# VOLUNTEER HEALTH CARE PROVIDER PROGRAM

# CLIENT-PATIENT ELIGIBILITY AND REFERRAL PROCESS TRAINING GUIDE

DH 1032G (08/24), Incorporated by Rule 64I-2.002, F.A.C.

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*This guide is to be used in training persons to serve as Eligibility and Referral Specialists to perform the eligibility and referral function for the Department of Health referred to in Florida Administrative Code Rule 64I-2.002.*

**Introduction**

All clients/patients must be determined eligible and referred by the Department of Health or its agent in accordance with this document prior to receiving health care services from a contracted health care provider providing services under the Volunteer Health Care Provider Program.

The patient shall be informed that eligibility determination is required to ensure that the volunteer medical or dental provider serves only those persons who have no other source of care and meet the financial criteria as provided by law. Additionally, the patient must be notified that the health care provider is acting as an agent of the state and therefore potential damages are limited to those outlined in section 768.28, Florida Statutes. All personal identifying information provided during the eligibility process is exempt from Florida's public records laws.

Completing an Eligibility Form (DH 1032E) will determine who in a family unit is eligible to receive services. A family unit is individuals related through blood, marriage, law, or conception. The applicant's self declaration of income and expenses is acceptable for income determination; however applicant income and expenses may be verified. When more than one family member is to receive services, one form for the head of the household should be completed and copies used for the other family members receiving services. The Eligibility Form will be maintained in the client/patient's medical/dental record. If a client/patient has been determined eligible prior to the current visit, the existence of an eligibility form should be verified and the client/patient should be asked if there is any change in their financial or health insurance status. If there are changes, the eligibility determination process must be completed again. If no changes have occurred, the Eligibility Form is valid for one year from the date the form was last completed.

# PART 1

**INSTRUCTIONS FOR COMPLETING THE ELIGIBILITY FORM (DH 1032E)**

Print the name of the ***Clinic/Program/Provider*** at the top of the form.

**Section 1**

1. Ask the person if he/she or other family members have any health or dental insurance to cover the medical treatment being sought.

    - If the answer is No, mark with an "X," then proceed to the next line.

    - If the patient has health or dental insurance for the treatment being sought, this person is ineligible for the program and cannot be seen by a volunteer health care provider.

    - If the person has no telephone number, obtain a phone number of his/her nearest relative or friend. A telephone number may be needed if there is a need for follow-up.

2. Patients with an active Medicaid number are only eligible for services under this program IF there are no Medicaid providers in the area.

    - The applicant's self-attestation of the unavailability of Medicaid providers in the area is acceptable.

**Section 2**

1. **FAMILY UNIT**: List the number of adults and children (children include those unborn), and add together for a total.

    - Family unit means one or more persons living in the same house who are related by blood, marriage, law (adoption or legal custody), or conception, or who are cohabitating partners. If the dwelling includes more than one family or more than one unrelated individual, eligibility determination is separate for each family unit or unrelated individual, and not for the dwelling as a whole.

    - A single adult, 18 and over, living with relatives is considered a separate family for income determination purposes. However, a student, age 18-21, living at home, shall be considered a family member.

2. List the name of the patient or head of household or legal guardian; the name of his/her employer; his/her **Gross Earned Income**; and any **Gross Unearned Income** received in the last 4 weeks. Do not include anticipated income.

    - **GROSS EARNED INCOME** (before deductions): Wages, tips, salaries from all current employment (gross income) for the last 4 weeks, and self-employment income minus employee expenses, payments for building, utilities, or advertising costs (not personal expenses). If a spouse or child works for the business and receives a salary, that salary is counted as earned income for that family member.

    - **GROSS UNEARNED INCOME**: Monies received in the last 4 weeks from sources other than employment, i.e.; child support, Social Security (SSDI, Survivor's Benefits for spouse or minor of a deceased parent, SSA retirement income), unemployment compensation, alimony, workers' compensation, veteran's pension, pensions and annuities, dividends and interest on savings, stocks, bonds; income from estates and trusts; rental income or royalties; and contributions from other people. Do not include TCA or SSI payments.

3. List the first and last names, and dates of birth or age of all family members. Document all income for all family members, listing his/her **Gross Earned Income** and any **Gross Unearned Income**.

4. Add the income totals for **Gross Earned Income** and **Gross Unearned Income** for all family members and place the total on the line below **TOTAL INCOME**.

5. Refer to current Federal Poverty Level (FPL) to determine if a client/patient is financially eligible for services.

    - Locate **Family Size Total** and **Total Income** in Section 2 on the eligibility form.

    - Compare the **Family Size Total** and **Total Income** with the FPL to ensure the family income does not exceed 300% of FPL.

    - **Total Income** must be equal to or less than 300% of the amount listed in the FPL for the family size.

**NOTE:** If the client/patient's income exceeds 300% of the FPL for the family size, complete the Budget Computations in Section 3 to determine if the person is eligible with deductions.

**Section 3: BUDGET COMPUTATION**

Step 1: Enter amount from **Total Income** on line (1).

Step 2: Enter $90 for each employed person in the family unit ($180 for two working family members, etc.) on line (2). Subtract this amount from line (1), and enter the amount on line (2a).

Step 3: Childcare Deductions:

A. For each child, two years or older, enter monthly childcare expenses actually paid, not to exceed $175 per child.

B. For each child under two years of age, enter monthly childcare expenses actually paid, not to exceed $200 per child. Enter total childcare deduction on line (3).

C. Subtract total childcare deduction, line (3) from line (2a), and enter the amount on line (3a).

Step 4: Enter up to $50 monthly for the total amount of child support received on line (4). Use the actual amount received up to $50 monthly.

Step 5: Subtract child support deduction on line (4) from line (3a) and enter the amount on line (5). This will provide the **Total Net Income**.

Refer to the current Federal Poverty Level to determine if the client/patient is eligible.

- Locate **Family Size Total** in Section 2 and **Total Net Income** in Section 3 on the eligibility form.
- Compare the **Family Size Total** and **Total Income** with the FPL to ensure the family income does not exceed 300% of FPL.
- **Total Net Income** must be equal to or less than 300% of the amount listed in the FPL for the family size.

If the patient is still **not** eligible, retain this form for future reference.

**Section 4:**

1. Ensure the client/patient reads and affirms he or she understands the acknowledgment on the eligibility form.
2. The client/patient, head of household, or guardian must sign the eligibility form.
3. The individual preparing the form must sign and date as indicated.
4. File the form with client/patient's dental/medical record.

PART 2

## INSTRUCTIONS FOR COMPLETING THE PATIENT REFERRAL FORM

A Patient Referral Form (DH 1032) must be completed for each client/patient referred to a health care provider contracted under the Volunteer Health Care Provider Program. A referral form is valid for the initial medical/dental visit and all follow-up visits for the same condition with the same provider. In cases where a client/patient's medical/dental treatment plan for a specific medical/dental issue requires a pathologist, radiologist, anesthesiologist or laboratory services in addition to service rendered by the contracted provider, the referral form may include these providers. These ancillary providers must be identified by name on the referral form when they agree to provide treatment. Ancillary providers only have status as an agent of the state if under contract with a government contractor as provided in section 766.1115, Florida Statutes. A patient referral does not convey status as an agent of the state. If a client/patient presents for a medical/dental issue different from the initial referral or is scheduled to see a different provider, then a new referral must be completed. Blank Patient Referral Forms can not be signed and dated in anticipation of possible future referrals. A client/patient can be asked to sign an incomplete referral form in anticipation of scheduling an appointment with an appropriate provider for a specific medical/dental issue. All signatures on the Patient Referral Form must be original. "Signature on file" is not an acceptable alternative to original signatures.

### NOTICE TO PATIENT

1. The client/patient must be informed that he/she is being referred to a volunteer health care provider under contract to provide volunteer, uncompensated medical services and thereby, acting as an agent of the state entitled to liability damage limitations.
2. This section must be explained to the client/patient, and the client/patient must have the opportunity to read this notice. The client/patient, parent, or legal guardian must sign and date this notice.

NO CLIENT/PATIENT SHOULD BE TREATED BY A VOLUNTEER HEALTH CARE PROVIDER UNLESS HE/SHE HAS RECEIVED THIS NOTICE.

### PATIENT INFORMATION

1. Document all appropriate client/patient information. A social security number is not required for the client/patient to be referred.
2. Mark the appropriate eligibility designation for the client/patient. The client/patient being seen by a volunteer health care provider must have a net income of 300% or less of the federal poverty level.

### REFERRAL INFORMATION

1. Mark the appropriate type of referral for the client/patient.
2. In the "Notes" section, document the client/patient's primary medical complaint.
3. The authorized referring person (DOH employee or qualified volunteer) must sign and date this form.
4. The volunteer health care provider may NOT sign as the authorized referring person. The only persons with authority to sign the patient referral form are trained DOH employees or volunteers.

### REFERRED TO INFORMATION

1. Complete "***Referred To***" with the full name of the health care provider and/or the entity providing the uncompensated medical care.
2. Complete the address and phone number of the provider with the appointment time if appropriate.
3. If the health care provider determines ancillary providers are needed, these must be identified on the referral form by name.

**RESPONSE TO REFERRAL ORIGINATOR**

1. If the treating health care provider uses progress notes or dictation to document medical services in the client/patient medical record, the provider must write "See Progress Notes" in this section. If the health care provider does not create progress notes then services must be documented in this section.
2. The "***Estimated Value of Health Care Provided***" is the value assigned to the service provided. This value should represent an amount a self-pay patient would be charged.
3. The volunteer health care provider must sign the form at, "***Volunteer Health Care Provider Signature***" if the provider is not using progress notes to document services rendered to a client/patient. If the provider uses progress notes there is no requirement for the provider to sign this form because progress notes have the required dates and signatures.

**DISTRIBUTION OF COPIES**

1. The original referral form is sent to the provider and returned to the referring source with any documentation associated with the medical/dental services rendered. The original referral is maintained in the client/patient medical/dental record.
2. One copy is given to the client/patient at the time of referral.
3. One copy is kept by referral originator.
4. One copy is kept by health care provider

# VOLUNTEER HEALTH CARE PROVIDER PROGRAM ELIGIBILITY FORM

**CLINIC/PROGRAM/PROVIDER:**

**Section 1**

Does the client/patient have insurance that covers the health or dental condition? YES _____NO _____
Does anyone in the client/patient's family have an active FL Medicaid card? YES ____ NO ____

Name of the card holder and Medicaid No. _____

Client/Patient/Head of Household's Name: _____
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

Address: _____
(STREET) (CITY/STATE) (ZIP CODE)

Telephone or Contact Number: _____ Name of Contact: _____

**Section 2**

**Family Size: Adults____ Under 18 ____** **18-21--Student ____** **Unborn _____** **Family Size TOTAL _____**

| **FAMILY MEMBERS NAME (First and Last)** | **DOB** | **EMPLOYER** | **GROSS EARNED INCOME LAST 4 WKS** | **GROSS UNEARNED INCOME LAST 4 WKS** (Do not include TCA or SSI) |
|---|---|---|---|---|
| **SELF** | | | **$** | **$** |
| **SPOUSE/PARTNER** | | | **$** | **$** |
| **CHILD** | | | **$** | **$** |
| **CHILD** | | | **$** | **$** |
| **CHILD** | | | **$** | **$** |
| **CHILD** | | | **$** | **$** |
| | | **TOTALS** | **$** | **$** |
| | | Add earned and unearned income to determine total | | **TOTAL INCOME** **$**_____ |

**Section 3 BUDGET COMPUTATION (To be completed if family income is above federal poverty level.)**

**Step 1.** **"TOTAL FAMILY INCOME"** for family unit (Earned and unearned income). (1) $_____ (Above)

**Step 2.** Subtract $90 for EACH employed member of the family unit. (2) $_____ (Minus)

(2a) $_____ (Total)

**Step 3.** Subtract childcare PAID each month (up to $175 per child age 2 and older; up to $200 per child under age 2). (3) $_____ (Minus)

(3a) $_____ (Total)

**Step 4.** Subtract up to $50 per month of total child support received. (4) $_____ (Minus)

**Step 5.** **TOTAL NET INCOME** (5) $_____ (Total)

**Section 4** **USE CURRENT YEAR FEDERAL POVERTY GUIDELINES FOR INCOME DETERMINATION**

I certify by my signature that, to the best of my knowledge, the above information is a true and complete statement of my financial situation. I understand that the information I have given is subject to verification by the Department of Health. I acknowledge I am responsible to inform the Department of Health of any change in my financial or health insurance status prior to my next visit. I acknowledge receipt of the Department of Health's Notice of Privacy Practices.

**SIGNATURE OF CLIENT/PATIENT/PARENT OR GUARDIAN AND DATE**

**PRINT NAME OF DEPARTMENT OF HEALTH VOLUNTEER OR EMPLOYEE**

(VALID FOR ONE YEAR) Expiration date: _____

DH 1032E (12/14), 64I-2.002, F.A.C.

Appendix B

VOLUNTEER HEALTH CARE PROVIDER PROGRAM
PATIENT REFERRAL FORM

Referral # _____

NOTICE TO PATIENT

You are being referred to a volunteer health care provider who will provide free care to you or someone for whom you are legally responsible. Depending on the determination of the volunteer health care provider, you may also receive services from pathologists, laboratories, radiologists, and anesthesiologists. Your participation in this referral process is voluntary. The care you receive from the volunteer health care professionals will be provided at no charge to you. However, you may be billed for pharmaceuticals. The health care providers are providing care on behalf of the State of Florida and each serves as an agent of the State. By acceptance of this referral, you acknowledge that the state solely is liable for any injury or damage suffered by you, or someone that you permit to receive treatment, that results from authorized treatment by the volunteer providers and that the State's liability is limited as found in section 768.28, Florida Statutes (copy provided)

I hereby certify that I have read the above notice and understand that I am being referred to a volunteer health care provider who will provide free care for me or someone for whom I am legally responsible. I further understand the volunteer health care provider may also refer me to pathologists, laboratories, radiologists, and anesthesiologists whose specialized services may be needed to treat my health condition. I authorize examination, diagnostic procedures and treatment as deemed necessary by the doctor(s) or other health care professional(s) (and whomever she/he may designate as assistants). In addition, I certify that the information I have provided regarding my eligibility, including income information, is true and complete to the best of my knowledge.

I also acknowledge I am responsible to inform the clinic of any change in my financial or health insurance status.

Signature: _____ Date: _____

If treatment is for a minor, indicate relationship to child _____

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Patient's Name: _____ Date of Birth: _____

Address: _____ Sex: _____ Male _____ Female

_____ Race: _____ White _____ Black _____ Asian/PI

_____ _____ Am Indian/Alaskan Native

Phone: _____ Ethnicity: _____ Hispanic _____ Non-Hispanic

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Eligibility*: (check one)* _____ DOH client/patient _____ 300% poverty or less _____ Medicaid eligible *(no provider available)*

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Referral Type: _____ Medical Care _____ Dental Care _____ Other *(specify)*

Notes: _____ Print Name of DOH Referring Person: _____

_____

_____ _____
DOH Referring Person's Signature Date

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Referred to: _____

Address/Phone: _____ _____ _____

As needed, the above-named health care provider is referring this patient to the following health care providers who are under contract as outlined in section 766.1115, Florida Statutes, and are agents of the state:

Pathologist _____ Laboratory _____ Radiologist _____ Anesthesiologist _____

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Response to Referral Originator: _____ Date of Initial Service Received: _____
*(actual services provided)*

**Estimated Value of Health Care Provided $** _____ _____ _____
Volunteer Health Care Provider Signature Date
☐ In lieu of signature, see progress notes.

ORIGINAL-To Patient Medical Record COPY-To Patient at Time of Referral

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**Excerpt from Chapter 768.28, Florida Statutes**

768.28 Waiver of sovereign immunity in tort actions; recovery limits; civil liability for damages caused during a riot; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(1) In accordance with s. 13, Art. X of the State Constitution, the state, for itself and for its agencies or subdivisions, hereby waives sovereign immunity for liability for torts, but only to the extent specified in this act. Actions at law against the state or any of its agencies or subdivisions to recover damages in tort for money damages against the state or its agencies or subdivisions for injury or loss of property, personal injury, or death caused by the negligent or wrongful act or omission of any employee of the agency or subdivision while acting within the scope of the employee's office or employment under circumstances in which the state or such agency or subdivision, if a private person, would be liable to the claimant, in accordance with the general laws of this state, may be prosecuted subject to the limitations specified in this act. Any such action may be brought in the county where the property in litigation is located or, if the affected agency or subdivision has an office in such county for the transaction of its customary business, where the cause of action accrued. However, any such action against a state university board of trustees shall be brought in the county in which that university's main campus is located or in the county in which the cause of action accrued if the university maintains therein a substantial presence for the transaction of its customary business.

(2) As used in this act, "state agencies or subdivisions" include the executive departments, the Legislature, the judicial branch (including public defenders), and the independent establishments of the state, including state university boards of trustees; counties and municipalities; and corporations primarily acting as instrumentalities or agencies of the state, counties, or municipalities, including the Florida Space Authority.

(3) Except for a municipality and the Florida Space Authority, the affected agency or subdivision may, at its discretion, request the assistance of the Department of Financial Services in the consideration, adjustment, and settlement of any claim under this act.

(4) Subject to the provisions of this section, any state agency or subdivision shall have the right to appeal any award, compromise, settlement, or determination to the court of appropriate jurisdiction.

(5)(a) The state and its agencies and subdivisions shall be liable for tort claims in the same manner and to the same extent as a private individual under like circumstances, but liability shall not include punitive damages or interest for the period before judgment. Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000. However, a judgment or judgments may be claimed and rendered in excess of these amounts and may be settled and paid pursuant to this act up to $200,000 or $300,000, as the case may be; and that portion of the judgment that exceeds these amounts may be reported to the Legislature, but may be paid in part or in whole only by further act of the Legislature. Notwithstanding the limited waiver of sovereign immunity provided herein, the state or an agency or subdivision thereof may agree, within the limits of insurance coverage provided, to settle a claim made or a judgment rendered against it without further action by the Legislature, but the state or agency or subdivision thereof shall not be deemed to have waived any defense of sovereign immunity or to have increased the limits of its liability as a result of its obtaining insurance coverage for tortious acts in excess of the $200,000 or $300,000 waiver provided above. The limitations of liability set forth in this subsection shall apply to the state and its agencies and subdivisions whether or not the state or its agencies or subdivisions possessed sovereign immunity before July 1, 1974.

(b) A municipality has a duty to allow the municipal law enforcement agency to respond appropriately to protect persons and property during a riot or an unlawful assembly based on the availability of adequate equipment to its municipal law enforcement officers and relevant state and federal laws. If the governing body of a municipality or a person authorized by the governing body of the municipality breaches that duty, the municipality is civilly liable for any damages, including damages arising from personal injury, wrongful death, or property damages proximately caused by the municipality's breach of duty. The sovereign immunity recovery limits in paragraph (a) do not apply to an action under this paragraph.

(6)(a) An action may not be instituted on a claim against the state or one of its agencies or subdivisions unless the claimant presents the claim in writing to the appropriate agency, and also, except as to any claim against a municipality, county, or the Florida Space Authority, presents such claim in writing to the Department of Financial Services, within 3 years after such claim accrues and the Department of Financial Services or the appropriate agency denies the claim in writing; except that, if:

1. Such claim is for contribution pursuant to s. 768.31, it must be so presented within 6 months after the judgment against the tortfeasor seeking contribution has become final by lapse of time for appeal or after appellate review or, if there is no such judgment, within 6 months after the tortfeasor seeking contribution has either discharged the common liability by payment or agreed, while the action is pending against her or him, to discharge the common liability; or

2. Such action is for wrongful death, the claimant must present the claim in writing to the Department of Financial Services within 2 years after the claim accrues.

(b) For purposes of this section, the requirements of notice to the agency and denial of the claim pursuant to paragraph (a) are conditions precedent to maintaining an action but shall not be deemed to be elements of the cause of action and shall not affect the date on which the cause of action accrues.

(c) The claimant shall also provide to the agency the claimant's date and place of birth and social security number if the claimant is an individual, or a federal identification number if the claimant is not an individual. The claimant shall also state the case style, tribunal, the nature and amount of all adjudicated penalties, fines, fees, victim restitution fund, and other judgments in excess of $200, whether imposed by a civil, criminal, or administrative tribunal, owed by the claimant to the state, its agency, officer or subdivision. If there exists no prior adjudicated unpaid claim in excess of $200, the claimant shall so state.

(d) For purposes of this section, complete, accurate, and timely compliance with the requirements of paragraph (c) shall occur prior to settlement payment, close of discovery or commencement of trial, whichever is sooner; provided the ability to plead setoff is not precluded by the delay. This setoff shall apply only against that part of the settlement or judgment payable to the claimant, minus claimant's reasonable attorney's fees and costs. Incomplete or inaccurate disclosure of unpaid adjudicated claims due the state, its agency, officer, or subdivision, may be excused by the court upon a showing by the preponderance of the evidence of the claimant's lack of knowledge of an adjudicated claim and reasonable inquiry by, or on behalf of, the claimant to obtain the information from public records. Unless the appropriate agency had actual notice of the information required to be disclosed by paragraph (c) in time to assert a setoff, an unexcused failure to disclose shall, upon hearing and order of court, cause the claimant to be liable for double the original undisclosed judgment and, upon further motion, the court shall enter judgment for the agency in that amount. Except as provided otherwise in this subsection, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 6 months after it is filed shall be deemed a final denial of the claim for purposes of this section. For purposes of this subsection, in medical malpractice actions and in wrongful death actions, the failure of the Department of Financial Services or the appropriate agency to make final disposition of a claim within 90 days after it is filed shall be deemed a final denial of the claim. The statute of limitations for medical malpractice actions and wrongful death actions is tolled for the period of time taken by the Department of Financial Services or the appropriate agency to deny the claim. The provisions of this subsection do not apply to such claims as may be asserted by counterclaim pursuant to s. 768.14.

(7) In actions brought pursuant to this section, process shall be served upon the head of the agency concerned and also, except as to a defendant municipality, county, or the Florida Space Authority, upon the Department of Financial Services; and the department or the agency concerned shall have 30 days within which to plead thereto.

(8) No attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement.

(9)(a) An officer, employee, or agent of the state or of any of its subdivisions may not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. However, such officer, employee, or agent shall be considered an adverse witness in a tort action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. The exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state or any of its subdivisions or constitutional officers is by action against the governmental entity, or the head of such entity in her or his official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless such act or omission was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. The state or its subdivisions are not liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of her or his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider when providing services pursuant to s. 766.1115; any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, and its employees or agents, when providing patient services pursuant to paragraph (10)(f); any public defender or her or his employee or agent, including an assistant public defender or an investigator; and any member of a Child Protection Team, as defined in s. 39.01, or any member of a threat management team, as described in s. 1006.07(7), when carrying out her or his duties as a team member under the control, direction, and supervision of the state or any of its agencies or subdivisions.