West Volusia Hospital Authority
BOARD OF COMMISSIONERS REGULAR MEETING
May 16, 2019 5:00 p.m.
Deland City Hall
120 S. Florida Avenue, DeLand, FL
AGENDA

1. Call to Order

2. Opening Observance followed by a moment of silence

3. Approval of Proposed Agenda

4. Consent Agenda
   A. Approval of Minutes - Special Meeting April 18, 2019
      - Joint Meeting April 18, 2019
5. Citizens Comments

6. Citizens Advisory Committee-Elmer Holt, Chair
   A. Overview CAC Meeting May 7, 2019 – Discussion/Q&A

7. Contractual Utilization Reports to the WVHA Board of Commissioners
   A. Nicole Sharbono, VP, Stewart-Marchman-Act
   B. Brenda Flowers, CEO/Founder, Rising Against All Odds
8. Reporting Agenda
   A. UMR April 2019 Report - Written Submission
   B. FQHC Report - Laurie Asbury, Chief Executive Officer, Northeast Florida Health Services, Inc. (NEFHS) d/b/a Family Health Source (FHS)
      1. April Report
      2. Quarterly Prescription Audit
   C. The House Next Door April 2019 Application Processing Report
9. Hospital Quarterly Report
   A. Advent Health Fish Memorial (AHFM) – Rob Deininger, CEO and/or Eric Ostarly, CFO
      1. AHFM Annual Certification of Compliance
   B. Advent Health DeLand (AHD) – Lorenzo Brown, CEO and/or Kyle Glass, CFO
      1. AHD Annual Certificate of Compliance
10. Discussion Items
   A. The House Next Door – Tracking Undocumented HealthCard Applicants
   B. Follow Up Items
      1. WVHA Eligibility Guidelines Revised/Updated 5/16/2019

11. Finance Report
   A. April Financials

12. Legal Update

13. Commissioner Comments

14. Adjournment

WEST VOLUSIA HOSPITAL AUTHORITY
WVHA BOARD OF COMMISSIONERS SPECIAL MEETING

DeLand City Hall
120 S. Florida Avenue, DeLand, Florida
April 18, 2019
5:00 pm

Those in Attendance:
Commissioner Dolores Guzman
Commissioner Andy Ferrari
Commissioner John Hill
Commissioner Judy Craig

CAC Members Present:
Voloria Manning
Jenneffer Pulapaka
Alissa Lapinsky
Ann Flowers
Lynn Hoganson
Sarah Prado
Elmer Holt
Donna Pepin

Others Present:
Attorney for the Authority: Ted Small, Law Office of Theodore W. Small, P.A.
Accountant for the Authority: Ron Cantlay, Dreggors, Rigsby & Teal, P.A. (DRT)
Administrative Support: Eileen Long, DRT

Call to Order Special Meeting

Chair Craig called the meeting to order and declared that a quorum was established with the presence of four Commissioners. The meeting took place at DeLand City Hall, 120 S. Florida Avenue, DeLand, Florida, having been legally noticed in the Daytona Beach News-Journal, a newspaper of general circulation in Volusia County.

Approval of Proposed Agenda

Motion 035 - 2019 Commissioner Guzman motioned to approve the amended agenda as presented. Commissioner Hill seconded the motion. The motion passed unanimously.

Citizens Comments

There were three.

Motion 036 – 2019 Commissioner Guzman motioned to appoint Voloria Manning to fill Commissioner Shepard's vacancy.

The motion died for lack of a second.

Applicants Presentations (Applications Alphabetically Attached)

Roger Acardi
Elmer Holt
Voloria Manning
Jenneffer Pulapaka (Applicant pulled her name from the running see attached letter dated April 18, 2019)
Michael Ray

Each applicant was given an opportunity to address the Board and explain their professional background.

Commissioner Ferrari seconded Commissioner Guzman's motion from earlier upon hearing all of the applicant's presentations. The motion passed unanimously.

CAC Member Resignation (if necessary)

CAC Chair Voloria Manning submitted her written resignation from the CAC (attached).

Swearing in of New Commissioner

Commissioner Voloria Manning was sworn into office by Attorney Theodore W. Small.

Commissioner Comments

There being no further business to come before the Board, the meeting was adjourned.

Adjournment,

Judy Craig, Chair

WEST VOLUSIA HOSPITAL AUTHORITY
WVHA BOARD OF COMMISSIONERS JOINT MEETING WITH THE CITIZENS ADVISORY COMMITTEE

DeLand City Hall
120 S. Florida Avenue, DeLand, Florida
April 18, 2019
Commencing upon the conclusion of the Special Meeting

Those in Attendance:
Commissioner Dolores Guzman
Commissioner Andy Ferrari
Commissioner John Hill
Commissioner Judy Craig
Commissioner Voloria Manning

CAC Members Present:
Jenneffer Pulapaka
Alissa Lapinsky
Ann Flowers
Lynn Hoganson
Sarah Prado
Elmer Holt
Donna Pepin

Others Present:
Attorney for the Authority: Ted Small, Law Office of Theodore W. Small, P.A.
Accountant for the Authority: Ron Cantlay, Dreggors, Rigsby & Teal, P.A. (DRT)
Administrative Support: Eileen Long, DRT

Call to Order Joint Meeting with the CAC

Chair Craig called the meeting to order. The meeting took place at DeLand City Hall, 120 S. Florida Avenue, DeLand, Florida, having been legally noticed in the Daytona Beach News-Journal, a newspaper of general circulation in Volusia County. The meeting was opened with The Pledge of Allegiance.

Approval of Proposed Agenda

Motion 037– 2019 Commissioner Ferrari motioned to approve the amended agenda as presented. Commissioner Guzman seconded the motion. The motion passed unanimously.

Consent Agenda
Approval of Minutes – Regular Meeting March 21, 2019

Motion 038 - 2019 Commissioner Ferrari motioned to approve the Consent Agenda. Commissioner Hill seconded the motion. The motion passed unanimously.

Citizens Comments

There was one.

Reporting Agenda

UMR March 2019 Report – Written Submission
FQHC Report, Laurie Asbury, CEO, Northeast Florida Health Services, Inc. d/b/a Family Health Source (FHS) March 2019 Report
The House Next Door (THND) March 2019 HealthCard Application Report

Discussion Items

Citizens Advisory Committee Vacancies/Appointees
Commissioner John Hill Appointees
Linda White
Brian Soukup

Motion 039 – 2019 Commissioner Hill motioned to appoint Linda White and Brian Soukup as his CAC Representatives. Commissioner Guzman seconded the motion. The motion passed unanimously.

CAC Applicants (In Alphabetical Order)
Elmer Holt
Alissa Lapinsky
Donna Pepin
Althea Whittaker

Motion 040 – 2019 Commissioner Ferrari motioned to appoint Elmer Holt to the CAC on behalf of Commissioner Guzman. Commissioner Hill seconded the motion. The motion passed unanimously.

Motion 041 – 2019 Commissioner Manning motioned to re-appoint the late Commissioner Shepard's CAC Representatives, Alissa Lapinsky and Althea Whittaker. Commissioner Ferrari seconded the motion. The motion passed unanimously.

Chair Craig passed the gavel to Vice-Chair Guzman

Motion 042 – 2019 Commissioner Craig motioned to appoint Donna Pepin as her CAC Representative. Commissioner Hill seconded the motion. The motion passed unanimously.

Vice-Chair Guzman passed the gavel back to Chair Craig.

Mr. Small suggested that the seven CAC members present represented a quorum and the Committee could take this opportunity to hold an Organizational meeting to appoint their new CAC Chair and CAC Vice-Chair, as well as approving their meeting minutes.

CAC Organizational Meeting

Election of Officers

Member Alissa Lapinsky motioned to nominate Elmer Holt as the new CAC Chair. Member Lynn Hoganson seconded the motion.

There we no other nominations.

Member Elmer Holt was declared CAC Chair by acclimation.

CAC Chair Elmer Holt motioned to nominate Member Alissa Lapinsky as CAC Vice-Chair. Member Sarah Prado seconded the motion.

There we no other nominations.

Member Alissa Lapinsky was declared CAC Vice-Chair by acclimation.

Chair Elmer Holt stated for the record that a quorum was established with the presence of seven CAC members.

Citizens Advisory Committee-Elmer Holt, Chair
CAC Meeting Minutes February 5, 2019
CAC Meeting Minutes March 5, 2019

Member Ann Flowers motioned to approve the CAC meeting minutes of February 5, 2019 and March 5, 2019. Member Jenneffer Pulapaka seconded the motion. The motion passed unanimously.

WVHA Funding Applications Received (list attached)
2019-2020 WVHA Funding Applications Non-Compliant Worksheet
Vessel of Honor Outreach Center-Application received via email on 4/5/2019 at 2:43 p.m. without any required documentation or 17 additional copies

Motion 043 – 2019 Commissioner Ferrari motioned to exclude the Vessel of Honor Outreach WVHA Funding Application for being non-compliant. Commissioner Guzman seconded the motion. The motion passed unanimously.

Subrogation Settlement from $11,194.86 down to $5,597.43 (See UMR April 18, 2019 Report attached)

Mr. Small questioned why the reduction was 50% rather than the usual 33 & 1//3rd% for these type of legal settlements. The attorney in this case was paid 40%. He concluded by recommending a 40% reduction as a 50% reduction would establish a bad precedent.

Motion 044 – 2019 Commissioner Ferrari motioned to allow the settlement reduction at 40% or $6,716.91. Commissioner Guzman seconded the motion. The motion passed unanimously.

WVHA as Plaintiff in Federal Multidistrict Litigation for National Prescription Opiate Litigation (see Legal Update attached)

Contingent Fee Retainer Agreement (attached)
Letter from Commissioner Guzman (attached)

Motion 045 – 2019 Commissioner Guzman motioned to authorize the Chair to sign the Contingent Fee Retainer Agreement. Commissioner Manning seconded the motion. Commissioners Guzman, Manning and Craig voted in favor; Commissioners Ferrari and Hill were opposed. The motion passed.

29th Annual NAACP Freedom Fund Banquet
Past contributions 5/19/17 $1500.00; 5/18/18 $200.00

Motion 046 – 2019 Commissioner Guzman motioned to support the 29th Annual NAACP Freedom Fund Banquet at the Bronze level in the amount of $350.00 and she would like the CAC members to receive the tickets to attend the banquet. Commissioner Hill seconded the motion.

Commissioner Manning wanted to support at the Silver level in the amount of $500.00 so that the WVHA Logo can be displayed on the video screen.

Motion 046 – 2019 (AMENDED) Commissioner Guzman accepted Commissioner Manning's friendly amendment to support the 29th Annual NAACP Freedom Fund Banquet at the Silver level of $500.00, so that the WVHA logo will be displayed on the video screen, and now 4 tickets are available for the CAC members to claim and attend this event. Commissioner Hill seconded the friendly amended motion. The motion passed unanimously.

Follow Up Items

NEFHS Letter to Board dated 2-12-2019 (attached) Re: 2017-2018 Budget overage $43,349.00 and request to reinstate original funding request of $1,253,930.00 for 2018-2019

There was Board discussion regarding the importance of the WVHA's primary care providers, NEFHS as the first line of defense for the HealthCard population. Further, based upon the NEFHS current budget utilization and the trajectory seems to place NEFHS on a path to overshoot their 2018-2019 WVHA approved budget.

Motion 047 – 2019 Commissioner Guzman motioned to increase the NEFHS WVHA Primary Care funding from $918,322.00 for FY 2018-2019 to the amount of $1,150,000.00. Commissioner Ferrari seconded the motion.

There was Board discussion to make a public commitment to cover any NEFHS budget overages.

The motion passed unanimously.

Mr. Cantlay requested that the Board make a formal budget amendment to increase the NEFHS Primary Care Budget from $918,322.00 to $1,150,000.00, taking those additional dollars from the currently budgeted line item for Other Healthcare Services.

Motion 048 – 2019 Commissioner Ferrari motioned to formally amend the budget to increase the NEFHS Primary Care Budget from $918,322.00 to $1,150,000.00 and to take that increase from the budget line item for Other Healthcare Services. Commissioner Guzman seconded the motion. The motion passed unanimously.

UMR Administrative Services Agreement

Motion 049 – 2019 Commissioner Ferrari motioned to accept the proposed UMR Administrative Services Agreement, with the amendment of the proposed performance guarantee, authorizing the Chair to sign both the main agreement along with Exhibit E Performance Guarantee, on the basis of UMR's commitment that they will waive one month of fees, calculated to be roughly $30,000.00 if the Board signs off on this agreement. Commissioner Hill seconded the motion. The motion passed unanimously.

Financial Report

Mr. Ron Cantlay, DRT reviewed for the Board the March financial statements (see attached).

Motion 050 – 2019 Commissioner Guzman motioned to pay bills totaling $2,548,804.85 (See attached). Commissioner Manning seconded the motion. The motion passed unanimously.

Legal Update

Mr. Theodore Small, Legal Counsel for the WVHA submitted his legal update memorandum dated April 9, 2019 (See attached).

Commissioner Comments

There being no further business to come before the Board, the meeting was adjourned.

Adjournment,

Judy Craig, Chair

UMR

May 16, 2019

Submission Report for WVHA Board Members

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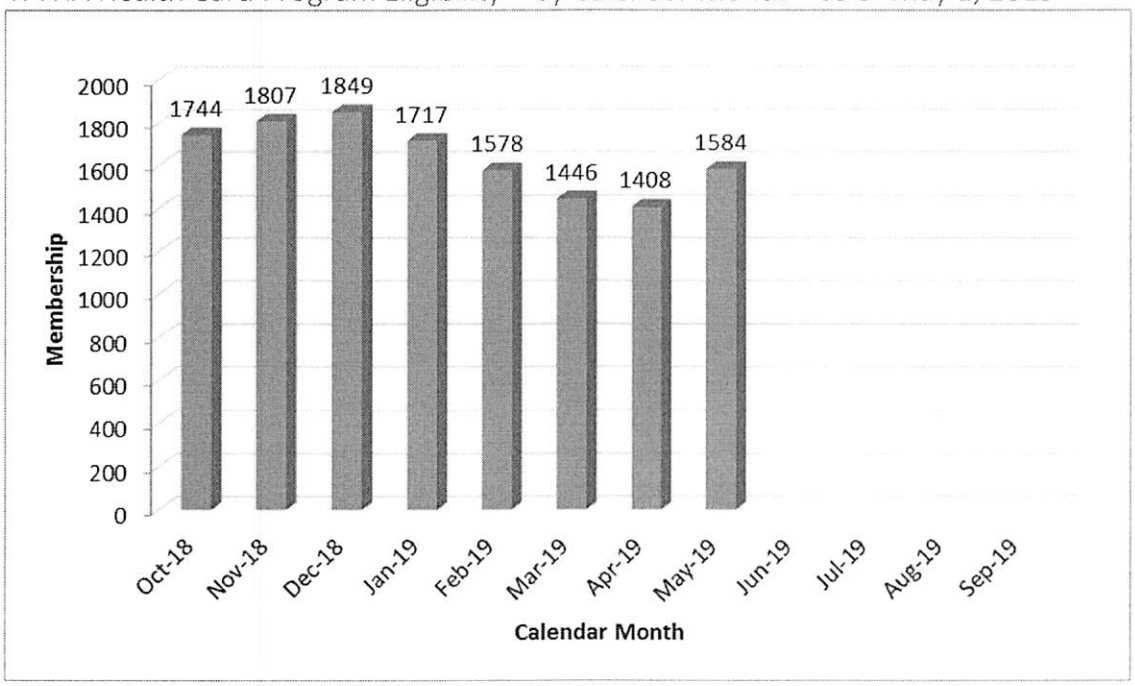
WVHA Health Card Program Eligibility – by Calendar Month – as of May 1, 2019

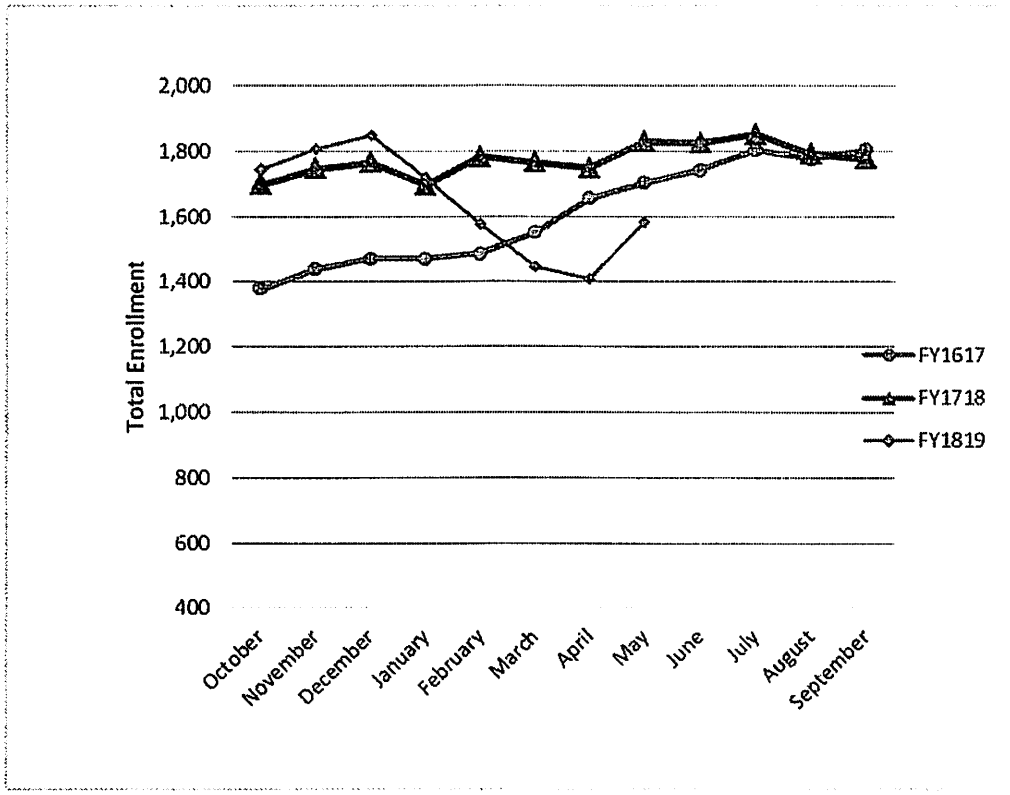


Eligibility reported above reflects eligibility as of the first of each month.

As of May 1, 2019, total program eligibility was 1,584 patients.

WVHA Enrollment by Fiscal Year – as of May 1, 2019

WVHA Enrollment By Fiscal Year	
Month of Fiscal Year	FY1819
October	1,744
November	1,807
December	1,849
January	1,717
February	1,578
March	1,446
April	1,408
May	1,584
June	
July	
August	
September	
Grand Total	13,133


2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
Total Enrollment
October
November
December
January
February
March
April
May
June
July
August
September
FY1617
FY1718
FY1819

WVHA Enrollment by Zip Code – as of May 1, 2019

WVHA Enrollment by Zip Code by Month					
Zip Code	May-19	Jun-19	Jul-19	Aug-19	Sep-19
32102	4				
32117	1				
32130	53				
32180	97				
32190	13				
32238	1				
32713	56				
32720	342				
32721	4				
32724	277				
32725	303				
32727	1				
32728	4				
32730	2				
32732	1				
32735	1				
32738	275				
32744	24				
32759	1				
32762	1				
32763	107				
32764	13				
32774	3				

Medical and Prescription Drug Claim Data

Pharmacy Claims by Fiscal Year by Service Month (Month Prescription Filled)

	FY1819				
Month	Drug Costs	Dispensing Fee Less Copayments	Total Costs	Total Rx's Filled	Avg Cost Per Rx
October	$55,005.45	$7,661.22	$62,666.67	3,451	$18.16
November	$55,658.13	$7,008.54	$62,666.67	3,157	$19.85
December	$85,000.00	$4,502.16	$89,502.16	2,027	$44.15
January	$66,232.60	$4,930.62	$71,163.22	2,221	$32.04
February	$53,124.87	$5,151.28	$58,276.15	2,324	$25.08
March	$35,517.40	$4,886.40	$40,403.80	2,220	$18.20
April					
May					
June					
July					
August					
September					
Grand Total	$350,538.45	$34,140.22	$384,678.67	15,400	$24.98

Combined Medical Costs (as of Claims Payment through 4/30/2019)

Fiscal Year	Hospital	Lab	PCP	Specialty	Facility Physicians	Pharmacy	Total Costs	Member Months	Overall Per Member Per Month (PMPM)	Hospital PMPM	Lab PMPM	PCP PMPM	Specialty PMPM	Pharmacy PMPM
FY1819	**$3,956,338.04**	**$279,669.99**	**$565,792.48**	**$1,918,895.00**	**$63,188.97**	**$384,678.67**	**$7,168,563.15**	**11,389**	**$629.43**	**$347.38**	**$24.56**	**$49.68**	**$168.49**	**$33.78**
October	$14,319.08	$64,081.46	$124,186.81	$351,047.84	$0.00	$62,666.67	$616,301.86	1,807	$341.06	$7.92	$35.46	$68.73	$194.27	$34.68
November	$64,583.26	$26,032.33	$74,964.35	$186,963.92	$0.00	$62,666.67	$415,210.53	1,849	$224.56	$34.93	$14.08	$40.54	$101.12	$33.89
December	$261,035.64	$65,053.76	$91,409.27	$305,262.72	$0.00	$89,502.16	$812,263.55	1,717	$473.07	$152.03	$37.89	$53.24	$177.79	$52.13
January	$1,068,458.10	$23,389.99	$53,066.17	$287,311.72	$39,478.62	$71,163.22	$1,542,867.82	1,578	$977.74	$677.10	$14.82	$33.63	$182.07	$45.10
February	$2,464,398.16	$36,655.51	$1,991.59	$287,643.00	$0.00	$58,276.15	$2,848,964.41	1,446	$1,970.24	$1,704.29	$25.35	$1.38	$198.92	$40.30
March	$385,346.04	$34,197.22	$64,117.36	$250,263.73	$23,710.35	$40,403.80	$798,038.50	1,408	$566.79	$273.68	$24.29	$45.54	$177.74	$28.70
April	-$301,802.24	$30,259.72	$156,056.93	$250,402.07	$0.00		$134,916.48	1,584	$85.17	-$190.53	$19.10	$98.52	$158.08	$0.00
May							$0.00							
June							$0.00							
July							$0.00							
August							$0.00							
September							$0.00							
Grand Total	**$3,956,338.04**	**$279,669.99**	**$565,792.48**	**$1,918,895.00**	**$63,188.97**	**$384,678.67**	**$7,168,563.15**	**11,389**	**$629.43**	**$347.38**	**$24.56**	**$49.68**	**$168.49**	**$33.78**

Medical and pharmacy costs are reported on a paid basis

PCP Encounter Claims by Clinic by Month (as of Claims Payment through 4/30/2019)

	FY1819					
Month	NEFHS Deland	NEFHS Deltona	NEFHS Pierson	NEFHS Stone Street	NEFHS Daytona	Total
October	453	511	158	0	19	1,141
November	274	358	85	0	4	721
December	338	296	121	0	13	768
January	197	233	55	0	11	496
February	33	26	8	0	3	70
March	174	238	103	0	10	525
April	668	634	161	0	17	1,480
May						0
June						0
July						0
August						0
September						0
Grand Total	2,137	2,296	691	0	77	5,201

PCP encounter claims are reported on a paid basis

Specialty Care Services by Specialty – Top 25 (April, 2019)

SPECIALTY CARE SERVICES BY SPECIALTY - TOP 25 FOR APRIL					
Order	SPECIALTY	Unique Patients	Claim Volume	Paid	Cost Per Patient
1	Internal Medicine	68	169	$ 45,115.16	$ 266.95
2	Surgery Center	33	40	$ 30,127.00	$ 753.18
3	Radiology	273	545	$ 20,307.92	$ 37.26
4	Hematology Oncology	25	44	$ 19,067.86	$ 433.36
5	Orthopedic Surgery	54	74	$ 15,624.10	$ 211.14
6	Physical & Occupational Therapy	31	132	$ 13,569.29	$ 102.80
7	Pain Management	57	74	$ 12,168.80	$ 164.44
8	Gastroenterology	53	71	$ 9,673.24	$ 136.24
9	Ophthalmology	55	68	$ 9,078.80	$ 133.51
10	Cardiovascular Diseases	41	70	$ 8,964.55	$ 128.07
11	Pulmonary Medicine	26	56	$ 8,522.95	$ 152.20
12	Obstetrics & Gynecology	26	30	$ 7,042.92	$ 234.76
13	Oncology	22	47	$ 6,626.87	$ 141.00
14	Dermatology	24	29	$ 6,471.18	$ 223.14
15	Nurse Anesthetist	35	49	$ 5,823.27	$ 118.84
16	Nephrology	22	78	$ 5,302.05	$ 67.98
17	Anesthesiology	38	43	$ 5,254.80	$ 122.20
18	Infectious Diseases	34	53	$ 4,603.52	$ 86.86
19	Family Practice	30	49	$ 4,250.25	$ 86.74
20	Urology	29	35	$ 3,916.78	$ 111.91
21	Nurse Practitioner	32	40	$ 3,292.59	$ 82.31
22	General Surgery	9	10	$ 2,933.68	$ 293.37
23	Cardiology	20	33	$ 2,647.82	$ 80.24
24	Podiatry	18	22	$ 2,549.43	$ 115.88
25	Pathology	18	33	$ 2,127.17	$ 64.46

New Items

WVHA Healthcard Enrollment Counts by Zip Code

Per recent request, this report now includes a breakdown of the WVHA Healthcard enrollment by zip codes as shown on page 5.

This breakdown will also be included on all subsequent monthly reports.

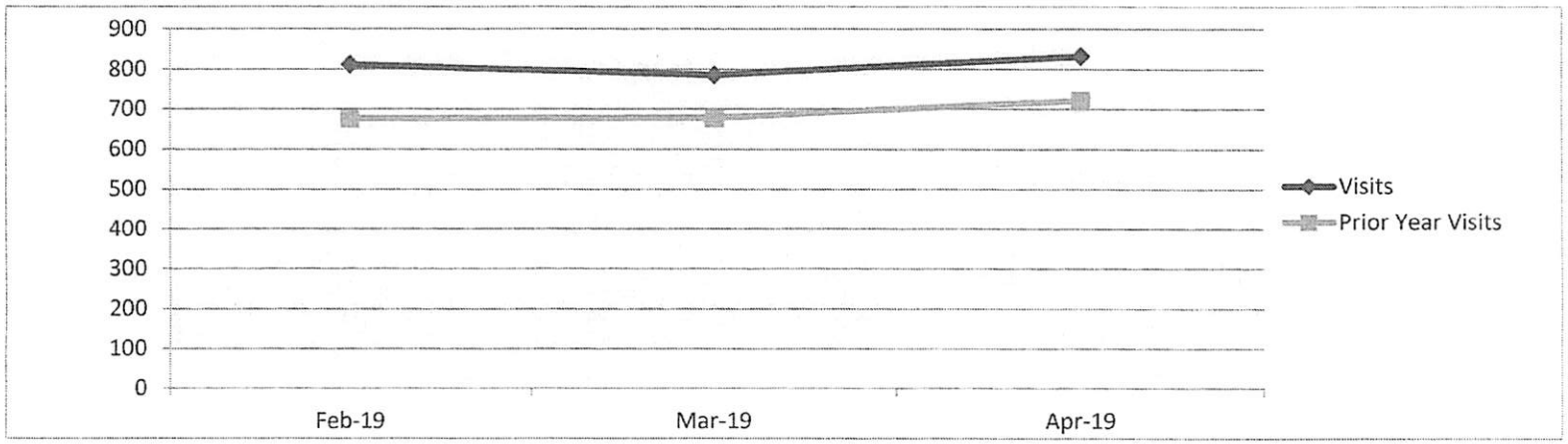
FAMILY Health Source

Northeast Florida Health Services

April-19

Patient Visits

	Feb-19	Mar-19	Apr-19
Visits	811	786	832
Prior Year Visits	677	678	722



Patient Visits by Location

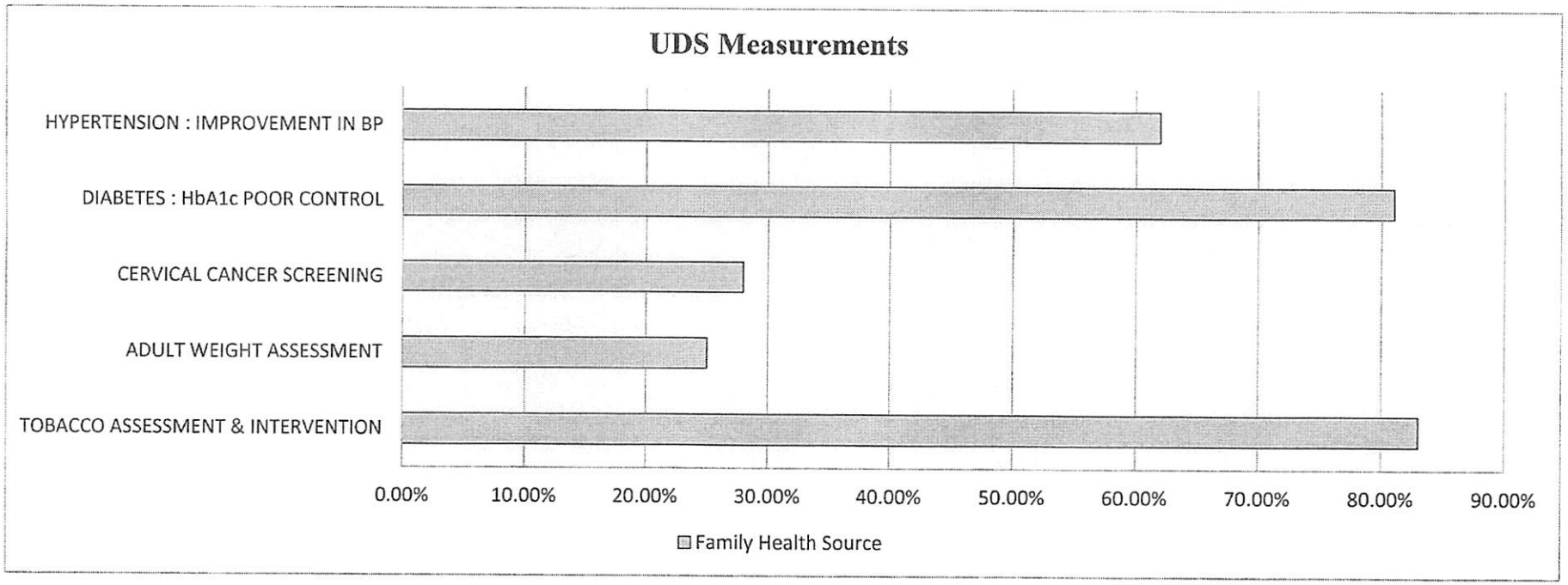
Location	Feb-19	Mar-19	Apr-19
Deland Medical	382	338	373
Deltona Medical	328	315	348
Pierson Medical	90	108	98
Daytona	11	14	13
Total	811	775	832

Appointment Times

Location	Provider	Appointments
Daytona	Johnson	Same Day
Daytona	Sauls	Same Day
DeLand	Kodish	Same Day
DeLand	Smith	Same Day
Deland	Hoblick	Same Day
DeLand	Sanchez	Same Day
DeLand	Vasanji	Same Day
Deltona	Baldassarre	Same Day
Deltona	Rodriguez	Same Day
Deltona	Macalua	Same Day
Deltona	Mancini	Same Day
Pierson	Roberson	Same Day
Pierson	Kessack	Same Day

UDS Measures

Clinical Measures for the month of April 2019	Family Health
TOBACCO ASSESSMENT & INTERVENTION	83.00%
ADULT WEIGHT ASSESSMENT	25.00%
CERVICAL CANCER SCREENING	28.00%
DIABETES : HbA1c POOR CONTROL	81.00%
HYPERTENSION : IMPROVEMENT IN BP	62.00%



Pierson
216 N. Frederick St.
Pierson, FL 32180
(386) 749-9449
Fax: (386) 749-9447

Deltona
2160 Howland Blvd.
Deltona, FL 32738
(386) 532-0515
Fax: (386) 532-0516

DeLand
844 W. Plymouth Ave.
DeLand, FL 32720
(386) 738-2422
Fax: (386) 738-2423

Daytona
801 Beville Rd.
Daytona Beach, FL 32119
(386) 267-6214
Fax: (386) 999-0414

Pediatrics
800 W. Plymouth Ave.
DeLand, FL 32720
(386) 736-7933
Fax: (386) 736-7934

Pharmacy
1205 S. Woodland Blvd.
Ste. 5
DeLand, FL 32720
(386) 888-4912
Fax: (386) 269-9950

Administration
1205 S. Woodland Blvd
DeLand, FL 32720
(386) 202-6025
Fax: (386) 269-4149

FAMILY Health Source

"GROWING WELLNESS IN OUR COMMUNITIES"

WVHA Prescription Audit – January 2019 – March 2019

	Jan-19	Feb-19	Mar-19	Total
Total Scripts:	2,231	2,225	2,124	6,670
Script Sample:	20	20	20	60
Specialist Scripts:	2	3	2	7
Total Acute Scripts:	3	1	4	8
Total Chronic Scripts:	17	19	17	53
Total Rx filled Incorrectly:	0	0	0	0
Total Scripts filled in error:	0	0	0	0

RX Fill Fee:	$2.22
Total Overage:	$0.00

***All 53 Chronic scripts written and filled over 90 days.**

Nurturing Families
Building Communities

The House Next Door
Serving
Volusia and Flagler Counties

Administrative Offices 804 North Woodland Blvd. DeLand, FL 32720
386-734-7571
386-734-0252 (fax)

DeLand Counseling Center
121 W. Pennsylvania Ave.
DeLand, FL 32720
Counseling: 386-738-9169
Programs: 386-734-2236
386-943-8823 (fax)

Deltona Counseling Center 840 Deltona Blvd., Suite K Deltona, FL 32725
Counseling and Programs:
386-860-1776
386-860-6006 (fax)

Flagler Counseling Center
25 N Old Kings Road #7B
Palm Coast, FL 32137
386-738-9169
386-943-8823

S. Daytona Counseling Center
1000 Big Tree Road Daytona Beach, FL 32114 386-301-4073
386-492-7638 (fax)

May 2, 2019

West Volusia Hospital Authority

Monthly Enrollment Report

In the month of April there were 348 appointments to assist with new applications and 62 appointments to assist with pended applications from February for a total of 410 face to face contact with clients.

286 applications were submitted for verification and enrollment. Of these, 407 were processed by the end of the month leaving the balance of 99 to roll over into May for approval.

Of the 407 that were processed, 362 were approved and 24 were denied. The remaining 21 were pended and letters were sent out to the clients.

Currently applications are being processed, approved and the client enrolled in 10 business days. Please note it takes up to five days once we enter the data into the UMR system for the client to be enrolled.

Respectfully submitted by Gail Hallmon

AdventHealth
Fish Memorial

May 7, 2019

West Volusia Hospital Authority
1006 N. Woodland Blvd.
DeLand, FL 32720

Dear West Volusia Hospital Authority:

As requested, this annual certification of compliance attests that we are meeting requirements per Agreement executed on September 29, 2000 between MEMORIAL HOSPITAL-WEST VOLUSIA, INC., SOUTHWEST VOLUSIA HEALTHCARE CORPORATION D/B/A FLORIDA HOSPITAL FISH MEMORIAL and WEST VOLUSIA HOSPITAL AUTHORITY (WVHA) and amended as of 5/16/2002, 7/31/2003, 11/18/2010, 8/23/2011, 9/10/2012, 9/19/2013, 6/2/2014, 6/3/2015 and 6/1/2016 as sub-agreements incorporated into the Termination of Lease, Settlement and Asset Transfer Agreement dated 9/29/2000.

Southwest Volusia Healthcare Corporation d/b/a Florida Hospital Fish Memorial hereby duly affirms we continue compliant as it relates to the requirements under said agreement.

- Upon request from the WVHA, we will provide evidence that the Hospital is duly licensed, certified and accredited. (Indigent Care Reimbursement Agreement ¶7.1).

- We will also promptly notify the WVHA of any legal or governmental action, "or any other matter", that could materially affect the Hospital's performance under the Indigent Care Reimbursement Agreement. (Indigent Care Reimbursement Agreement ¶7.2).

Sincerely,

Rob Deininger, President/CEO

Eric Ostarly, VP/CFO

cc: Theodore W. Small, Jr., Esquire
Dreggors, Rigsby & Teal, P.A.

5-16-2019 Summary of WVHA Eligibility Revisions-Final to be presented for Board Approval 6-20-2019

Revised date changed from 6/21/2018 to 6/20/2019
Page numbering will be corrected once tracking has been turned off

Page 5, 1. deleted Section 12.03 inserted Section 11.03
Page 5, 2 deleted Article XI inserted Article VII
page 5, 3 deleted Article X inserted Article IX
page 5, 4 deleted applicants inserted US Citizens
page 6, 1. g. underlined and highlighted
page 7, 2. c. deleted Section 12.07
page 8, v. deleted FHS inserted The House Next Door
page 9, 1. b. deleted primary clinic inserted WVHA Enrollment Certifying Agency
page 11, Section 7.03 last sentence, last paragraph deleted window envelopes are not acceptable
page 21, Federal Poverty Guidelines chart deleted 2018 inserted 2019
page 22, delete link to 2019 Mediciad Medically Needy Guidelines-Asset Limitations-link to page broken-couldn't be found
page 35, Federal Poverty Guidelines chart deleted 2018 inserted 2019

Bold and highlighted are recommendations from THND

West Volusia Hospital Authority (WVHA)

Health Card Program

Eligibility Guidelines and Procedures

Revised –June 2~~1~~0~~sth~~th, 201~~8~~9

Rev. 6/20/2019

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WVHA Statement of Purpose

Section 1.01 Purpose

To document the establishment of an eligibility policy.

Section 1.02 Policy

The West Volusia Hospital Authority (WVHA) Enabling Act recognizes that it is in the public interest to provide a source of funding for indigent and medically needy residents of the West Volusia Hospital Authority Taxing District and to maximize the health and well-being of residents by providing comprehensive planning, funding, and coordination of health care service delivery. Program elements may include, but not be limited to, preventive health services, ~~community nursing services,~~ ambulatory care, outpatient services, hospital services, trauma health services, and rehabilitative services, as feasible. All programs should be coordinated to maximize the delivery of quality health care.

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The WVHA Board of Commissioners has established policies and procedures to qualify clients who are in need of medical services, who do not have the ability to pay, and are residents of the WVHA Taxing District.

WVHA Health Card availability is restricted until all other means of payment have been exhausted, including, but not limited to, bank accounts, certificates of deposit, stock ownership, bank loans, savings accounts, mutual funds, non-exempt property, insurance loans, family member loans and the like. If an individual or a family member receives benefits under WVHA Health Card to treat an injury or medical condition that was caused by a third party, then WVHA hereby claims a right to be subrogated to the rights of that beneficiary to recover damages from that third party (e.g. a defendant in a lawsuit or a defendant's insurer). WVHA must be reimbursed for the benefits it has paid if the WVHA Health Card member or his/her family recovers any damages or receives payments from that third party or an insurer on account of that injury or medical condition.

As this policy cannot cover all variables, it should be noted that on occasion a determination must be made upon the available facts coupled with the good judgment of the WVHA Enrollment Certifying Agent.

Article II. WVHA Summary of Criteria

Section 2.01 Purpose

To provide an overview of the WVHA criteria for eligibility.

Section 2.02 Policy

Each applicant must meet the following criteria for consideration of enrollment:

1. Residency (Article VIII).
   All applicants must reside within the WVHA District (refer to Section 11.03~~Section 12.03~~)
   a. Residency exists when the applicant has been residing for at least three (3) months within the District.
   b. Exception - Those qualified as "homeless" are subject to a one (1) month residency requirement.

2. Identification (Article VIII~~Article IX~~).
   An applicant must provide the forms of identification that are required under this policy.

3. Income (Article IX~~Article X~~).
   The calculated family income must be equal to or below the West Volusia Hospital Authority Board approved percentage of the Federal Poverty Level Guidelines for that family unit size.

4. Medical Coverage.
   All US Citizens ~~applicants~~ must produce proof of Medicaid application or denial before consideration for WVHA programs. Denials for reasons of noncompliance will not be accepted.

   Note: The ACA insurance exchange will also be a point of entry for Medicaid applications

5. WVHA Affordable Care Act (ACA) Requirements
   The WVHA policy is that the WVHA Health Care Program funds health care for indigent residents only as a payer of last resort (thereby avoiding replacement of affordable private insurance or displacement of available federal programs). It is the policy of the WVHA Board of Commissioners that an application for insurance coverage, tax credits, and subsidies under the ACA insurance exchange (www.healthcare.gov) is a requirement before an applicant can qualify for a WVHA health card. All other provisions of the WVHA Eligibility Guidelines are in addition to the ACA requirements.
   Denials of eligibility, tax credits or cost-sharing subsidies for reasons of noncompliance with established exchange procedures will not be accepted.

WVHA reserves the right to verify all information. Verification includes but is not limited to income, assets, credit, and employment. This may be accomplished at any time during the application process, enrollment or after benefits have been assigned. If any information is discovered to be false or altered in any way, WVHA may deny the application or dis-enroll the member and recover any charges previously adjusted under this program. Any member or applicant denied for falsification of information may be prohibited from ever applying again.

WVHA is the payer of last resort and assists patients with no medical benefits. Patients that have health coverage are excluded from the program. Certain programs, such as 'Aids Drugs Assistance Program' (ADAP) that are targeted to offer limited services towards one specific disease, will not disqualify an applicant from the WVHA Health Card program because such programs are not considered inclusive medical benefits.

Section 2.03 Purpose

To summarize the eligibility process.

Section 2.04 Policy

All applicants follow a three (3) step process to verify enrollment into WVHA programs. The steps include: Application, Evaluation and Determination, and Enrollment. The Evaluation, Determination, and Enrollment steps are performed exclusively by a WVHA Enrollment Certifying Agent.

Procedures

The following is the procedure used for determining eligibility for the WVHA program:

1. Application: The application (Section 12.04) and assessment form (Section 12.05) must be fully completed by the applicant. The following documentation is required to complete the application.
    a. Proof of residency in WVHA Taxing District (Article VIII)
    b. Identification (Article IX)
    c. Proof of Income (Article X)
    d. Proof of Assets (Article XI)
    e. Proof of Medicaid Application or Medicaid Application Denial Letter
    f. Proof of Affordable Care Act (www.healthcare.gov) Application
    g. **Applicants can only apply for WVHA Assistance during periods of Open Enrollment as defined by the Federal Government for coverage under the Affordable Care Act. WVHA adopts the Open Enrollment Period set forth by the Federal Government, including Special Enrollment Periods.** Formatted: Font: Bold, Underline, Highlight
        i. Exceptions:
            1. New applicants: applicants that were not eligible during the prior six (6) months AND were NOT eligible during the last Open Enrollment Period may apply for WVHA assistance outside of the Open Enrollment Period set forth by the Federal Government.
                a. Unless the new applicant is determined to have a non-citizen resident exemption, all new applicants must still apply for and obtain an ACA Determination Letter to be submitted with their application for WVHA Assistance.
                    i. If a Special Enrollment Period is indicated, and the cost of a plan, net of premium tax credits, is less than 8% of gross income, the WVHA application will be denied.
                    ii. If no Special Enrollment Period is indicated, the patient may obtain WVHA assistance if all other WVHA eligibility requirements are met.
            2. Renewal applicants: applicants that were eligible on the date that their application was received by the Enrollment Certifying Agent.
                a. Unless the renewal applicant is determined to have a non-citizen resident exemption, all renewal applicants must still apply for and obtain an ACA Determination Letter to be submitted with their application for WVHA Assistance.
                    i. If a Special Enrollment Period is indicated, and the cost of a plan, net of premium tax credits, is less than 8% of gross income, the WVHA application will be denied.
                    ii. If no Special Enrollment Period is indicated, the patient may obtain WVHA assistance if all other WVHA eligibility requirements are met.
            3. Applicants Eligible for ACA Special Enrollment Periods
                i. If a Special Enrollment Period is indicated on the ACA Determination Letter, and the cost of a plan, net of premium tax credits, is less than 8% of gross income, the WVHA application will be denied.

ii. If a Special Enrollment Period is indicated, but the cost of a plan is more than 8%, the patient may obtain WVHA assistance if all other WVHA eligibility requirements are met.

h. Available ACA Plans
   i. If the cost of a plan, net of premium tax credits, is less than 8% of gross income (excluding child support, gifts, Supplemental Security Income (SSI), Veteran's disability payments, Worker's compensation, proceeds from loans (like student, home equity or bank loans)), the WVHA application may be denied entirely, or approved for a shortened period of assistance.
      1. The WVHA Enrollment Certifying Agent will make the determination of whether or not a plan is available at a cost of less than 8% of the applicant's annual gross income by reviewing premium costs for the applicant (based upon age, gender, residence) indicated on the ACA Marketplace website in concert with the ACA Determination Letter information.
         a. In this case, the WVHA Application will be denied
         b. If, however, the applicant submits proof of coverage within the month they enroll for the ACA plan, and the applicant meets all other WVHA eligibility guidelines, the WVHA Enrollment Certifying Agent may approve a shortened period of eligibility, This is to allow for WVHA assistance during the short period prior to the patient's effective date with the ACA Plan.
            i. Patients that apply for an ACA plan prior to the 15th of the month become effective for the ACA plan on the 1st day of the following month.
            ii. Patients that apply for an ACA plan after the 15th of the month become effective on the first day of the second month following enrollment.
               1. WVHA assistance for the gap between the date the patient enrolled in an ACA plan and the ACA plan effective date shall not exceed a period of 45 days.

2. Evaluation and Determination:
   a. Upon receipt of the application and assessment form, the WVHA Enrollment Certifying Agent will evaluate the application and documentation for accuracy and appropriateness.
   b. Prior to submitting an application for WVHA, applicants must first submit an application for insurance on the ACA insurance exchange (www.healthcare.gov)
      i. Note: The ACA insurance exchange will also be a point of entry for Medicaid applications.
      ii. Note: Non-citizen Residents of the WVHA Taxing District may submit an attestation from the Farm Workers Association (FWA) in lieu of an ACA Application. The date of the FWA attestation shall not be dated any earlier than 30 days prior to the receipt of the WVHA Application to the WVHA Enrollment Certifying Agent.
      iii. Note: Deferred Action for Childhood Arrivals (DACA) residents may submit proof of their Employment Authorization Card in lieu of an ACA determination letter.
      iv. Note: Homeless residents of the WVHA Taxing District may submit a Homeless Verification Form (See Appendix G, Section 12.11) in lieu of an ACA Application. The date of the Homeless Verification Form shall not be dated any earlier than 30 days prior to receipt of the WVHA Application to the WVHA Enrollment Certifying Agent.
   c. WVHA Applicants must submit an ACA determination letter along with their WVHA application as proof of their ACA application. The date of the ACA Determination Letter shall not be dated any earlier than 30 days prior to the receipt of the WVHA Application to the WVHA Enrollment Certifying Agent; provided however, the ACA may be dated up to and including a date 6 months prior to the receipt of the WVHA Application by the WVHA Enrollment Certifying Agent if the ACA Determination Letter is accompanied by a ACA Pre-Qualifying Form (See Appendix K, ~~0~~Section ~~12.07~~) which is completed by a Person Assisting who is approved by WVHA.

i. Note: Non-citizen Residents of the WVHA Taxing District may submit an attestation from the Farm Workers Association in lieu of an ACA Determination Letter. The date of the attestation from FWA must be within 30 days of the application.

ii. Note: Homeless residents of the WVHA Taxing District may submit a Homeless Verification Form (See Appendix G, Section 12.11) in lieu of an ACA Determination Letter. The date of the Homeless Verification Form shall not be dated any earlier than 30 days prior to receipt of the WVHA Application to the WVHA Enrollment Certifying Agent.

iii. If the WVHA Applicant's Household income is less than 100% of the Federal Poverty Guidelines, and the ACA Determination Letter requests additional information in order to process the ACA insurance application, the WVHA applicant must provide the information in order for their WVHA application to be considered complete.

1. If the only item that the ACA Determination Letter requests additional information to complete the application is to confirm tax filing status, the ACA Determination Letter shall be considered complete.

iv. If the WVHA Applicant's Household income is greater than or equal to 100% of the Federal Poverty Guidelines, and the ACA Determination Letter requests additional information in order to process the ACA insurance application, the WVHA applicant must provide the information in order for their WVHA application to be considered complete.

1. The WVHA applicant **CANNOT** be approved for WVHA assistance unless the ACA Determination Letter is complete (does not require additional information to determine eligibility for coverage or eligibility for premium tax credits or out of pocket costs credits/subsidies).

v. The WVHA Enrollment Certifying Agent has discretion to approve an applicant if the ACA Determination Letter is plainly in error based on a generally known computer glitch or other similar problem that prevents the issuance of accurate ACA Determination Letters, but the Agent may exercise this discretion only after verifying that this computer glitch or other problem has been reported in writing to CMS and/or HHS officials who have responsibility to work on a solution. This includes the attestation process where ~~FHS~~ The House Next Door (THND) has assisted the applicant with uploading documentation after verifying that the application would not meet the ACA subsidy or tax credit requirement based on income.

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d. The information provided in the application and accompanying documentation is the basis for one of three determinations. The application determination must be made on a timely basis.
   a. Denied- The case is denied and a "Notice of Determination" is sent to the applicant and documented. Applicant does not proceed to enrollment.
   b. Pending – The case may be returned for corrections or the submission of additional information. Cases can only be pended for a total of 30 calendar days. While an application is pending submission of additional information, the WVHA Enrollment Certifying Agent has discretion to accept in lieu of requested documents the written clarifications on basic questions about an applicant (e.g., marital status, relationship to applicant) submitted by a supervisory level staff member at a WVHA funded agency; provided however, the applicant must be mailed a copy of any such clarification with notice that it will be considered as a part of the application unless objected. If the required information or some such clarification is not received, the case will be denied on the 31st calendar day.
   c. Approved – The case is approved. "Notice of Determination" is sent to the applicant. Applicant proceeds to enrollment.

3. Enrollment: The enrollment process includes:
   a. Explanation of the benefits covered under the assigned plan and how to receive care.
   b. Explaining the policy and providing a copy of the WVHA guidelines.
   c. The issuance and explanation of the WVHA Health Card.

Article III. WVHA Application Time Standards

Section 3.01 Purpose

To define the allowable time standards for submission of applications and supporting documentation for the purpose of eligibility determination.

Section 3.02 Policy

Time Standards – Applications:

1. Date of Application: The application date is determined in one of the followings ways:
    a. The date the application is received by WVHA Enrollment Certifying Agent becomes the enrollment date should the applicant be found to be eligible.
    b. The date of emergency room treatment or date of discharge if patient was subsequently admitted to an approved WVHA area hospital. These applicants must be instructed to make arrangements for initial screening and application at designated ~~primary clinic~~ WVHA Enrollment Certifying Agency within fifteen (15) business days.
2. Time Standards – Submission for eligibility determination:
    a. WVHA Enrollment Certifying Agent will respond to applications and make a determination in a timely manner.
3. Reapplication – (after denial)
    a. Effective February 16, 2016, an applicant may reapply 21 days from date of denial should there be a material change in application circumstances. After submitting three (3) applications and receiving three (3) denials, the applicant may reapply ONLY after presenting a money order in the amount of $21.00 and payable to the WVHA.
4. Renewal
    a. A WVHA Enrollee can apply for renewal no earlier than 30 days prior to expiration date of existing card. If a cardholder applies at renewal, and a lapse occurs within 30 days from coverage term date, dates will be adjusted to avoid a lapse in coverage. Each reapplication is treated as a new application and all forms and updated documents need to be submitted accordingly.
5. Eligibility Term
    a. WVHA Health Cards are issued for a period of six (6) months. WVHA reserves the right to issue short term eligibility periods for special circumstances to be determined by WVHA Enrollment Certifying Agent.

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Article IV. WVHA Family Size

Section 4.01 Purpose

To identify the person or persons to be considered as part or all of a family unit.

Section 4.02 Policy

WVHA Enrollment Certifying Agent shall consider family size as part of the eligibility process. Inmates under the control of a law enforcement authority or under prison control are excluded from consideration.

Section 4.03 Definitions

To determine if the family unit's gross income is within the WVHA income standards, it must first be determined who is in the applicant's family unit.

A family unit is defined as one or more persons residing together in the same household, whose needs, income, and assets are included in the household budget (excluding: roomers, boarders, lodgers, wards, employees, foster children, or adult dependents who are not Full Time Students). Members include the applicant, legal spouse, dependent children, stepchildren, adopted children, unrelated minor children for whom the individual has legal guardianship or custody, legal guardian, or natural parents of minor children, or minor siblings.

Other relatives under the age of 18 and living in the household must be dependent on the Head of the Family for financial support and claimed as a dependent for income tax purposes and does not have an independent income, to be considered part of the family unit.

Full Time Students-Persons 18 years of age or older who are full-time students (this must be proven and documented by IRS tax documentation in which the student is claimed as a dependent) are considered part of the family unit size until 24 years of age, after which they are considered as a separate family unit. Documentation must be provided and placed in the eligibility file.

Persons Not Considered Part of the Family Unit- Parent, grandparent, son, daughter, brother, or sister 18 years of age or older who resides in the family residence is not considered part of the family unit size, but a separate family except as described above. (Full Time Students)

Emancipated persons are not considered part of the family unit size, but rather as a separate family.

If a residence is shared by one or more family units, the Federal Poverty Level Guideline levels are applied to each family unit and not to the residence as a whole.

Eligibility is based on the entire family unit.

Qualifying Levels - The family size along with the gross income is compared to approved qualifying levels for the purpose of determining eligibility.

Article V. WVHA Qualifying Levels

Section 5.01 Purpose

To identify the application of qualifying levels based on family size and income.

Section 5.02 Policy

WVHA utilizes the Federal Poverty Level Guidelines, published annually in the Federal Register and approved for use on April 1 of each year. The guidelines are used to determine qualifying levels for eligibility. The WVHA Board establishes the qualifying percentages which cannot be modified without WVHA Board approval.

Section 5.03 Guideline

150% of the approved Federal Poverty Level Guidelines for children and adults - Link below: (See Appendix A – Current Federal Poverty Guidelines).

http://www.familiesusa.org/resources/tools-for-advocates/guides/federal-poverty-guidelines.html

Article VI. WVHA Termination

Section 6.01 Purpose

To establish criteria for the termination of member eligibility for WVHA Health Card programs.

Section 6.02 Policy

Termination of individuals from assigned programs may occur if evidence of the following is discovered:

1. Providing false information by evidence of submission or omission.
2. Failure to keep appointments
3. Abusive or disruptive behavior
4. Inappropriate or excessive use of Emergency Room Services
5. Inappropriate or excessive use of other provided services, including altered RX Prescriptions
6. Illegal possession of firearms or weapons
7. Physical or verbal threats
8. Enrollment in a Health Insurance Plan
9. Eligible for Medicaid
10. Eligible to enroll in ACA Marketplace private insurance, net of premium tax credits, for cost that is less than 8% of gross income.

If terminated for reasons 1,4,5,6,or 7, individuals may be determined temporarily ineligible by any agency contracted by WVHA to provide enrollment, access to healthcare, or healthcare services to indigent residents. Such temporary ineligibility shall continue until the next WVHA Board meeting where the Board shall determine how long the ineligibility will continue based on all information presented by the individual and contracted agency.

Termination of entire family unit from assigned programs may occur if evidence of the following is discovered:

1. Providing false information by evidence of submission or omission; changing, tampering or altering information printed on a Health Card in any way
2. Income exceeds guidelines
3. Assets exceed guidelines

If terminated for reason 1, entire family unit is ineligible for future consideration.

Article VII. WVHA Residency

Section 7.01 Purpose

This section defines residency as it relates to the WVHA Health Card eligibility process and identifies acceptable documentation to prove residency in the WVHA Taxing District (Appendix C - WVHA Taxing District (Zip Codes Included in District)).

Section 7.02 Policy

The applicant must reside in WVHA Taxing District. Except for those qualified as "homeless", residency exists when the applicant has lived within the WVHA Taxing District and has been a permanent resident for a minimum of three (3) months.

- Homeless residency is established when a homeless applicant registers at an approved social service agency and has been seen by that agency for at least one (1) month.
- Residency does not exist when the stay is for a temporary purpose or there is intent to return to another location outside of the WVHA Taxing District.
- Admission to an institution located within WVHA Taxing District does not constitute fulfillment of the residency requirement.
- A student attending school away from home is considered a resident of the county in which his parents reside if he is claimed as a dependent for federal income tax purposes.
- A visit to West Volusia County for any purpose does not qualify as residency.
- A temporary living arrangement in WVHA Taxing District prior to admission/treatment in a medical facility does not qualify as residency.
- Documentation supplied by the applicant to prove residency may not be used to verify the applicant's identity.
- For applications containing multiple applicants from the same household, documents for the head of household shall apply to all applicants in the same application for the purposes of establishing residency.
- For addresses not verifiable through the Volusia County Property Appraiser or Volusia County Tax Collector website, supporting documentation can be provided from the Property Appraiser or County Tax office confirming the street residence listed on the application is within the Volusia County taxing district. This is an option for the applicant to allow processing of the application to continue without being pended or denied.

Section 7.03 Procedures

All residency documentation must be copied and placed in the applicant's permanent case file. WVHA may request to see original documentation.

Residency for WVHA programs is satisfied when an applicant provides proof of WVHA Taxing District residency by presenting any two (2) of the following documents (The documents may be from different street addresses, as long as the street addresses are within the WVHA Tax District).

APPLICANT IS HOMELESS (only one (1) document required):

- WVHA Homeless Verification Form (Section 12.06) from an approved social service agency. (must have a valid mailing address)

APPLICANT LIVES WITH OTHERS **OR** RENTS/OWNS (Two (2) Documents required):

- WVHA Verification of Support (Section 12.07)
- Vehicle Registration
- Children registered in West Volusia Schools
- Mail received by applicant in West Volusia County for three (3) month period. (i.e. government correspondence, USPO change of address, court documents, other bills) If mail sent to a P.O. Box, the applicant's physical address must be noted in document. If online bills are provided they must include Date (Billing Period), Name, & Address. ~~Window envelopes are not acceptable.~~

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- Property tax bill
- Mortgage payment
- Lease Agreement/Contract
- WVHA Verification of Rent (Section 12.08)
- Utility bills

APPLICANT IS ENROLLED IN A FACILITY OR AGENCY PROGRAM:

- Letter from agency or group home where applicant is enrolled.
- Proof of West Volusia residency as outlined above for immediate past three (3) month period,
- If applicant was homeless prior to enrollment, then proof of residency for one (1) month as outlined above.

Section 7.04 Definitions

a. Property Tax Bill - For current or prior year depending on the date of application (most recent bill issued). WVHA Enrollment Certifying Agent will confirm data from Volusia County website.

b. Lease Agreement/Contract - The lease must be for the current year. The documentation must include landlord's name, address, telephone number, and lease start and end date.

c. Rent Receipts – The rent receipts must be for the immediate past three (3) months. If the required receipts are not available, a WVHA Verification of Rent form may be completed and signed by the rentor/lessor (Section 12.08).

d. Utility Bills - Electric, water, telephone, gas or other city or county utilities or other contracted service (i.e. pest control, cable service...) that would indicate the address the service is provided, for the past immediate three (3) months. These are only accepted as proof of residency for applicants that own or rent and must be in the same name as the applicant.

e. Enrollment in a Facility or Agency Program - Letter from agency or group home where applicant is enrolled. This form of documentation must be accompanied by an approved proof of residence for the past immediate three (3) months in the WVHA Taxing District prior to enrollment in the facility program. (Homeless – one (1) month –(Section 12.06)

f. WVHA Verification of Support- if the applicant is living with another party (Section 12.07).

g. WVHA Homeless Verification Form from a WVHA approved social service agency (Section 12.06)

h. Vehicle Registration in the name of applicant/spouse. Must be current and include address in the WVHA Taxing District.

i. Proof of children registered in area schools.

- Applicants that provide a WVHA Verification of Support, may be subject to verification through skip tracing, credit report and property search tools. The relationship between the applicant(s) and the person providing support to the applicant must be indicated.
- All proof of residency documents must show street address within the WVHA Tax District.
- Post office boxes may be used for mailing purposes only. Applicants mailing address must include their residence physical address. Applicants with post office boxes are still required to meet all residency requirements. The USPO will deliver mail to a post office box shown on the line directly above City and State line and physical address shown below name.

Example: Name of applicant
Street Address
Post Office Box
City, State and Zip

Note: Any WVHA member mail or correspondence returned to WVHA Enrollment Certifying Agent as undeliverable or with an invalid address will be subject to suspension of coverage until a new application can be processed or address is verified by applicant.

Article VIII. WVHA Identification

Section 8.01 Purpose

To define identification as it relates to WVHA eligibility.

Section 8.02 Policy

Every applicant must provide copies of two (2) acceptable documents (one must be a photo I.D.) to prove his/her identity. Identification must be current.

Section 8.03 Procedures

The following define acceptable documentation for proving identification.

a. Birth Certificate
b. Florida Picture Identification Card (Such as Florida Driver's License with West Volusia address)
c. Social Security Card
d. The Farmworker Association of Florida, Inc. (Photo Identification with correct address)
e. Passport
f. Certificate or official document that includes name, address, and social security number (such as a tax form or social security document).
g. Alien Registration receipt card, (Green card, Form I-151 or I-551)
h. Any government issued photo identification

Article IX. WVHA Income

Section 9.01 Purpose

To identify the sources, calculation, and verification of income and how it relates to the WVHA Health Card eligibility process.

Section 9.02 Policy

The WVHA Board will set the income levels allowable for inclusion into the WVHA programs.

All income must be verified by the source of the income.

Income will be calculated using a Quarterly (thirteen weeks) or Annual (fifty-two weeks) method.

Section 9.03 Definitions

Gross Income-The amount of income received as of the date of the application for the prior twelve (12) month time period under consideration. For family size of two or more, income for all household members must be included.

Section 9.04 Procedures

The following are considered as sources of income or value for the purposes of determining eligibility:

1. Wages, salaries and gratuities, Pay Stubs for previous 8 weeks
2. Social Security Benefits for any household member
3. Supplemental Social Security Income (SSI) or Disability Benefits
4. Temporary Assistance for Needy Families (TANF)
5. Retirement or Pension Benefits, Stocks, Bonds and Annuities (e.g., 401K, 403B, IRA, SEP)
6. Royalties and Rents/Income from Rental Property
7. Unemployment/Worker's Compensation Statement
8. Veterans or Military Benefits/Allotments
9. Strike Benefits
10. Insurance and Annuity Income
11. Dividends and Interest Earnings (stocks, bonds, etc...)
12. Estate and Trust Fund Income
13. Private Loans of a Recurring Nature
14. Training Stipends
15. Alimony/Child Support
16. Inheritance
17. Compensation for an Injury/Settlements
18. Gifts-(include donations from churches, other organizations and family members.)
19. Insurance Payments
20. Self-employment Income. Defined as the amount of "net profit (loss)" as reported on tax return Form 1040 Schedule C, line 31. The WVHA Enrollment Certifying Agent may request supporting documentation for deductions not in line with industry standards. Deductions for personal expenses and wages will be adjusted accordingly. (Include last Quarter Financial Statements, bank settlements and most recent Tax Return)
21. All sources of value including free rent and barter goods will be used to determine the applicant's income
22. Housing Assistance Statement (Section Eight)
23. Food Stamps/Social Pensions
24. DCF Verification of Employment/Loss of Income Form

25. WVHA Verification of Support Form (Section 12.07) (unemployed applicants)
26. Most Recent Tax Return, 1040
27. Other income from any other source

(a) Verification of Income

1. Income verification is accomplished by submitting copies of the
    a. Most recent individual income tax return, Form 1040 and W-2's for all wage earners in household
    b. Recent paystubs- Eight (8) weeks prior or Florida DCF Verification of Employment/Loss of Income Form from current employer and/or Year to Date for all jobs.
        1. If applicant has recently lost their job, the Loss of Income Section of the DCF Verification of Employment/Loss of Income Form must be completed.
    c. Bank Statements (previous three (3) months) include all pages
    d. Medicaid Denial Letter or proof of Medicaid application and date of application. (Clinics, specialists, pharmacy and hospitals should check for Medicaid eligibility each time a patient presents for services, even if the patient has a current WVHA Health Card). Applicants unable to provide documentation of citizenship will be exempt from applying for Medicaid.
    e. Unemployment/Worker's Compensation Statement. Applicants unable to provide documentation of citizenship will be exempt from applying for unemployment benefits.
    f. Child Support/Alimony
    g. Social Security Benefits for any family member
    h. Pensions/Retirements/Interest
    i. Veterans Benefits
    j. Any settlements, court ordered or otherwise. Evidence of amount and duration of all settlements are required.
    k. Other appropriate supporting documents.
    l. Self-Employment
        1. Bank Statements for all business accounts for the last 3 (three) months; all pages must be included
        2. Previous Year's Business Tax Return-complete w/attachments/schedules
        3. Most recent self-employment quarterly financial statement

(b) Calculation of Income

2. The calculation of income is calculated by the annual method. This method calculates the previous twelve (12) months of gross earnings received to establish a monthly average income (MAI). This MAI is compared to the WVHA Board approved level as it relates to the Federal Poverty Level Guidelines, to determine qualification for the WVHA programs.
3. The following methods shall be used to compute MAI:
    a. Hourly rate known x 2080 hours (year) divided by 12 = monthly income
    b. Weekly rate known x 52 weeks (year) divided by 12 = monthly income
    c. Bi-weekly rate known x 26 weeks (year) divided by 12 = monthly income
    d. Yearly rate known divided by 12 = monthly income
    e. If the applicant has worked or will work part of the year, the monthly income amount will be determined predicated upon the number of months worked. For example, if the applicant

works 9 months, then the total amount of earnings during the 9 months will be divided by 12 to arrive at a monthly income amount.

If an applicant is claiming $0 income and **lives alone**, the applicant must provide a notarized WVHA Verification of Support Form which includes statement of monthly household expenses that are paid on his/her behalf. This amount is considered applicant's monthly income. The relationship between the applicant(s) and the person providing support to the applicant must be indicated.

If an applicant is claiming $0 income and **resides with others** the applicant must provide a notarized Verification of Support Form which includes statement of monthly household expenses and the number of people in the household. (Divide the total expenses by the number of people in household to calculate the applicant's monthly income amount) The relationship between the applicant(s) and the person providing support to the applicant must be indicated.

Article X. WVHA Assets

Section 10.01 Purpose

To identify sources, calculation and verification of assets and how it relates to the WVHA Health Card eligibility process

Section 10.02 Policy

The WVHA Board will set the asset levels allowable for inclusion into the WVHA programs.

Section 10.03 Procedures

The following are considered assets that are ***excluded*** from asset calculations.

1. Assets Excluded
    a. One homestead-A homestead is defined as a house, trailer, boat or motor vehicle in which the family unit resides.
    b. Household furnishings
    c. One automobile in operating condition
    d. Clothing
    e. Tools used in employment
    f. Cemetery plots, crypts, vaults, mausoleums and urns
    g. Produce and animals raised for the applicant's personal home consumption
    h. Long term fixed retirement accounts (e.g., 401K, 403B, IRA, SEP). Income from these accounts will still be included when calculating household income.
    i. Assets that are jointly owned by an applicant who is deemed a victim of domestic violence can be excluded when that asset is jointly owned with the accused and the applicant is no longer residing in the homestead.
        i. Official court documentation, such as a restraining order, must be supplied as proof that the applicant is a victim of domestic violence.
        ii. The WVHA Health Card program will require a certified statement from a court official, or a notarized statement from the applicant attesting that the applicant is unable to liquidate the subject asset because of a domestic violence situation.

In order to be considered, an asset must first be "available" to the applicant or family unit. An asset is available if the applicant or member of the family unit has the right, authority or power to liquidate the property or his share of the property. The following assets, if "available," must be considered toward the asset limit:

2. Assets to be considered
    a. Checking and saving accounts- the value of a checking or savings account excludes amounts deposited in the four (4) weeks prior to application because such funds are counted as income.
    b. Equity value of real property other than homestead. The value is verified by the county appraiser of the county in which the property is located. The equity value is determined by subtracting the amount of any encumbrances from the value of the asset. The encumbrances subtracted from the property value (for the purpose of the asset calculation under this program) must be tied to the property through formalized legal obligation. Generally this is a recorded lien or mortgage where the financial institution retains the title to a property until the borrower repays the amount, in turn prohibiting the owner from exercising full control over their property (i.e.: receiving payment from a buyer when selling or transferring the title). An unrecorded loan provided to the property owner [for example a loan from a friend or family member] is not considered an encumbrance for asset amount determination.
    c. Cash surrender value of life insurance, if the combined face value of all policies owned by the family unit exceeds $1,500.

d. Additional automobiles or motor vehicles- applicant should provide either the N.A.D.A. Book value or the vehicle registration and mileage. Otherwise, the WVHA Enrollment Certifying Agent will assign value at the average N.A.D.A. value of the vehicle.

e. Recreational vehicles-With value determined by a statement from a commercial seller of such vehicles and verified by photocopies of registration.

f. Trusts. With value based on the principal of the trust and verified by a statement from the Trustee.

g. Stocks, bonds and other investment assets. With value verified by the value listed in stock value of newspaper or statement from other reliable sources.

- To determine whether Assets are within the Limits for the WVHA Health Card Program, refer to the chart located in Section 12.03.
- If family unit's available assets are less than or equal to the amount shown on the chart for a household of the same size, then the applicant has met the asset criterion for the WVHA Health Card Program.
- If family unit's available assets are greater than the amount shown on the chart for a household of the same size, then the applicant is not eligible to participate in the WVHA Health Card Program.

Article XI. Appendices

Section 11.01 Appendix A – Current Federal Poverty Guidelines

2019 POVERTY GUIDELINES FOR THE 48 CONTIGUOS STATES AND THE DISTRICT OF COLUMBIA

~~2018 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA~~

Persons in family/household~~Persons in family/household~~	Poverty guideline ~~Poverty guideline~~	150% ~~150%~~
1	$12,490~~$12,140~~	$18,735~~$18,210~~
2~~2~~	$16,910$16,460	$25,365$24,690
3~~3~~	$21,330~~$20,780~~	$31,995~~$31,170~~
4~~4~~	$25,750~~$25,100~~	$38,625~~$37,650~~
5~~5~~	$30,170~~$29,420~~	$45,255~~$44,130~~
6~~6~~	$34,590~~$33,740~~	$51,885~~$50,610~~
7~~7~~	$39,010~~$38,060~~	$58,515~~$57,090~~
8~~8~~	$43,430$42,380	$65,145$63,570
For families/households with more than 8 persons, add $4,420 for each additional person.For families/households with more than 8 people, add ~~$4,320 for each additional person.~~		

SOURCE: https://aspe.hhs.gov/poverty-guidelines

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Section 11.02 Appendix B - Asset Limits

WVHA Health Card Program
ASSET LIMITS

If family unit's available assets are <= the amount shown on the chart for a household of the same size, then the patient has met the asset criterion for the WVHA Health Card Program.

If family unit's available assets are > the amount shown on the chart for a household of the same size, then the applicant is not eligible to participate in the WVHA Health Card Program.

FAMILY SIZE	ASSET LIMIT
1	$5,000
2	$5,500
3	$6,000
4	$6,500
5	$7,000
6	$7,500
7	$8,000
8	$8,500
9	$9,000
10	$9,500

Each Additional Person $500

http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Public_Notice.pdf

(this link to the medically needy guidelines does not work & I couldn't find this chart for 2019 anywhere)

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These limits follow limits set forth in the Medicaid Medically Needy guidelines and may be updated accordingly.

West Volusia Hospital Authority Taxing District

Zip Codes

32102	Astor * (Only Volusia County Side)
	If address has 5 numbers- Lake County
32105	Barberville
32130	DeLeon Springs
32180	Pierson
32190	Seville
32706	Cassadaga
32713	DeBary
32720	DeLand * (Only Volusia County Side)
	If address has 5 numbers – Lake County Side
32721	DeLand (P.O. Boxes)
32722	Glenwood
32723	DeLand
32724	DeLand
32725	Deltona
32728	Deltona
32738	Deltona
32739	Deltona
32744	Lake Helen
32754	Mims * (Only Volusia County)
32763	Orange City
32764	Osteen
32774	Orange City

* These zip codes overlap other counties. Look up record on ***Volusia County Property Appraiser*** or ***Volusia County Tax Collector*** websites to confirm they are located within the county.

WVHA HEALTH CARD APPLICATION

Application Date:	

Section 1: Applicant Information. All members of Household may apply through same application. Please indicate all applicants in Section 2 'Members of the Household'.

Last	First	Middle	Maiden or Other Name

Physical Address (where you reside)

City	County	State	Zip

Mailing Address

City	State	Zip

How long have you lived at residence?	Temp/Perm	Rent/Own/Other	Daytime Telephone	Evening Telephone

Date of Birth	Sex (circle one) Male Female	Social Security Number

Previous address if less than 3 months

City	State	Zip

Section 2: Members of the Household. List legal spouse, dependent children, stepchildren, adopted children, unrelated minor with proof of custody, children over 18 up to 24 years old that are full time students and claimed on parent's income taxes as dependents.

Name	Applying for Health Card	DOB	Relationship	SS#
1.	Yes No (circle one)			
2.	Yes No (circle one)			
3.	Yes No (circle one)			
4.	Yes No (circle one)			
5.	Yes No (circle one)			
6.	Yes No (circle one)			
7.	Yes No (circle one)			
8.	Yes No (circle one)			

Section 3: Authorization to Release Medical and Individually-Identifiable Protected Health Information (PHI).

All Applicants over 18 must sign below or application will be pended.

I on my behalf and on behalf of any applying family member under the age of 18, do hereby authorize West Volusia Hospital Authority (WVHA), Northeast Florida Health Services, Inc. (NFHS), and any of their successors and/or assigns and any of their independent sub-contractors and participating providers, to release and exchange any and all data, records and information related to medical records and individually identifiable protected health information (PHI) in their respective capacities as covered entities under HIPAA, and as allowable under federal and state laws, including but not limited to the data, records and information as necessary to provide care and/or administer the WVHA Indigent Health Card Program.

I hereby waive, relinquish and release the organizations referenced above, who have been granted the authority to release information to each other and otherwise, from any and all claims arising out of my authorization to release this information in accordance with the terms of this document.

A photocopy of this Authorization is considered as valid as the original. You are entitled to make and return a photocopy of this authorization. The authorization referenced above in regards to medical records shall remain in effect indefinitely unless property terminated by written notice.

I certify that the information given by me for the purpose of qualifying for the WVHA Health Card Program is true and correct. I understand and hereby authorize WVHA and its agents to conduct such investigation, including, but not limited to obtaining my credit report, as necessary to verify the accuracy of the information provided. I understand that any misrepresentation by evidence of submission or omission may result in my termination from the WVHA Health Card Program.

Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date
Signature of Applicant or Legal Representative	Date

WVHA HEALTH CARD ASSESSMENT FORM

Screened by
(THND Representative):_____

Instructions: Please complete this form in its entirety. This form must be completed by all applicants over 18, including legal spouses who are not applying. *Failure to provide separate WVHA Health Card Assessment Forms will results in a Pended application.*

Section 1: General Information.

Date	Applicant Name	Date of Birth	Clinic

How did you hear about the WVHA Health Card Program? Check one box:

☐ WVHA Webpage ☐ Printed advertisement or flyer ☐ Public meeting ☐ Florida Hospital ☐ The House Next Door
☐ Rising Against All Odds ☐ The Neighborhood Center ☐ Healthy Start ☐ Hispanic Health ☐ Other

Section 2: Insurance Information.

2.1 Do you have any Medical Insurance?	☐ Yes *If Yes, please indicate Carrier and ID #:* _____	☐ No
2.2 Are you eligible for COBRA Benefits from a current/prior employer?	☐ Yes	☐ No
2.3 Do you have Medicare A or B?	☐ Yes *If Yes, please indicate which coverage you are enrolled in & effective date* _____	☐ No
2.4 Do receive healthcare assistance or aid other than WVHA?	☐ Yes *If Yes, please indicate the assistance and/or aid you receive & effective date* _____	☐ No
2.5 If you are seeking services for an injury, is your injury due to a work related or auto accident?	☐ Yes *If Yes, please describe* _____	☐ No

2.6 Proof of Medicaid application or denial is required. Please ensure to include this with your submission

Section 3: Family Size.

3.1 Marital Status (Circle One): Married Separated Divorced Single Widow

3.2 Do you have any dependent children living in the household?	☐ Yes *If Yes, how many?* _____	☐ No

Section 4: Identification.

4.1 Do you have a Driver License or other Government ID?	☐ Yes *If Yes, please provide a copy of ID*	☐ No

4.2 Two (2) forms of ID are required, one (1) must be a picture ID. Please circle any other proof of identification provided other than a Driver License.

Non-Picture ID:	Picture ID:
-Social Security Card	-Passport
-Birth Certificate	-Green Card
-Certificate or Official Document w/ Name, Address, & SSN	-Form I-151
	-Form I-551
	-Farmworkers Association of Florida-Photo ID

Section 5: Residency.

5.1 Do you own the house where you live?	☐ Yes *If Yes, please provide Property Tax Bill of current or prior year*	☐ No
5.2 Do you rent?	☐ Yes *If Yes, please provide a copy of current Lease Contract or Verification of Rent Form*	☐ No
5.3 Do you live in someone else's house?	☐ Yes *If Yes, please provide Verification of Support Form*	☐ No
5.4 Do you consider yourself homeless?	☐ Yes *If Yes, please provide Homeless Verification Form*	☐ No

5.5 All proof of residency documents must show street address within the WVHA Tax District and must be for the past immediate 3 months. Two (2) forms of residency are required, unless you are homeless applicant. Homeless applications only need to submit the Homeless Verification Form.

Please circle any other proof of residency provided:

- Utility Bills (Electric, Water, Telephone, Gas, etc.)
- Mail received for three (3) month period
- Vehicle Registration in the applicant/spouse's name
- Mortgage Payment
- Proof of children registered in West Volusia School

Section 6: Financial Information.

6.1 Have you been employed in the last 8 weeks?	☐ Yes *If Yes, complete the below & provide previous 8 weeks worth of paystubs or DCF Verification of Employment/Loss of Income Form*	☐ No

Employer Name	Pay Rate (circle one) Hourly Daily Weekly Biweekly Monthly
Employer Address	
City State	Zip

6.2 Have you lost your job in the last 8 weeks?	☐ Yes *If Yes, please provide a DCF Verification of Employment/Loss of Income Form*	☐ No
6.3 Are you self-employed?	☐ Yes *If Yes, please provide most recent tax return (complete with all schedules/forms) or self-employment quarterly statement*	☐ No
6.4 Are you receiving Unemployment or Worker's Comp benefits?	☐ Yes *If Yes, please provide Unemployment or Worker's Comp Documents*	☐ No
6.5 Is someone else supporting you financially?	☐ Yes *If Yes, please provide notarized Verification of Support Form*	☐ No
6.6 Do you receive Veteran or Military Benefits?	☐ Yes *If Yes, please provide benefits paperwork*	☐ No
6.7 Do you receive any settlements?	☐ Yes *If Yes, please provide settlement paperwork*	☐ No
6.8 Do you receive Food Stamps?	☐ Yes *If Yes, please provide supporting documentation from Florida DCF along with approved amount.*	☐ No
6.9 Are you receiving any monthly Pension or Retirement Income?	☐ Yes *If Yes, please provide documentation with amount you receive, if applicable*	☐ No
6.10 Do you receive Alimony/Child Support Income?	☐ Yes *If Yes, please provide documentation with amount you receive, if applicable*	☐ No
6.11 Do you receive any income from rental properties?	☐ Yes *If Yes, please provide rental income amount and rental agreement*	☐ No
6.12 Do you receive Social Security Income/Disability Benefits?	☐ Yes *If Yes, please provide supporting documentation*	☐ No

Section 7: List All Sources of Income for the Household (i.e. Temporary Assistance for Needy Families, Strike Benefits, Insurance/Annuity Income, Dividend/Interest Earning, Training Stipends, Compensation for Injury/Settlement, Gifts-from Churches/family/organizations, etc.) Please provide all supporting documentation for any income listed below.

Individual's Name	Type of Income	Source of Income or Employer	Monthly Amount (before deductions)

Section 8: Assets		
8.1 Do you have a checking/savings account?	☐ Yes *If Yes, please provide copy of statements for all the accounts for last 3 months*	☐ No
8.2 Do you own a Business?	☐ Yes *If Yes, please provide last Quarter Business Financial Statements and Bank Statements*	☐ No
8.3 Do you own property(ies) in other counties/states or country (including rental properties that you own)?	☐ Yes *If Yes, please list all the properties you own below, including lots, & provide any outstanding mortgage documentation outside of your permanent residence*	☐ No

Property Address		Is this a rental property? ☐ Yes	☐ No
Property Address		Is this a rental property? ☐ Yes	☐ No
Property Address		Is this a rental property? ☐ Yes	☐ No
8.4 Have you sold or transferred title to any property in the last 3 years?	☐ Yes *If Yes, please list all the properties, including lots and supply supporting documentation as proof of this sale*		☐ No
Property Address	Date of Sale: __/__/_____	Is this a rental property? ☐ Yes	☐ No
Property Address	Date of Sale: __/__/_____	Is this a rental property? ☐ Yes	☐ No
Property Address	Date of Sale: __/__/_____	Is this a rental property? ☐ Yes	☐ No
8.5 How many automobiles, motorized vehicles or motorcycles do you own? Single automobile should only be recorded on one applicant's assessment form	_____ *For two or more vehicles also include the value as determined by N.A.D.A book along with vehicle(s) registration.*		
8.6 Do you own any recreational vehicles?	☐ Yes *If you do own, please provide vehicle(s) registration along with the value determined by a statement from a commercial seller of such vehicle(s)*		☐ No

Section 9: List All Sources of Assets for the Household (i.e. IRAs, CDs, Inheritances, pensions, stocks, trust funds, cash surrender value of life insurance, etc.). Please provide all supporting documentation for any assets listed below.

Asset Type	Source of Asset	Amount	Monthly or Lump Sum	
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum
			☐ Monthly	☐ Lump Sum

Section 10: Applicant Certification.

I certify that the information given by me for the purpose of qualifying for the WVHA Health Card Program is true and correct. I understand and hereby authorize WVHA and its agents to conduct such investigation, including, but not limited to obtaining my credit report, as necessary and at any time during the application process, enrollment or after benefits have been assigned to verify the accuracy of the information provided. I understand that any misrepresentation by evidence of submission or omission may result in my termination from the WVHA Health Card Program.

Signature of Individual or Legal Representative	Date

WVHA Homeless Verification Form

Agency Instructions: *To be printed on Agency letterhead.* Please complete this form in its entirety.
Failure to provide all information on Homeless Verification Form will result in a Pended application.

Section 1: General Information.

Date	Client Name	Date of Birth	Photo ID Number

Section 2: Mailing Address.

Mailing Address (where your WVHA Health Card correspondences should be mailed)

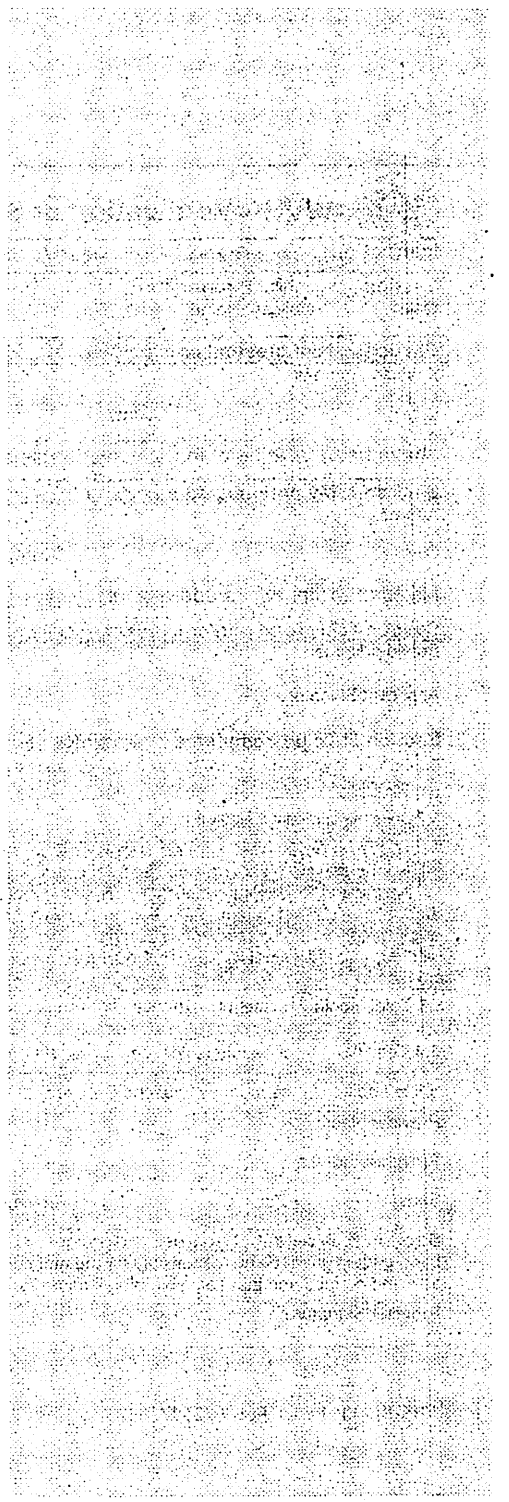
City	County	State	Zip

Length of time in Volusia County

Section 3: Agency Assessment.

I, _____, based on my assessment certify that the client has met the H.U.D. definition of homeless and has been within the West Volusia Tax District for at least one month.

Agency Signature:	Date:
Client Signature:	Date:



WVHA Verification of Support

Instructions: Please complete this form in its entirety. *Failure to provide all information on Verification of Support Form will result in a Pended application.*

Section 1: General Information.

Date	Applicant Name	Date of Birth	Last Four Digits of SSN

Section 2: I am presently residing at.

Physical Address			
City	County	State	Zip

I have been residing at the above address since: _____

Section 3: My previous address was.

Address			
City	County	State	Zip

I lived at this previous address for: _____

Section 4: My food and/or living expenses are provided by.

Provider Name	
Applicant Signature	Date

Section 5: To be completed by Provider.

5.1 Do you only provide a place to stay (rent free) and no monthly expenses are provided to the applicant?	☐ Yes	☐ No
5.2 Does the applicant reside with you?	☐ Yes	☐ No

- INSTRUCTIONS FOR QUESTIONS 5.3, 5.4, AND 5.5 -

- The amount listed below should be the household expenses for where the applicant resides.
- If the provider pays for household expenses on behalf of the applicant (even if they live in separate homes) the dollar amount must be listed here. Question 5.4 would then indicate the qualified family members on the WVHA Health Card application that the provider is supporting.
- If the provider DOES NOT pay for household expenses on behalf of the applicant, please indicate $0 or N/A on 5.3 and 5.4

5.3 Total monthly household expenses covering all residents (rent, electric, water, groceries, etc.) $_____

5.4 Total number of people residing in household (including the applicant) _____

5.5 In addition to the monthly household expenses, I provide $_____ per month to the applicant.

Provider Name		Relationship to Applicant
Provider Address		City
State	Zip	Provider Phone No.

Section 6: Provider Signature & Notary.

I, the undersigned, being responsible for the named applicant, do hereby swear that the information contained herein is true and correct, and that I am providing support for named applicant.

Provider Signature:	Date:

Notary Public	Notary Public Seal:

Section 12.07 Appendix G - WVHA Verification of Support Form

WVHA Verification of Rent

Instructions: Please complete this form in its entirety. *Failure to provide all information on Verification of Rent Form will result in a Pended application.*

Section 1: General Information.

Date: Applicant Name:	Date of Birth:	Last Four Digits of SSN:

Section 2: I am presently residing at.

Physical Address			
City	County	State	Zip

2.1 The monthly rent is $_____.

2.2 I began renting at the above location on the following date _____.

Applicant Signature	Date

Section 3: Rentor/Lessor Information. Must be completed by the Rentor/Lessor

Rentor/Lessor Name	Rentor/Lessor Phone Number

Rentor/Lessor Address		
City	State	Zip

Relationship to Tenant

Tenant Name

3.1 I am renting the address listed above in Section 2 to the applicant since _____ (date).

3.2 The current monthly rental rate is $_____.

3.3 The monthly rent does / does not (circle one) include utilities.

3.4 If yes, list utilities included.

Section 4: Rentor/Lessor Signature

I, the undersigned, do hereby swear that the information contained herein is true and correct.

Rentor/Lessor Signature	Date

Affordable Care Act Enrollment Prequalifying Intake Interview 2017-18

Person Assisting_____**DATE:**_____

Last Name _____ **First Name**_____ **MI**_____

Phone #_____**Zip Code**_____ **County**_____

The below set of questions will help us determine if you are eligible for the Affordable Care Marketplace. Upon qualification the Person Assisting will help you enroll in HealthCare.Gov.

In the event you're not eligible at this time, you will be given this supporting document which will serve as proof you attempted to apply for the marketplace. At such time you will be given options for health care and instructions on how to apply for alternative coverage.

Those that are not covered by the marketplace due to ineligibility are protected from the:

- **2% yearly household income penalty or**
- **$325 per person for the year ($162 per child under 18. The maximum penalty per family using this method is $925 per family.**

If you don't have coverage in 2018, you'll pay the higher of these two amounts.

1. A Veteran? Yes__ No__ If yes, will they be willing to drop all of their coverage through VA? (If both Yes, proceed with enrollment)
2. A Native American? Yes_____ No_____ (If yes, will not qualify for subsidy.)
3. Parent of children already on Healthy Kids plan? Yes_____ No_____
4. Under age 64? Yes_____No_____ If older, they are or soon will be covered by Medicare
5. Currently Covered by Medicaid? Yes_____ No_____
6. Do you or anyone in your household have employer coverage or been offered employer coverage? Yes__ No__ (If Yes, will not qualify for subsidy but may still shop the marketplace)
7. Do you have verifiable income? Yes____ No____ Threshold is $11,770 for 1 person or $15,930 for a couple.

20189 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

Persons in family/household	Poverty guideline	150%
1	~~$12,140~~12,490	$18,~~210~~735
2	$16,~~460~~910	$25,~~365~~4,~~690~~
3	$21,~~330~~0,~~780~~	$31,~~995~~1~~70~~
4	$25,~~750~~100	$38,~~625~~7,~~650~~
5	$30,~~170~~29,420	$45,~~255~~4,130
6	$34,~~590~~3,~~740~~	$51,~~885~~0,~~610~~
7	$39,~~010~~8,~~060~~	$58,~~515~~7,~~090~~
8	$43,~~430~~2,380	$65,~~145~~3,~~570~~
For families/households with more than 8 people, add $4,~~3~~420 for each additional person.		

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I attest that the Person Assisting has discussed the qualifications to enroll and that I understand my eligibility and options for healthcare. (Check circle that applies)

- o **I qualify for the Marketplace and I'm enrolling today**
- o **I don't qualify for the Marketplace because my income falls below the poverty guideline**
- o **I qualify for the Marketplace but the cost of the premiums (net of any tax credits/subsidies) is more than 8% of my gross annual income.**

_____ _____

Signature of Consumer **Signature of Person Assisting**

WVHA Health Card: Self Employment Quarterly Statement

Instructions: Please complete this form in its entirety. This form must be completed if you are self-employed and do not make enough to file on income taxes. *Failure to provide all information on the form will result in a Pended application.*

1. **APPLICANT'S NAME:** (First) (M.I.) (Last)
2. **APPLICANT'S PERCENTAGE OF OWNERSHIP IN THIS BUSINESS:** _____%
3. **BUSINESS OWNER NAME(S)** (First) (M.I.) (Last)
4. **BUSINESS NAME:**
5. **BUSINESS ADDRESS:** | 6. **BUSINESS PHONE #**

Section 1: -Total Gross Income- Add total monthly income and sales from your business each of the past 3 months	**MONTH 1** _____/_____ (MM) (YY)	**MONTH 2** _____/_____ (MM) (YY)	**MONTH 3** _____/_____ (MM) (YY)
	1A: $	**2A:** $	**3A:** $

Section 2: Business Expenses	**DEDUCTIONS**	**DEDUCTIONS**	**DEDUCTIONS**
Supplies	$	$	$
Heat/Utilities/Phone			
Business property rent			
Business Equipment Rent			
Business Vehicle Expenses			
Business Taxes			
Advertising			
Insurance			
Bank Charges			
Other (specify)			
TOTAL Business Expenses	**1B:** $	**2B:** $	**3B:** $
NET INCOME: Subtract A FROM B = C	**1C:** $ (1A minus 1B)	**2C:** $ (2A minus 2B)	**3C:** $ (3A minus 3C)

Section 3: Calculate average monthly income

TOTAL 3 MONTHS: $_____ (ADD 1C, 2C, 3C)	**AVERAGE 3 MONTHS:** $_____ (DIVIDE TOTAL 3 MONTHS BY 3)

APPLICANT SIGNATURE: Applicants must read and sign the below

I certify that I have no other way to document the above self-employment income and that all of the above information is true and correct. I attest that all income and expenses on this form are truly for my self-employment business.

Signature	**Date**

West Volusia Hospital Authority
Financial Statements
April 30, 2019

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountant | Registered Investment Advisor
1006 N. Woodland Boulevard ■ DeLand, FL 32720
(386) 734-9441 www.drtcpa.com

Ronald J. Cantlay, CPA/CFP®
James H. Dreggors, CPA
Victoria A. Kizma, CPA
Robin C. Lennon, CPA

John A. Powers, CPA
Ann J. Rigsby, CPA/PFS/CFP®
Melissa J. Trickey, CPA

To the Board of Commissioners
West Volusia Hospital Authority
P. O. Box 940
DeLand, FL 32720-0940

Management is responsible for the accompanying balance sheet (modified cash basis) of West Volusia Hospital Authority, as of April 30, 2019 and the related statement of revenues and expenditures - budget and actual (modified cash basis) for the month then ended and year-to-date, in accordance with accounting principles generally accepted in the United States of America. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

The accompanying supplemental information contained in Schedules I and II is presented for purposes of additional analysis and is not a required part of the basic financial statements. This information is the representation of management. The information was subject to our compilation engagement; however, we have not audited or reviewed the supplementary information and, accordingly, do not express an opinion, a conclusion, nor provide any assurance on such supplementary information.

Management has elected to omit substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Authority's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

We are not independent with respect to West Volusia Hospital Authority.

Dreggors, Rigsby & Teal, P.A.

Dreggors, Rigsby & Teal, P.A.
Certified Public Accountants
DeLand, FL

May 02, 2019

West Volusia Hospital Authority
Balance Sheet
Modified Cash Basis
April 30, 2019

Assets

Current Assets		
Petty Cash	$	100.00
Intracoastal Bank - Money Market		8,912,098.91
Intracoastal Bank - Operating		1,101,686.55
Mainstreet Community Bank - MM		10,508,213.70
Taxes Receivable		92,073.00
Total Current Assets		**20,614,172.16**
Fixed Assets		
Land		145,000.00
Buildings		422,024.71
Building Improvements		350,822.58
Equipment		251.78
Total Fixed Assets		**918,099.07**
Less Accum. Depreciation		(296,440.64)
Total Net Fixed Assets		**621,658.43**
Other Assets		
Deposits		2,000.00
Total Other Assets		**2,000.00**
Total Assets		**21,237,830.59**

Liabilities and Net Assets

Current Liabilities		
Security Deposit		5,110.00
Deferred Revenue		88,660.00
Total Current Liabilities		**93,770.00**
Net Assets		
Unassigned Fund Balance		10,444,019.53
Restricted Fund Balance		208,000.00
Nonspendable Fund Balance		621,658.43
Net Income Excess (Deficit)		9,870,382.63
Total Net Assets		**21,144,060.59**
Total Liabilities and Net Assets	$	**21,237,830.59**

West Volusia Hospital Authority
Statement of Revenue and Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 7 Months Ended April 30, 2019

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Revenue				
Ad Valorem Taxes	20,194,000	1,034,434	19,391,343	802,657
Investment Income	55,000	15,241	81,720	(26,720)
Rental Income	70,968	11,384	45,536	25,432
Total Revenue	**20,319,968**	**1,061,059**	**19,518,599**	**801,369**
Healthcare Expenditures				
Adventist Health Systems	5,848,544	314,446	3,216,981	2,631,563
Northeast Florida Health Services	1,700,603	278,889	803,132	897,471
Specialty Care	4,375,000	238,006	1,666,171	2,708,829
County Medicaid Reimbursement	2,385,000	195,966	1,371,765	1,013,235
The House Next Door	120,000	10,320	52,870	67,130
The Neighborhood Center	70,000	7,625	46,325	23,675
Community Life Center Outreach Services	20,000	0	550	19,450
Rising Against All Odds	235,000	12,000	86,508	148,492
Community Legal Services	76,931	7,326	34,921	42,010
Hispanic Health Initiatives	75,000	7,475	28,050	46,950
Florida Dept of Health Dental Svcs	200,000	20,179	117,682	82,318
Good Samaritan	60,000	0	0	60,000
Stewart Marchman - ACT	925,336	240,629	770,295	155,041
Health Start Coalition of Flagler & Volusia	142,359	12,051	69,517	72,842
H C R A	819,612	0	116,115	703,497
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**1,344,912**	**8,380,882**	**9,767,593**
Other Expenditures				
Advertising	5,000	656	4,358	642
Annual Independent Audit	16,000	0	16,100	(100)
Building & Office Costs	6,500	0	2,437	4,063
General Accounting	68,100	4,490	34,568	33,532
General Administrative	65,100	4,890	23,686	41,414
Legal Counsel	70,000	5,300	29,410	40,590
Special Accounting	5,000	0	0	5,000
City of DeLand Tax Increment District	100,000	0	72,444	27,556
Tax Collector & Appraiser Fee	603,880	20,684	528,198	75,682
TPA Services	500,000	35,967	337,355	162,645
Eligibility / Enrollment	30,000	0	4,221	25,779
Healthy Communities	72,036	5,650	33,875	38,161
Application Screening				
Application Screening - THND	317,872	31,122	138,893	178,979
Application Screening - RAAO	34,005	3,264	24,768	9,237
Application Screening - SMA	3,000	84	84	2,916
Workers Compensation Claims	25,000	7,390	13,429	11,571
Other Operating Expenditures	250,000	663	3,509	246,491
Total Other Expenditures	**2,171,493**	**120,160**	**1,267,335**	**904,158**
Total Expenditures	20,319,968	1,465,072	9,648,217	10,671,751
Excess (Deficit)	**0**	**(404,013)**	**9,870,382**	**(9,870,382)**

See Accountants' Compilation Report

West Volusia Hospital Authority
Schedule I - Healthcare Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 7 Months Ended April 30, 2019

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Healthcare Expenditures				
Adventist Health Systems				
Florida Hospital DeLand	2,811,772	256,771	1,770,603	1,041,169
Florida Hospital Fish Memorial	2,811,772	56,402	1,383,190	1,428,582
Florida Hospital DeLand - Physicians	112,500	547	32,921	79,579
Florida Hospital Fish - Physicians	112,500	726	30,268	82,232
Northeast Florida Health Services				
NEFHS - Pharmacy	752,281	98,855	384,854	367,427
NEFHS - Obstetrics	30,000	10,357	28,537	1,463
NEFHS - Primary Care	918,322	169,677	389,741	528,581
Specialty Care	4,375,000	238,006	1,666,171	2,708,829
County Medicaid Reimbursement	2,385,000	195,966	1,371,765	1,013,235
Florida Dept of Health Dental Svcs	200,000	20,179	117,682	82,318
Good Samaritan				
Good Samaritan Health Clinic	30,000	0	0	30,000
Good Samaritan Dental Clinic	30,000	0	0	30,000
The House Next Door	120,000	10,320	52,870	67,130
The Neighborhood Center	70,000	7,625	46,325	23,675
Community Life Center Outreach Services	20,000	0	550	19,450
Rising Against All Odds	235,000	12,000	86,508	148,492
Community Legal Services	76,931	7,326	34,921	42,010
Hispanic Health Initiatives	75,000	7,475	28,050	46,950
Stewart Marchman - ACT				
SMA - Homeless Program	75,336	6,992	47,355	27,981
SMA - Residential Treatment	550,000	77,528	460,016	89,984
SMA - Baker Act - Match	300,000	156,110	262,923	37,077
Health Start Coalition of Flagler & Volusia				
HSCFV - Outreach	73,500	5,937	25,904	47,596
HSCFV - Fam Services	68,859	6,114	43,613	25,246
HCRA				
H C R A - In County	400,000	0	99,388	300,612
H C R A - Outside County	419,612	0	16,727	402,885
Other Healthcare Costs	1,095,090	0	0	1,095,090
Total Healthcare Expenditures	**18,148,475**	**1,344,913**	**8,380,882**	**9,767,593**

West Volusia Hospital Authority
Schedule II - Statement of Revenue and Expenditures
Modified Cash Basis
For the 1 Month and 7 Months Ended April 30, 2019 and April 30, 2018

	1 Month Ended April 30, 2019	1 Month Ended April 30, 2018	7 MonthsEnded April 30, 2019	7 Months Ended April 30, 2018
Revenue				
Ad Valorem Taxes	1,034,434	750,121	19,391,343	19,080,898
Investment Income	15,241	5,805	81,720	33,531
Rental Income	11,384	5,692	45,536	39,844
Other Income	0	0	0	203
Total Revenue	1,061,059	761,618	19,518,599	19,154,476
Healthcare Expenditures				
Adventist Health Systems	314,446	442,627	3,216,981	3,893,982
Northeast Florida Health Services	278,889	108,829	803,132	790,997
Specialty Care	238,006	213,938	1,666,171	1,447,111
County Medicaid Reimbursement	195,966	185,652	1,371,765	1,299,566
The House Next Door	10,320	8,169	52,870	51,726
The Neighborhood Center	7,625	0	46,325	35,000
Community Life Center Outreach Services	0	6,350	550	14,600
Rising Against All Odds	12,000	14,450	86,508	107,450
Community Legal Services	7,326	4,841	34,921	18,071
Hispanic Health Initiatives	7,475	5,600	28,050	53,250
Deltona Firefighters Foun Access to Hlth	0	0	0	661
Florida Dept of Health Dental Svcs	20,179	25,601	117,682	161,402
Good Samaritan	0	3,124	0	23,430
Stewart Marchman - ACT	240,629	47,394	770,295	434,792
Health Start Coalition of Flagler & Volusia	12,051	15,270	69,517	70,902
H C R A	0	43,886	116,115	78,126
Total Healthcare Expenditures	**1,344,912**	**1,125,731**	**8,380,882**	**8,481,066**
Other Expenditures				
Advertising	656	147	4,358	1,394
Annual Independent Audit	0	0	16,100	15,800
Building & Office Costs	0	(20)	2,437	3,281
General Accounting	4,490	3,213	34,568	30,998
General Administrative	4,890	5,816	23,686	32,594
Legal Counsel	5,300	4,100	29,410	33,800
City of DeLand Tax Increment District	0	0	72,444	69,746
Tax Collector & Appraiser Fee	20,684	61,263	528,198	521,526
TPA Services	35,967	0	337,355	240,467
Eligibility / Enrollment	0	0	4,221	21,819
Healthy Communities	5,650	5,623	33,875	33,079
Application Screening				
Application Screening - THND	31,122	15,812	138,893	94,871
Application Screening - RAAO	3,264	3,456	24,768	14,784
Application Screening - SMA	84	342	84	2,350
Workers Compensation Claims	7,390	5,481	13,429	21,730
Other Operating Expenditures	663	170	3,509	1,592
Total Other Expenditures	**120,160**	**105,403**	**1,267,335**	**1,139,831**

See Accountants' Compilation Report

West Volusia Hospital Authority
Schedule II - Statement of Revenue and Expenditures
Modified Cash Basis
For the 1 Month and 7 Months Ended April 30, 2019 and April 30, 2018

	1 Month Ended April 30, 2019	1 Month Ended April 30, 2018	7 MonthsEnded April 30, 2019	7 Months Ended April 30, 2018
Total Expenditures	1,465,072	1,231,134	9,648,217	9,620,897
Excess (Deficit)	**(404,013)**	**(469,516)**	**9,870,382**	**9,533,579**