of regulating/advisory agencies in the delivery of public health services.

**Purpose:**

The purpose of this policy is to ensure that the Orange County Board of Health and Orange County Health Department workforce consults and follows federal, state, and local laws and regulations and the current recommendations of regulating and advisory agencies in the delivery of essential and mandated public health services.

**Definitions:**

1. Centers for Disease Control and Prevention (CDC) – an agency of the United States government that serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.
2. North Carolina Department of Health and Human Services (NCDHHS) – a department of State government that is charged with “protecting health, fostering self-reliance and protecting the vulnerable.”
3. Essential public health services – defined in NC General Statute 130A.
4. North Carolina General Statutes (NCGS) – The laws passed by the North Carolina General Assembly. Public health statutes are generally located in Chapter 130A.
5. North Carolina Administrative Code (NCAC) – a compilation of the administrative rules of approximately 26 state agencies and more than 50 occupational licensing boards.
6. United States Code of Federal Regulations (USCFR) – the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government.
7. Ordinance – local rules adopted by the Board of Commissioners.
8. Regulating and advisory agencies – agencies that are created by a governing body to recommend best practices for public health or are charged with interpreting and enforcing public health laws. (Examples include the CDC, the National Immunization Advisory Committee, US Department of Health and Human Services, the NCDHHS)
9. Mandated public health services – the public health services that a local health department is required by state statute or administrative code to implement.
10. Workforce – Orange County Health Department employees, contract personnel, volunteers, trainees, and students.

Review Annually (July)

Original Effective Date: October 24, 2004

Last Revision Date: 1/2006, 11/2013, 11/2014, 8/2015

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**Procedures:**

1. The Board of Health and Health Department workforce must follow laws, established guidelines, and consistent procedure in order to assure that the public receives fair, efficient, and effective services.
2. The Board of Health must consult legal counsel such as the Orange County attorney, the NC Attorney General or the UNC School of Government whenever legal assistance is indicated to interpret laws and rules.
3. The Board of Health delegates to the Health Department Division Directors and Supervisors of the appropriate division through the Health Director, the development and implementation of all policies, procedures and/or task outlines to assure effective and efficient service delivery of programs within the scope of the most current public health laws and regulations.
4. All pertinent laws, regulations, and policy and procedure manuals shall be maintained in the appropriate division. The NCGS 130A and related statutes on public health law and administrative codes shall be maintained in the Health Director's Office and in a Board of Health Manual.

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**Section I: Board Adopted Policies**

**Policy B: Program and Policy Adoption**

Reviewed By: Health Director, Board of Health

Approved By: Board of Health

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**Policy I.B.**

The Orange County Board of Health authorizes and delegates the implementation of all programs and services as defined by North Carolina General Statute 130A, the related NC Administrative Code, and other programs approved by the Board to the staff of the Orange County Health Department under the direction of the Health Director.

**Purpose:**

The purpose of this policy is to ensure that the Orange County Board of Health provides guidance for programs and policies that affect the entire Health Department.

**Procedures:**

1. The Orange County Board of Health, upon recommendation of the Health Director, shall review and approve policies or programs that commit the Health Department to utilize significant additional or new resources outside of the scope of the approved annual budget.
2. The Board of Health authorizes continuation of program activities through the annual approval of a Health Department budget.
3. The Board of Health delegates the approval of all administrative policies and procedures for the general functioning of the Health Department to the Health Director.
4. The Board of Health reviews and approves policies as requested or in response to a Board of County Commissioner initiative and forwards recommendations to the Board of Commissioners on relevant changes. The Board of Health delegates the implementation of these policies to the appropriate division staff through the Health Director.
5. The Orange County Board of Health shall review at least annually all policies adopted by the Board of Health.

Review Annually (July)

Original Effective Date: October 24, 2007

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<b>Section I:</b>	<b>Board Adopted Policies</b>
<b>Policy C:</b>	<b>Confidentiality Agreement and Conflict of Interest Statement</b>
Reviewed By:	Board of Health, Health Director
Approved By:	Board of Health

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**Policy I.C.** Each Board member will sign a confidentiality agreement and conflict of interest statement upon accepting a seat on the Board of Health.

**Purpose:**

To prevent individuals from deriving any profit or gain directly or indirectly by reason of their association with the Orange County Health Department. All members of the Orange County Board of Health will promptly disclose any conflict of interest between his or her personal interests and the interests of the organization. To protect the disclosure of information that is judged to be of a confidential nature by state or federal statute or policy.

**Procedures:**

1. Each new Board of Health member must sign a Confidentiality Agreement and Conflict of Interest Statement (I.C. Appendix A) prior to attending their first meeting of the Board of Health that states the following:

**Confidentiality**

*In connection with my responsibilities as a member of the Orange County Board of Health, I agree to treat all information concerning health department clients, personnel, and financial matters in a confidential manner as required by state and federal statute and will not divulge this information to unauthorized personnel or the public. I understand that if I wrongfully and/or willfully disclose such information, I may be subject to removal from the Orange County Board of Health.*

**Conflict of Interest**

1. *Each board member, upon accepting a seat on the board, agrees in writing by signing below, to carefully guard against any conflict of interest that might develop between his or her personal interest and that of the Orange County Health Department.*
2. *If an issue arises in which a member of the board has a conflict of interest, the member shall promptly disclose the conflict to the Chair of the Board prior to consideration of the issue by the board.*
3. *In matters involving a conflict of interest, a board member must state the reason for which they reasonably think a conflict exists and the board member shall not vote on such policies or transactions unless requested by the board.*
4. *The abstention and the reason for it shall be recorded in the minutes.*
5. *A board member may not directly or indirectly benefit except as provided for as members of the board of directors, from the county's disbursement of funds.*
6. *Violation of this policy shall be grounds for recommending dismissal of a board member. The Board of Health will forward recommendation for dismissal to the Board of County Commissioners for action.*

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2. The original, signed copy of the Confidentiality Agreement and Conflict of Interest Statement will be filed in the Board of Health member's file and kept at the Health Department by the Administrative Assistant to the Health Director.

**I have read and understand the confidentiality and conflict of interest statements. I agree to abide by these policies.**

\_\_\_\_\_  
Board Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Board Member Name (Printed)

**Confidentiality & Conflict of Interest Statement**  
**For New Board of Health Member**  
Board Adopted Policy I.C. Appendix A

**Confidentiality**

In connection with my responsibilities as a member of the Orange County Board of Health, I agree to treat all information concerning health department clients, personnel, and financial matters in a confidential manner as required by state and federal statute and will not divulge this information to unauthorized personnel or the public. I understand that if I wrongfully and/or willfully disclose such information, I may be subject to removal from the Orange County Board of Health.

**Conflict of Interest**

1. Each board member, upon accepting a seat on the board, agrees in writing by signing below, to carefully guard against any conflict of interest that might develop between his or her personal interest and that of the Orange County Health Department.
2. If an issue arises in which a member of the board has a conflict of interest, the member shall promptly disclose the conflict to the Chair of the Board prior to consideration of the issue by the board.
3. In matters involving a conflict of interest, a board member must state the reason for which they reasonably think a conflict exists and the board member shall not vote on such policies or transactions unless requested by the board.
4. The abstention and the reason for it shall be recorded in the minutes.
5. A board member may not directly or indirectly benefit except as provided for as members of the board of directors, from the county's disbursement of funds.
6. Violation of this policy shall be grounds for recommending dismissal of a board member. The Board of Health will forward recommendation for dismissal to the Board of County Commissioners for action.

**I have read and understand the confidentiality and conflict of interest statements. I agree to abide by these policies.**

\_\_\_\_\_  
Board Member Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Board Member Name (Printed)

\_\_\_\_\_  
Staff initials

\_\_\_\_\_  
Date

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**Section I:** Board Adopted Policies  
**Policy D:** Requests for Environmental Services and Assessments  
Reviewed By: Board of Health & Health Director  
Approved By: Board of Health

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**Policy I.D.**

This policy covers processing and budgetary considerations regarding requests from citizens and communities for environmental services and assessments to determine whether environmental contaminants are present, environmental degradation has occurred or for the applicant's information for future reference.

**Purpose:**

The purpose of this policy is to determine when environmental services, surveys or assessments will be conducted and also to set forth the funding mechanisms for those actions. Also covered within the policy scope are the decision tree for when community assessments will be considered and the ensuing financial responsibilities for those expanded efforts. This policy is not intended to cover nor does it cover applications, inspections, approvals or other processes for regulatory programs generally administered in the Environmental Health Services Division.

**Section I Policy Overview**

1.0 Environmental Health routinely receives concerns and queries from Orange County residents regarding environmental investigations to determine whether an environmental exposure exists and also whether unusual disease prevalence is occurring. These requests may arise from an individual or from communities. This policy addresses general and specific practices for these requests and assigns responsibilities for their dispensation.

**Section II Individual Requests**

1.0 Individual residents may request services and environmental assessments for their property, whether owned outright, leased, rented, or otherwise legally occupied. These services include septic inspections, water samples, indoor air quality (IAQ) assessments, vector control inspections, single disease case investigations, or other services germane to current or future environmental health programs.

**Section III Community or Collective Requests**

1.1 The following types of community or collective studies and assessments will be considered and acted upon by staff with the appropriate approval(s) when environmental conditions are suspected as a causative factor:

1.2 Acute and Chronic Disease

- a. Airborne, vector-borne and waterborne diseases are environmentally related in their transmissions and may affect a community as a whole. Chronic diseases such as asthma and cancer can have causative factors

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related to environmental conditions and exposures. The investigation of acute and chronic diseases would be indicated with confirmed cases of those diseases in rates extraordinary to baseline rates for Orange County or statistically expected rates for that community. Investigations will be carried out in accordance with best epidemiological practices established by the EPI Team\* in each community or collective request.

- b. OCHD will conduct community studies for acute and chronic diseases suspected of originating from environmental exposures and for wells and septic systems failures when data or reports indicate that study beyond the individual level is needed to confirm or deny multiple sources of contamination leading to acute and/or chronic disease under investigation.

1.3 Wastewater and Well Water Studies

- a. Community studies will be considered and acted on or deferred by OCHD based on several risk factors and other defined considerations. Those include the following:
  - 1. The study area consists of more than 5 households.
  - 2. Known disease-causing environmental contamination (chemical releases, improper biosolids applications, underground storage tanks, junkyards, etc.) that could adversely affect a natural resource (groundwater, stream, etc.) or negatively impact more than a single property in that community.
  - 3. Known geophysical conditions (e.g., underlying rock structure that might lead to high levels of natural radon release, severe disturbances of the underlying structure) with a scientifically documented negative environmental impact potential that could affect the intended use and sustainability of property in the community.
  - 4. More than 30% of the individual wells in a given geographical community were drilled prior to 1981 or more than 30% of the septic systems in the community are more than 20 years old.
  - 5. Protection of water supply resources (protected water supply watersheds, water quality critical areas, wellhead protection areas, etc.).
- b. Statistical Studies may be considered in order to gain important information about septic system failure rates or groundwater quality or quantity characteristics. Examples in this category might include:



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1. comparing septic system failure rates in mobile home parks with those of neighborhoods with stick built construction;
2. examining the existing data for septic system repairs to identify common characteristics of failed systems;
3. studying the effect of water softener systems on septic system failures;
4. exploring the relationship between well water quality and the age of the well, length of casing, landscape position, etc.
5. gathering baseline water quality data and tracking water quality over time in a defined geographical study area near a suspected environmental hazard (such as a biosolid application site)

**Section IV Funding**

- 1.0 Individual Requests: The cost recovery for individual testing and assessments will come from fees for service administered according to the Environmental Health Division's Fee and Application Policy and from the fee schedule approved by the Board of Health and the Board of County Commissioners. In the case of an individual disease investigation that is a direct follow-up to an outbreak, the individual charge is waived.
- 2.1 Community Surveys: The direct operational costs for materials needed for community related surveys, assessments and other studies will be paid for by Orange County as specified in Section V of this policy **if**:
- a. surveillance data or other confirmed and documented medical or scientific reports indicate a potentially environmentally caused or transmitted disease prevalence at abnormal levels in that community, or
  - b. at least three of the five items in Section III. 1.2a are met.
- 3.0 Studies requested by other governmental agencies will be evaluated by the Health Director and County Manager as appropriate.

**Section V Community Study Funding Approvals**

- 1.0 When estimated operational costs are less than or equal to \$250, the Orange County Health Director will approve or deny the study and the study will be funded through the Environmental Health Services budget.
- 2.0 When estimated operational costs are greater than \$250 but less than or equal to \$2,500, the Orange County Health Director will approve or deny the study based on current availability of budgetary and staff resources and present it to the Orange County Board of Health for final decision. The Health Director will determine the specific funding source for an approved study.

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- 3.0 When estimated operational costs are greater than \$2,500, or if the budgetary and staff resource needs are greater than available in the Health Department budget, the Orange County Health Director will recommend to approve or deny the study and present the recommendation to the Orange County Board of Health for consideration. The Board of Health's recommendation will be presented to the Orange County Board of County Commissioners for final decision and funding source identification if approved.

\*The EPI Team is the interdisciplinary health department staff team that is responsible for all outbreak investigations.

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**I. Purpose**

- A. Public health services are increasingly costly to provide. The Health Department serves the public's interest best by assuring that all legally required public health services are furnished to all citizens. The department provides recommended and requested public health services based upon the priorities established by the Board of Health.
- B. Fees are a means to help provide services to the residents of Orange County. Fees help finance and extend public health services when government funding is not sufficient to support the full cost of providing all required and requested services.
- C. Fees for Orange County Health Department services are authorized under North Carolina G.S. 130A-39, provided that:
  - 1. They are in accordance with a plan recommended by the Health Director and approved by the Board of Health and the Orange County Board of Commissioners.
  - 2. They are not otherwise prohibited by law.
  - 3. They are deposited to the account of the local Health Department for public health purposes in accordance with the provisions of the Local Government Budget and Fiscal Control Act.
- D. Fees for services must also be in compliance with N.C. Administrative Code, Title X Regulations, and Women's and Children's Health Program Rules.
- E. There will be no charge for Title X Services provided for individuals with income less than 100% of the Federal Poverty Level (FPL.)

**II. Policy Implementation**

The implementation of this policy is delegated to appropriate financial or support staff in each division of the health department.

**III. Income Eligibility**

**A. Definitions**

- 1. Definition: A family is defined as a group of individuals who are living together as one economic unit. Individuals are considered members of a single family or economic unit when their production of income and consumption of goods are related. A pregnant woman is counted as a family of two in determining family size.
- 2. Income eligibility requirements apply to: Dental Health, Family Planning, Child Health, Maternal Health, Adult Health, Nutrition Services and Primary Care Services.
- 3. The Health Department utilizes a sliding fee scale based on Federal Poverty Guidelines in accordance with the Fee Schedule approved annually during the County Budget process. NC DPH updates and issues the scale yearly. Specifically,

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the health department uses the 101% - 250% Federal Poverty Level sliding scale. Determination of Sliding Fee percentage is based on gross income and family size.

4. Verification of income is required at time of enrollment for services, at the annual financial interview, or if there is a change in the work status in the family unit for clients to be eligible for the sliding fee scale.
  - a. An annual gross income statement is preferred for evaluation.
    - i. Gross income is defined as the total of all cash income before deductions for income taxes, employee social security taxes, insurance premiums, bonds, etc. For self-employed applicants, net income after business expenses. Gross income does NOT include money earned by children for babysitting, lawn mowing and other tasks.
    - ii. In general gross income includes: salary, wages, commissions, fees, tips, overtime pay, unemployment compensation, public assistance money, alimony and child support payments, Social Security benefits, VA benefits, Supplemental Security Income (SSI) benefits, retirement & pension payments, worker's compensation, bonuses, prize winnings and other sources of cash income except those specifically excluded.

**B. Sources**

1. Sources of income verification may include, but are not limited to:
  - a. Current pay stub
  - b. Self-employment accounting records
  - c. Letter documenting current employment and wages from employer
  - d. Recent income tax return
  - e. Unemployment or workers compensation receipt
  - f. Public assistance letter
  - g. Prior income verification through enrollment in other Health Department programs
2. If an individual claims "no income" (except for minors consenting to specific services under G.S. 90-21.5), a signed "Verification of Income and/or Residency" form (Attachment A) indicating financial support from another party must be submitted.
3. Failure to provide verification within 10 business days of date of service will result in charges being assessed at 100% of sliding fee scale. The client will receive notification of required income verification at the time the initial appointment is made.
4. The client must read, sign and understand the "Determination of Eligibility Payment Plan for Clinical Services" and "Statement of Financial Responsibility Payment Plan" form (Attachment B) at their initial visit and annual financial reviews.

**C. Environmental Health**

Persons seeking Environmental Health services must obtain and properly complete an application for service and pay the corresponding fee for service (all applicants pay at the 100% pay status) before an appointment for a field visit will be scheduled. Sometimes

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additional fees may be necessary if during service delivery it is determined that the correct fees were not initially paid, or services requested are more than applied for. Wastewater Treatment Management Program (WTMP) and Mobile Home Park fees are the only Environmental Health services invoiced after the inspection. These inspections are not application based but occur on a regulated, recurring schedule.

#### **IV. Residency Requirements**

- A. Any individual, Orange County resident or non-resident, is eligible for services provided by the Health Department. Exceptions include non-STD Communicable Disease cases (Orange County residents only) and when prohibited by law or regulation.
- B. Proof of Residency may be determined by using the US Postal and/or Orange County GIS website and one of the following: Driver's License, Government-issued identification, Pay Stub (Within the last 30 days), Utility bill (Within the last 45 days); Current rental or lease agreement; Personal or property tax bill; Student identification, and Matrícula Consular (Mexican ID Card<sup>1</sup>). Clients without one of the above identifying information sources but reportedly living within the county will be required to produce a written statement or letter from the head of household, verifying that the person resides in their home. Special cases will be referred to the Clinic Manager or Supervisor. Failure to provide proof of residency may result in referral to another resource.
- C. Proof of Residency in Orange County is required for self-pay patients to be eligible for the sliding fee scale when requesting Maternal Health, Child Health, Primary Care, Nutrition Services, and Dental Health Services. Out-of-county residents will be assessed at 100% of charges not covered by a third party payer source.

#### **V. Service Limitation/Denial**

- A. Services will not be denied based solely on the inability to pay, with the exception of those services that require a flat or minimum fee. Emergency dental services and urgent primary care services will be provided to clients regardless of any outstanding balance due.
- B. Otherwise, services may be denied if the department does not have the resources needed to provide a quality non-mandated service or the individual does not meet the residency or financial requirement.

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<sup>1</sup> The **Matrícula Consular de Alta Seguridad (MCAS) (Consular Identification Card)** is an identification card issued by the Government of Mexico through its consulate offices to Mexican nationals residing outside of Mexico. Retrieved from [http://en.wikipedia.org/wiki/Matr%C3%ADcula\\_Consular](http://en.wikipedia.org/wiki/Matr%C3%ADcula_Consular) on October 14, 2012.

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- C. Family Planning clients will never be refused service due to an outstanding balance or inability to provide proof of income.
- D. Maternal and Child Health clients who are at 60% to 100% pay status may have services limited or denied for failure to make payments based on designated Payment Plans (“good faith” effort).
- E. Falsification of eligibility by the client may result in denial or limitation of services.
- F. The Health Department shall not deny a service due to religion, race, national origin, creed, sex, marital status, familial status, sexual orientation, veteran status or age.
- G. The Health Department shall assure that no otherwise qualified handicapped individual, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity covered by this agreement.
- H. The Health Director can override any decision to deny or limit services to a client in accordance with the existing fee waiver process.

**VI. Fees for Services**

- A. In order to facilitate early entry into prenatal care or family planning services, pregnancy tests will be provided free of charge unless they are required as part of another service.
- B. In order to facilitate early identification of and referral for hypertension, two blood pressure screenings will be provided in the clinic free of charge. Borderline readings will be checked free until determined to be normal or the client is referred for further evaluation. Follow-up of clients with a diagnosis of hypertension will be charged according to the fee policy.
- C. Fees are not charged for diagnosis and treatment of sexually transmitted diseases, or investigation and control of communicable diseases. There is also no charge to clients for any State-provided vaccine.
- D. Fees are charged for health and dental services provided to individuals unless prohibited by law or regulation. Fees are established based upon cost analysis, Medicaid and Medicare rates, comparable provider rates and/or state or contractual agreements. The Health Director shall inform the Board of Health and the Orange County Board of Commissioners of these adjustments in a timely manner.
- E. Fees may be charged to clients for “non-program” specific services without being adjusted on a sliding fee scale (flat fees).

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- F. Fees may be charged for education, community-based limited clinical services (such as influenza shots) and screening services provided to individuals or groups. The following applies to these services:
  - 1. They include orientation, field training, dental screening and education, and/or other health promotion activities such as infant and toddler car seats, bike helmets, or equipment rental.
  - 2. The Health Director will negotiate fees for services where fees have not been previously determined.
  - 3. Income eligibility requirements do not apply to these services.
  
- G. Per NC General Statute Chapter 7B, Subchapter 4, Article 35, and confidentiality regulations, emancipated minors and other individuals requesting confidential services will be considered a family of one for determination of charges. Private insurance will also not be billed for minors receiving services for which they can consent unless permission is received from the minor.
  
- H. Persons requesting any program services may be encouraged to apply for Medicaid, as applicable.
  
- I. The Personal Health Services Division clinical and nutrition services will use the appropriate sliding fee schedule for services when adjustable fees are allowed; all other fees will be charged at 100%.
  - 1. Clients, who require services provided on the sliding fee schedule, are expected to pay the appropriate fee in full based on sliding fee guidelines.
  - 2. This schedule will require assessment of the client's financial status on an annual basis or when a financial status change occurs, as specified in section III.
  
- J. Dental Health Services, Primary Care Services, and Nutrition Services will use a sliding fee schedule for all services, with a minimum charge to be established at the annual fee review during the budget preparation process.
  - 1. The minimum charge for dental, primary care, and nutrition services will apply regardless of the determination of the client's financial status.
  - 2. If a client is determined to fall at the 0% pay level, the minimum charge will be the only charge levied and collected.
  - 3. Minimum charge is due at time of service.
  
- K. Fee schedules will be reviewed annually during the budget process and adjusted as appropriate; a complete cost analysis for purposes of fee adjustments will be performed every five years. The process for this cost analysis includes a review of the following elements:
  - a. Most recent vaccine and drug purchase costs
  - b. Most recent lab pricing lists
  - c. Most recent Medicaid Cost Settlement data for procedure costs
  - d. Environmental Health equipment, labor, and staff costs
  - e. Review of fee schedules of surrounding jurisdictions

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- f. Analysis of existing self-pay client base and how increased costs would affect their ability to get necessary care
- L. Based on G.S. 130A-41, the Health Director is authorized to enter into contracts, which may include negotiated reimbursement rates.
- M. The Health Director may not make exceptions to the Fee Policy except to accommodate specific situations through the fee waiver process (Attachment C).
- N. Any minimum administrative fee or flat fees shall be applied without discrimination to all patients.
- O. There will be no “schedule of donations”, bills for donations, or any other implied coercion for donations from clients as a condition for being seen at the Health Department. Donations to the health department can be made through the Orange County Community Giving Fund. Fees for services will not be waived because of client donations.

**VII. Fee Collection**

- A. Environmental Health service fees are paid before an appointment is scheduled. Field staff cannot accept fees in the field.
- B. Fees collected from Medicaid and Medicare and other third party insurance for a covered service, combined with payment of any applicable co-pays and co-insurance, constitutes full payment for that service.
- C. A co-payment, deductible, or balance of charge can be collected at the time of service from individuals covered by other third party insurance plans when OCHD is a member of their provider panel (exception family planning). For Family Planning clients, family income should be assessed before determining whether co-payments or additional fees are charged; if their family income is verified to be at or below 250% FPL, they should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied. With regard to other insured clients, payments towards a deductible for clients whose family income is verified to be at or below 250% FPL should have the appropriate sliding fee schedule applied.
- D. If OCHD is not on the insurance provider panel, the client will be charged for the service(s) based on the Health Department’s fee schedule. The client will be provided with documentation of services for submission of a claim to their insurance company.
- E. At the time services are received, the client will be given a statement showing the cost of services for that visit as well as their total account balance.
- F. Payment is due at the time services are rendered.



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**Policy E:** Fee and Eligibility Policy  
Reviewed by: Financial Review Committee, Health Director  
Approved by: Board of Health, Health Director

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- G. When the client is unable to pay in full at the time services are rendered, a payment plan is established, and the client must sign a “Payment Agreement Form” (Attachment D) except for minimum-fee or flat-fee charges. Client must then make a payment in any amount in order to activate the payment plan.
- H. When a client requests “no mail”, discussion of payment of outstanding debt shall occur at the time the service is rendered. A remark regarding “no mail” is entered into the medical data system. No letters or other correspondence concerning insurance or past due accounts will be sent to any client that requests “no mail”. Reasonable efforts will be made to collect charges without jeopardizing client confidentiality.
- I. The Billing Cycle for the Health Department (by Division) is as follows:
1. Personal Health & Dental Health Divisions
    - a. Bills will be sent monthly by the tenth of the month for two months after services have been rendered indicating a statement of balance due. Every quarter, all accounts with a balance \$50 or more that are more than 60 days past due will be forwarded to the County Attorney Office and pursued through debt set-off in accordance with the county policy. Accounts with a balance of less than \$50 will remain delinquent until paid or written-off.
    - b. If a debt is not paid, when the client attempts to make another appointment, the client will be told they have a previous balance, and they must have an active payment plan or make a payment at time of next service except for Family Planning clients.
  2. Environmental Health Division
    - a. An initial invoice for additional or miscellaneous Wastewater Treatment Management Program (WTMP) charges is mailed with the inspection form.
    - b. If no payment is received within 90 days, a second notice is mailed.
    - c. If no payment is received after an additional 30 days and the debt is \$50 or greater, the account is forwarded to the County Attorney’s Office, which will pursue it through the county’s debt set-off procedure.
    - d. Debt owed by a corporation or non-individual is dissolved upon sale of property.
    - e. The county attorney’s office has deemed debt that becomes part of an estate will become dissolved.
    - f. If the client presents and voluntarily wishes to pay on the account, any amount the client offers will be accepted, documented in the client file, and a receipt will be provided.
    - g. Mobile Home Parks are billed annually on the calendar year. The procedure is the same as noted above.
- J. Insurance and Third Party Billing

**ORANGE COUNTY HEALTH DEPARTMENT**  
**Board of Health Policy and Procedures Manual**

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**Section I:**        **Board Adopted Policies**  
**Policy E:**        **Fee and Eligibility Policy**  
Reviewed by:      Financial Review Committee, Health Director  
Approved by:      Board of Health, Health Director

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1. Where a third party is responsible, bills are to be submitted to that party;
2. Third parties authorized or legally obligated to pay for clients at or below 100% FPL are properly billed
3. Third party bills (including Medicaid) show total charges without any discounts unless there is a contracted reimbursement rate that must be billed per the third party agreement.
4. The health department will bill insurance and managed care organizations for which provider approval has been established. The patient will be responsible for all deductibles, coinsurance and non-covered charges.
5. Patient or parent/guardian signature is required to give authorization to file claims and provide necessary information to the insurance company (Attachment E).
6. Patients, or the accompanying parent/guardian of an un-emancipated minor with appropriate insurance benefits, who receive public health services will be given the opportunity to choose whether to have insurance filed in order to avoid breach of confidentiality or pay the associated fee according to where the patient falls on the sliding fee scale.

**VIII. Review and Approval**

- A. This Policy shall be reviewed annually by members of the Financial Review Committee. The committee shall have representatives from each division, and must also include the Health Department's Finance and Administrative Services Director
  
- B. Any policy revisions must be approved by the Health Director and the Board of Health.

## VERIFICACIÓN DE INGRESO Y/O RESIDENCIA

A Quien Concierna:

El Departamento de Salud del Condado de Orange está intentando determinar la elegibilidad de \_\_\_\_\_ para los servicios solicitados en nuestra agencia.

**INGRESO** \_\_\_\_\_ (Si está marcado, se necesita verificación del ingreso)

Nuestra política es cobrar los honorarios en base al ingreso y a la cantidad de personas en el hogar. La persona nombrada arriba informa que él/ella y su familia no tienen ningún ingreso y no reciben Medicaid o asistencia pública.

\_\_\_\_\_ informa que él/ella está recibiendo ayuda financiera de usted. Por favor verifique aquí abajo la cantidad de apoyo financiero que usted le da mensualmente a esta persona y firme su nombre al final del formulario.

\$ \_\_\_\_\_ por (elija uno) \_\_\_ semana \_\_\_ quincena \_\_\_ mes

**RESIDENCIA** \_\_\_\_\_ (Si está marcado, se necesita verificación del lugar de residencia)

\_\_\_\_\_ informa que él/ella y su familia viven en la dirección anotada abajo. Antes de poder determinar elegibilidad para nuestros servicios, necesitamos que una tercera persona confirme esta información. Al firmar este formulario usted está indicando que, a su entender, esta persona/familia vive en esta dirección en el condado de \_\_\_\_\_.

\_\_\_\_\_  
Calle/Apartamento Ciudad Estado Código Postal

\_\_\_\_\_  
Firme Su Nombre

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Nombre en Letra de Imprenta

Escriba Su

Gracias por esta información. Esto nos ayudará a determinar cómo podemos brindar un mejor servicio a esta persona.

\_\_\_\_\_  
Firma del Asistente de Oficina

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Intérprete

\_\_\_\_\_  
Fecha

S:\MANAGERS WORKING FILES\BOH\Policies and Procedures\BOH Policy Manual\Current Policy Manual\I.E. Attachment A- Income & Resid Verification - Nov 2014 -Spanish.doc

Updated 11/2014

## VERIFICATION OF INCOME AND/OR RESIDENCY

To Whom It May Concern:

The Orange County Health Department is trying to determine the eligibility of \_\_\_\_\_ for services requested at our agency.

**INCOME** (\_\_\_\_\_ Check if required to provide)

It is our policy to charge fees based on the income and household size. The above named person reports that he/she and his/her family has no income and does not receive Medicaid or public assistance.

\_\_\_\_\_ reports that he/she receives financial support from you. Please verify below the amount of monthly support that you currently give to this person and sign your name at the bottom of the form.

\$\_\_\_\_\_per (check) week bi-weekly \_\_ month

**RESIDENCY** (\_\_\_\_\_ Check if required to provide)

\_\_\_\_\_ reports that he/she and his/her family live at the address listed below. Before we can determine eligibility, we need a third party to confirm this information. By signing this form, you are saying that, to the best of your knowledge, this person/family lives at this address in \_\_\_\_\_ County.

\_\_\_\_\_  
Street/Apt City State Zip

\_\_\_\_\_  
Sign Your Name Date

\_\_\_\_\_  
Print Your Name

Thank you for this information. This will help us determine how we can best serve this person.

\_\_\_\_\_  
Office Assistant Signature Date

\_\_\_\_\_  
Interpreter Signature Date

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Updated 11/2014

## DETERMINACIÓN DE ELEGIBILIDAD PARA LOS SERVICIOS DE LA CLÍNICA

El Departamento de Salud del Condado de Orange, siguiendo las políticas y los procedimientos aprobados, ha determinado que \_\_\_\_\_ (Nombre del Cliente) es elegible para servicios [circule uno] Médicos / Dentales, y se le cobrará \_\_\_\_\_ por ciento (%) de la tarifa total, basado en la cantidad de personas que viven en el hogar y la cantidad total del ingreso bruto en el hogar.

### DECLARACIÓN DE RESPONSABILIDAD FINANCIERA

\_\_\_\_\_  
Iniciales Entiendo que soy responsable de todos los cargos incurridos al recibir servicios en el Departamento de Salud del Condado de Orange (según lo indicado arriba)

\_\_\_\_\_  
Iniciales Entiendo que para ser elegible a la escala móvil de tarifa, es necesario que proporcione verificación del ingreso. De no proporcionar la verificación del ingreso **en los próximos 10 días hábiles** (a más tardar el \_\_\_\_\_), todos los servicios recibidos, que no estén cubiertos por un seguro, con excepción de los servicios de Planificación Familiar, serán facturados al 100% en la escala móvil de tarifas.

\_\_\_\_\_  
Iniciales Entiendo que si indico que estoy pendiente para elegibilidad de Medicaid, pero no completo el proceso de aplicación para Medicaid o no recibo la cobertura, Yo seré responsable de todos los cargos basado en lo determinado en la escala móvil de tarifa .

\_\_\_\_\_  
Iniciales Entiendo que los pagos son requeridos al momento de recibir los servicios. Además entiendo que, si por alguna circunstancia no puedo hacer el pago completo el día de los servicios, un plan de pago será establecido.

\_\_\_\_\_  
Iniciales Entiendo que si no hago un esfuerzo “de buena fe” para hacer pagos en cualquiera de mis cuentas pendientes, los servicios futuros podrían ser limitados o negados. Sin embargo, no se negarán los servicios de emergencia.

Entiendo que si no puedo asistir a mi cita, debo notificarlo a la clínica lo antes posible.

**Clínicas Médicas: 919-245-2400      Clínica Dental: 919-245-2435**

**Línea Telefónica para dejar Mensajes en Español: 919-644-3350**

\_\_\_\_\_  
Firma del Cliente/Persona Responsable

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Intérprete

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Empleado del OCHD

\_\_\_\_\_  
Fecha

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Updated 11/2014

### DETERMINATION OF ELIGIBILITY FOR CLINICAL SERVICES

The Orange County Health Department, following approved policy and procedures, has determined that \_\_\_\_\_ (Client Name) is eligible for [circle] Medical / Dental services and will be charged \_\_\_\_\_ percent (%) of the total fees, based on the number of people living in the home and the total amount of gross income in the home.

### STATEMENT OF FINANCIAL RESPONSIBILITY

\_\_\_\_\_  
Initial I understand that I am responsible for all fees involved in receiving services at the Orange County Health Department (as stated above)

\_\_\_\_\_  
Initial I understand that I am required to provide income verification to be eligible for the sliding fee scale. If I do not provide income verification in the next **10 business days** (by \_\_\_\_\_), any services I receive that are not covered by insurance, with the exception of Family Planning services, will be billed at 100% on the sliding fee scale.

\_\_\_\_\_  
Initial I understand that if I report that I am pending Medicaid eligibility, but I do not follow-through with the Medicaid application or do not receive coverage, I will be responsible for all charges based on the sliding fee scale determination.

\_\_\_\_\_  
Initial I understand that payment is due at the time services are provided. I further understand that, if circumstances do not allow full payment on the day of service, a payment plan will be established.

\_\_\_\_\_  
Initial I understand that if I do not make a “good faith” effort to pay on any past bills due, future services may be limited or denied. However, emergency services will not be denied.

I understand that if I am unable to keep an appointment, I am to notify the clinic as early as possible.      **Medical Clinics: 919-245-2400**                      **Dental Clinic: 919-245-2435**

\_\_\_\_\_  
Signature of Client/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Interpreter

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of OCHD Employee

\_\_\_\_\_  
Date

**Request for Waiver of Certain Fees**  
Orange County Health Department

- The Health Department’s Fee and Eligibility Policy states: “The Health Director may not make exceptions to the Fee Policy except to accommodate specific situations”  
*Section IV N: Fees for Services*
- It is recognized by OCHD that in certain rare or unusual situations, a client’s health and/or safety may be severely impacted by the inability to pay the sliding scale co-pay for services, pharmaceuticals, etc. In such cases the provider may submit this request for a one-time waiver of fee(s) by the Health Director
- Complete the following information:

**Division requesting waiver:**  PHSD  Dental  HPES  Environmental Health

**Information submitted by:** \_\_\_\_\_  
Employee Name

\_\_\_/\_\_\_/\_\_\_  
Date Submitted

**Client Information**

Name: _____		DOB: ____/____/____	
Last	First	MI	
Address: _____			
Street	City	State	Zip Code
Medicaid Eligibility Status: <input type="checkbox"/> N/A <input type="checkbox"/> Applied <input type="checkbox"/> Has Not Applied <input type="checkbox"/> Pending			
<input type="checkbox"/> Presumptive <input type="checkbox"/> Does Not Qualify			
Sliding Fee Determination: _____% <input type="checkbox"/> N/A			

**Request for Waiver of Fee**

*Explain concisely the circumstances that you feel requires consideration of fee waiver, including the type of fee and what potential effect the lack of service would have on the client*

  
  
  
  
  
  
  
  
  
  

*(Continued on Back)*

**Continuation of Narrative**

Reviewed by the Division Director: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Signature Date

Received by the Health Director: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_ Fee Waiver:  Approved  Not Approved

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Health Director's Signature Date

**Health Director's Comments:**

*\*If the fee waiver is approved and utilized, a copy of this form is filed in the client record and the original is returned to the Risk Management Coordinator*

*\*\*Management Support shall enter the following message in the comments section of the client's computer record "One-time fee waiver" along with the date*

*\*\*\*If the fee waiver is disapproved, the Health Director shall return this form to the Risk Management Coordinator who shall notify the employee applicant and his/her supervisor of the decision*



**Request for Waiver of Certain Fees**  
Orange County Health Department

- The Health Department’s Fee and Eligibility Policy states: “The Health Director may not make exceptions to the Fee Policy except to accommodate specific situations”  
*Section IV N: Fees for Services*
- It is recognized by OCHD that in certain rare or unusual situations, a client’s health and/or safety may be severely impacted by the inability to pay the sliding scale co-pay for services, pharmaceuticals, etc. In such cases the provider may submit this request for a one-time waiver of fee(s) by the Health Director
- Complete the following information:

**Division requesting waiver:**  PHSD  Dental  HPES  Environmental Health

**Information submitted by:** \_\_\_\_\_ /\_\_\_\_/\_\_\_\_  
Employee Name Date Submitted

**Client Information**

Name: _____		DOB: ____/____/____	
_____ Last	_____ First	_____ MI	
Address: _____			
_____ Street	_____ City	_____ State	_____ Zip Code
Medicaid Eligibility Status: <input type="checkbox"/> N/A <input type="checkbox"/> Applied <input type="checkbox"/> Has Not Applied <input type="checkbox"/> Pending <input type="checkbox"/> Presumptive <input type="checkbox"/> Does Not Qualify			
Sliding Fee Determination: _____% <input type="checkbox"/> N/A			

**Request for Waiver of Fee**

*Explain concisely the circumstances that you feel requires consideration of fee waiver, including the type of fee and what potential effect the lack of service would have on the client*

(Continued on Back)

**Continuation of Narrative**

Reviewed by the Division Director: \_\_\_\_\_ / \_\_\_/\_\_\_  
Signature Date

Received by the Health Director: \_\_\_/\_\_\_/\_\_\_ Fee Waiver:  Approved  Not Approved

\_\_\_\_\_/\_\_\_/\_\_\_  
Health Director's Signature Date

**Health Director's Comments:**

*\*If the fee waiver is approved and utilized, a copy of this form is filed in the client record and the original is returned to the Risk Management Coordinator*

*\*\*Management Support shall enter the following message in the comments section of the client's computer record "One-time fee waiver" along with the date*

*\*\*\*If the fee waiver is disapproved, the Health Director shall return this form to the Risk Management Coordinator who shall notify the employee applicant and his/her supervisor of the decision*

### PAYMENT AGREEMENT FORM

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

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

I, \_\_\_\_\_, agree to establish a payment plan for my account and agree to the following:

\_\_\_\_\_ My account balance is \$ \_\_\_\_\_.

\_\_\_\_\_ I will pay the amount of \$ \_\_\_\_\_ on my bill.

\_\_\_\_\_ Monthly      \_\_\_\_\_ Weekly      \_\_\_\_\_ Bi-weekly

I understand that I am responsible for any balance left owing if my insurance company should not pay the bill in full and that it will be based on my sliding fee scale status.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of OCHD Staff

\_\_\_\_\_  
Date

## Asignación de Beneficios

Nombre del Cliente (apellido, nombre, inicial del segundo nombre)

Fecha de Nacimiento

Compañía de Seguro (aseguradora)

# de identificación del seguro del cliente

Nombre del Subscriber (persona que obtuvo la póliza)

Fecha de Nacimiento  
del Subscriber

Número de Póliza

Dirección del Subscriber (si es diferente de la del cliente)

( ) -  
Teléfono del Subscriber

Autorizo al Departamento de Salud del Condado de Orange a hacer los reclamos de seguro por los servicios que me fueron proveídos. Estos reclamos pueden ser realizados a Medicaid, Medicare, seguro privado, y cualquier otro plan médico o dental.

Entiendo que es mi responsabilidad informar sobre cualquier cambio en mi cobertura de seguro.

Entiendo que soy financieramente responsable de cualquier cantidad que no esté cubierta por el seguro; a menos que esté indicado de otra manera en el acuerdo con el proveedor.

Entiendo que cualquier copago o deducible es adeudado al momento de recibir los servicios. Si la cobertura de seguros es denegada, entiendo que yo seré responsable de todos los cargos por estos servicios. Entiendo que, podría ser elegible para la escala móvil de tarifa (basada en el lugar de residencia e ingresos) **si proveo verificación dentro de 10 días hábiles de esta notificación.**

Autorizo que sea compartida cualquier información médica o la información pertinente necesaria para obtener estos beneficios, con mi proveedor de seguros, o con cualquier otra entidad médica para continuar el cuidado médico.

Por favor indique cualquier expediente que usted quiera que sea excluido de la información que pudiera ser compartida:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Firma de Autorización del Cliente

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Intérprete

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Firma del Empleado del OCHD/Testigo

\_\_\_\_\_  
Fecha

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Updated 11/2014

## Assignment of Benefits

\_\_\_\_\_  
Client Name (Last, First, Middle Initial)

\_\_\_\_\_  
Date of Birth (DOB)

\_\_\_\_\_  
Insurance Provider

\_\_\_\_\_  
Client's Insurance ID #

\_\_\_\_\_  
Subscriber's Name

\_\_\_\_\_  
Subscriber's DOB

\_\_\_\_\_  
Policy #

\_\_\_\_\_  
Subscriber's Address (If different from client)

(\_\_\_\_)\_\_\_\_-\_\_\_\_  
Subscriber's phone #

I authorize Orange County Health Department to file insurance claims for services provided to me. These claims may be filed with Medicare, Medicaid, private insurance, or any other medical/dental plan.

I understand that it is my responsibility to report any changes in insurance coverage.

I understand that I am financially responsible for any amount not covered by insurance, unless otherwise stated in the provider agreement.

I understand that any co-payment or deductible is due at the time that services are rendered. If insurance coverage is denied, I understand that I will be responsible for all charges for these services. I understand that I may be eligible for the sliding fee scale, based on residency and income, if I provide verification **within 10 business days** of being notified.

I authorize the release of any medical or pertinent information necessary to obtain these benefits to my insurance carrier or any other medical entity for continued medical care.

Please state any records you want excluded from information that may have to be released:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interpreter Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
OCHD Employee Signature/Witness

\_\_\_\_\_  
Date

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**ORANGE COUNTY HEALTH DEPARTMENT**  
**Board of Health Policy and Procedure Manual**

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**Section I: Board Adopted Policies**  
**Policy F: Community Assessment Policy**  
Reviewed by: Board of Health  
Approved by: Board of Health, Health Director

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**Policy I.F.**

This policy establishes that the Orange County Health Department will complete a Community Health Assessment (CHA) every four years that ensures community input and a State of the County Health (SOTCH) report in the interim years between assessments, according to guidelines published by the North Carolina Division of Public Health.

**Purpose**

The purpose of this policy is to provide guidelines for the development of the CHA and SOTCH report and to ensure that these are collaborative efforts that include input from community members, county agencies and organizations, the Board of Health and other county stakeholders.

**Delegation**

The development and implementation of procedures for the CHA and SOTCH reports are delegated to the Division of Health Promotion and Education Services through the Health Director.

**Procedures**

1. Community Health Assessment process procedures:
  - a. This process will be coordinated through the Health Promotion and Education Division every four years.
  - b. Health education staff will recruit a diverse group of partners to form a CHA team. Partners that will be approached about serving on this team include representatives from but not limited to the following:
    - i. Various ethnic and cultural backgrounds (Hispanic, Native American, etc.)
    - ii. Economic development and industry
    - iii. Educational systems
    - iv. Human service agencies
    - v. Organizations that serve children through senior adults
    - vi. Law enforcement
    - vii. And others as identified.
  - c. As funding is available, the Department will contract with an educational institution or consultant to facilitate the team in the collection, analysis, and reporting of the primary and secondary data.
  - d. The [\*Community Health Assessment Guide Book\*](#) available on the North Carolina Division of Public Health website will be used as a resource document or toolkit throughout the community health assessment process. This book will guide the

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**Section I: Board Adopted Policies**  
**Policy F: Community Assessment Policy**  
Reviewed by: Board of Health  
Approved by: Board of Health, Health Director

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team on the various components (i.e. demographics, economic factors, health needs, etc.) that need to be included in this process and the final document.

- e. Primary data will be collected from community members, clients receiving direct services from the health department, the Board of Health and other county stakeholders through their participation in written surveys, focus groups, or interviews.
- f. Secondary data will be obtained from the North Carolina State Center for Health Statistics (NC SCHS) and other resources identified and available to CHA team members.
- g. CHA team members will assist with the collection of primary and secondary data.
- h. The CHA team will collaborate with county stakeholders to prioritize health concerns according to the primary and secondary data collected. The CHA team will reference the CHA Guidebook for guidance on reporting data findings and involving community members, the Board of Health and other county stakeholders in the process to establish health priorities for the county.
- i. Designated members of the CHA team will summarize the data and priority health topics to produce a document to report the community health assessment process and its findings.
- j. The CHA document will be submitted to the North Carolina Division of Public Health by the first Monday in March every four years and will be disseminated to community and county stakeholders as specified in the North Carolina Local Health Department Accreditation Standards. This may include electronically via the department's website as well as presentations of findings and copies of reports to partner agencies and community organizations for public access.
- k. The CHA document will be used by the Orange County Health Department in the development of the department-wide strategic plan, grant writing, program planning and advocacy for funding. This document will be available as a resource for other individuals, agencies, and organizations.
- l. Using the CHA, Health Promotion and Education staff and the CHA team will create Community Health Action Plans to describe plans for health activities to be carried out in the county. The [Community Health Action Plan](#) form is due the first Monday of September the year the county was assigned to complete their CHA. The form is available through the NC Division of Public Health website.

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**Section I: Board Adopted Policies**  
**Policy F: Community Assessment Policy**  
Reviewed by: Board of Health  
Approved by: Board of Health, Health Director

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2. State of the County Health (SOTCH) report process procedures:
  - a. The SOTCH report will primarily be produced by the Department's Health Promotion and Education staff in the interim years between community health assessments.
  - b. This report will include:
    - i. A review of major morbidity and mortality data for the county
    - ii. A review of health concerns selected as priorities
    - iii. Progress made in the last year on these priorities
    - iv. A review of any changes in the data that guided the selection of these priorities
    - v. Other changes in the county that affect health concerns (such as economic or political changes, new funds or grants available to address health problems, etc.)
    - vi. New and emerging issues that affect health status
    - vii. Methods of direct community involvement with ongoing efforts
  - c. The primary source of data for this report will be the NC SCHS website.
  - d. The SOTCH report will be submitted to the state by the first Monday in March of each year it is due and will be disseminated to the community and county stakeholders according to North Carolina Local Health Department Accreditation Standards.

References:

*Community Health Assessment Guidebook* online at:

<http://publichealth.nc.gov/lhd/cha/docs/guidebook/CHA-GuideBook-June2014.pdf>

*Community Health Action Plan Form* online at:

<http://publichealth.nc.gov/lhd/cha/docs/guidebook/GuidelinesForCommunityHealthActionPlanForms.pdf>



**ORANGE COUNTY HEALTH DEPARTMENT**  
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**Section I: Board Adopted Policies**

**Policy G: Community and Public Input Policy**

Reviewed By: Board of Health

Approved By: Board of Health, Health Director

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**Policy I.G.**

It shall be the policy of the Orange County Board of Health and Health Department to ensure that reasonable mechanisms for community/public input are available.

**Purpose**

The purpose of this policy is to ensure that policies and services of the Orange County Board of Health and Orange County Health Department have considered the health and environmental safety needs of the general population and any at-risk populations of Orange County.

**Guidelines**

1. The Board of Health will reserve a public comment period on each regularly scheduled Board meeting. Each individual will be given a maximum of three minutes for comments, and the public comment period will be limited to 15 minutes each meeting.
2. Annually the Board of Health will receive from the staff of the Health Department the results of patient and client input on services received, including any corrective actions deemed necessary to improve services.
3. The Health Director or his/her designee will maintain current contact information on the Department and the Board of Health on the Health Department website.
4. The Health Director shall report significant community-wide input received by the staff to the Board at least quarterly.

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**Section I. Board Adopted Policies**

**Policy H: Policy and Procedure for Complaints**

Reviewed By: Board of Health

Approved By: Board of Health, Health Director

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**Policy I.H.**

The Board of Health and Health Department staff will ensure that a mechanism exists for complaints to be considered and resolved from clients, patients, or residents regarding services delivered by the Health Department.

**Purpose**

The purpose of this process is to ensure that the Orange County Board of Health and Orange County Health Department have reasonable means in place to ensure that timely appeals can be heard from clients, patients, or members of the public.

**Guidelines**

1. The Department will follow all provisions and requirements outlined by North Carolina General Statutes governing Health Departments, including but not limited to GS 130A.
2. If any provision of the following procedures is in conflict with General Statutes, the current Statute will govern.

**Procedures:**

**1. Procedure for a General Complaint**

- a. A complaint shall be made either verbally or in writing to any staff member in the Health Department.
- b. The staff member receiving the complaint shall attempt to resolve the complaint.
- c. If the complainant is not satisfied, the staff member shall provide contact information for the most closely aligned Division Director.
- d. The Division Director will contact complainants within one working day and attempt to resolve the complaint.
- e. If the complainant is not satisfied, the Division Director shall provide contact information to the complainant for the Health Director.
- f. The Health Director will attempt to contact complainants within one working day and attempt to resolve the complaint.
- g. If the complainant is not satisfied, the Health Director will provide the complainant with the time and date of the next regularly scheduled Board meeting and invite the complainant to speak to the Board. The Board Chair and Vice-Chair shall be informed prior to the meeting. A summary of actions taken to date along with a description of the complaint will be provided to the Board in the agenda packet.