WELCOME TO FOOTHILLS HEALTH & WELLNESS CENTER

Our History

Since 2005, Kentucky River Foothills Development Council, Inc. (KRFDC) has expanded its healthcare services across Estill and Powell counties. We began with a mobile health clinic and now offer services at our state-of-the-art 3,000 sq. ft. medical clinic in Clay City, as well as at the Estill Co Outreach Center and via our mobile healthcare vehicle.

Services Provided

We offer a wide range of services, including:

- Primary Care
- Behavioral/Mental Health Counseling
- Preventative Care/Chronic Disease Management
- Dental and Eye Exam Referrals
- Prescription Assistance
- Case Management/Supportive Services,
- Office and Laboratory Testing
- Transportation
- Well-Woman Exams
- Insurance Applications (Benefits, FFM)
- Vivitrol

We practice **evidence-based medicine** (EBM), integrating clinical experience with the best available research to provide comprehensive care.

Eligibility and Qualification

To qualify for services, individuals must meet specific criteria for homelessness or be part of an underserved population. Please review the full **Eligibility Criteria** outlined below and contact our staff if you have questions:

- **Emergency or transitional shelter**
- **Living situations that are unfit for human habitation** (e.g., dilapidated housing, living on the streets, etc.)
- **Living with family/friends without a choice or in overcrowded conditions**

Patients may continue receiving services if they no longer meet the homeless criteria but qualify as part of the underserved population.

Clinic Hours and Contact Information

- **Powell County Clinic**:
  - Monday: 8:00 a.m. - 7:00 p.m.
  - Tuesday - Friday: 8:00 a.m. - 5:00 p.m.
- **Estill County Location**

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Contact: Call our receptionist at 606-663-9011. For after-hours concerns, use our emergency page service at 866-986-9470.

Before Your First Visit

Please arrive **30 minutes early** for your first appointment to complete any necessary paperwork. Additionally, please bring:

- **Proof of household income** (if seeking financial assistance)
- **Photo ID**
- A list of **current medications** or bring the medication bottles

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Appointment and Cancellation Policies

- **Scheduling**: Appointments should be made in advance. Same-day appointments are available for urgent concerns but will typically address one issue per visit.
- **Cancellations**: Cancellations are accepted up to **24 hours** before the appointment time.
- **No-Show Policy**: After 3 no-shows within a year, patients may be dismissed or seen only on a walk-in basis.

Financial Assistance and Insurance

Accepted Insurance Plans

We accept **Medicare, Medicaid**, and most major insurance plans. Please verify benefits prior to your visit.

Sliding Fee Scale

For patients without insurance, we offer a sliding fee scale based on household income and family size. Please refer to our **2024 Sliding Fee Scale** to determine your eligibility.

Level I- patients at or below 100% FPG will receive a 100 % discount of charges with a nominal fee as outlined above. Nominal Fee was determined by assessing the collection rates by discount pay class, write-off rates by discount pay class, patient surveys and board input.

Patients that fall between Levels II – V will receive a 100 % discount of charges with a discounted price as outline above.

Patients over 200 % of FPG will be responsible for the full charge and receive no discount.

Applicability: This policy applies to all patients and all services offered at the clinic. No patient will be denied services regardless of ability to pay.

Below is a copy of the current Sliding Fee Scale:

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2024 Sliding Fee Scale

Annual Income Thresholds by Nominal Fee or Discounted Pay Class and Percent Poverty						
Poverty Level	**At or Below 100% Level I**	**101-125% Level II**	**126-150% Level III**	**151-175% Level IV**	**176-200% Level V**	**Above 200%**
Nominal Fee Discounted Class Price (Levels II- V)						
Family Size						
MEDICAL	**$10**	**$15**	**$20**	**$25**	**$30**	**100% Pay**
BEHAVIORAL HEALTH/ NUTRITION	**$5**	**$10**	**$15**	**$20**	**$25**	**100% Pay**
1	**0-$15,060**	**$18,825**	**$22,590**	**$26,355**	**$30,120**	**$30,121+**
2	**0-$20,440**	**$25,550**	**$30,660**	**$35,770**	**$40,880**	**$40,881+**
3	**0-$25,820**	**$32,275**	**$38,730**	**$45,185**	**$51,640**	**$51,641 +**
4	**0-$31,200**	**$39,000**	**$46,800**	**$54,600**	**$62,400**	**$62,401 +**
5	**0-$36,580**	**$45,725**	**$54,870**	**$64,015**	**$73,160**	**$73,161+**
6	**0-$41,960**	**$52,450**	**$62,940**	**$73,430**	**$83,920**	**$83,921+**
7	**0-$47,340**	**$59,175**	**$71,010**	**$82,845**	**$94,680**	**$94,681+**
8	**0-$52,720**	**$65,900**	**$79,080**	**$92,260**	**$105,440**	**$105,441+**
For Each Additional Family Member Add	**$5,380**	**$6,725**	**$8,070**	**$9,415**	**$9,953**	**$10,760**
Based on 2024 Federal Poverty Guidelines						

Financial Policy

- **Payment**: Co-pays or a nominal fee are required at the time of service.
- **Drug Assistance**: We provide prescription assistance for uninsured or underinsured patients.

Patient Rights and Responsibilities

You have the right to:

- Be treated with respect, dignity, and privacy.
- Receive information about your care and treatment options.
- Consent to or refuse treatment.
- Confidentiality of personal health information.

Patients must also comply with clinic policies or risk being terminated from the program. Specific behaviors leading to termination include disruptive actions or failure to follow prescribed treatment.

Emergency Procedures

- **Medical Emergencies**: Call **911** or visit the nearest emergency room.
- **Non-Emergencies**: For urgent concerns after hours, you may contact our on-call service at **866-986-9470**.

Patient Grievances

If you have a complaint or concern, you have the right to voice it:

- In person
- By phone
- In writing to our provider or designee

Sexual Harassment/Workplace Violence Policy

We have a zero-tolerance policy for workplace violence and harassment. Disrespectful or threatening behavior towards patients or staff will result in dismissal.

Thank you for trusting Foothills Health & Wellness Center with your healthcare. We look forward to supporting your wellness journey.

Sincerely,
The Staff at Foothills Health & Wellness Center

WELCOME TO FOOTHILLS HEALTH & WELLNESS CENTER

Your signature on the Patient Signature Confirmation page indicates your acceptance & agreements of the following policies:

Foothills Health and Wellness Center's Sliding Fee Authorization

My signature enrolls me in the Foothills Health & Wellness Center's Sliding Fee Discount Programs, so long as I provide all necessary proof of income and residence verification for all household members. I also understand that any false information that is found incorrect is considered fraud and I can be withdrawn from the program.

My signature authorizes Foothills Health & Wellness Center to share my financial information with pharmaceutical prescription assistance programs so that I may have access to those medications available from various drug companies.

Financial Policy

1. Our office accepts most insurance plans (Medicare, Medicaid, and Commercial Insurance). It is your responsibility to:
   - Bring your insurance card to every visit.
   - Be prepared to pay your co-payment or minimal fee. Payment can be made by cash, check or credit card.
   - You will be billed for medical care not covered under your insurance company.
2. If you have insurance which we do not participate in, our office is happy to file the claim upon request; however, you are expected to pay the nominal payment.
3. If you are unable to pay for necessary medical care, you may be eligible for financial assistance and receive a discount based on your household income. Our clinic provides discounts based on a sliding fee scale to individuals who do not have insurance coverage or are underinsured. It is the patient's responsibility to bring all required documentation before we can process a sliding fee application. Proper proof of income is the most current tax return, the most recent pay stubs, most recent statement from social services (Award letter, etc.), or a letter from the caregiver with explicit amounts of money that are given on a monthly basis. Sliding fee scale discounts will be based on the most recent Federal Poverty Index (FPI) guidelines. Patients lacking proper proof of income at the initial visit must provide this documentation within sixty (60) business days. The sliding fee discount will not be applied until proper proof of income is provided. Should this action not occur, the patient will then be placed in the full-pay (100%) category until income verification is provided unless other arrangements have been made with the Billing Specialist. Final determination of the eligibility and proof of income documents will be signed and reviewed by the Front Office Team Staff.
4. If the patient is a minor (18 years or younger), the parent or guardian must sign below unless the patient is an emancipated minor (they may then sign for themselves). The parent or guardian of a minor is responsible for the nominal payment at the time of service and any services that may be billed.
5. If you have questions about your insurance or would like to set up a payment plan, we are happy to help you. Our clinic staff firmly believes that a good provider/patient relationship is based upon understanding and good communications. Patients who have not made an

attempt to make payment arrangements or pay toward outstanding balances within one year after the date of service may result in discharge.

6. Questions about financial arrangements should be directed to the Front Office Staff. Please sign that you have read and agree to this Financial Policy.

Patient Centered Medical Home Letter

Foothills Health and Wellness Center (FHWC) has implemented the Patient Centered Medical Home (PCMH) model to improve our care for patients. A Patient Centered Medical Home is a trusting relationship between the provider and the patient and when appropriate family and or caregivers to improve care and health outcomes.
Your medical team will strive to:

- Provide comprehensive care with a team of care providers.
- Your care team might offer physicians, advanced practice nurses, nurses, dietitians, mental health providers, educators, and care coordinators.
- Address physical and mental health care needs, including prevention and wellness, acute care, and chronic care.
- Partners with patients and their families respecting each patient's unique needs, culture, values, and preferences.
- Recognize patients and families are core members of the care team and ensure that they are fully informed in establishing care plans.
- Coordinate care and promote clear communication with specialty care, hospitals, home health care, and community services and supportive services.
- Inform patients/families/caregivers about care obtained outside the medical home.
- Deliver accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone access to a member of the care team, and alternative methods of communication, such as patient portal.
- Demonstrate a commitment to quality and quality improvement by ongoing engagement in activities.
- Measure and respond to patient experiences and patient satisfaction.

We trust you, our patient too:

- Tell us what you know about your health and illnesses.
- Take part in planning your care and follow the care plan that is agreed upon or let us know why you cannot so we can try to help and change the plan.
- Let us know when you see other doctors or go to the hospital and what medications they put you on or changed.
- Keep your appointments as scheduled or call and let us know when you cannot.
- Give us feedback so we can improve our service and your experience.

As part of our Patient Centered Medical Home orientation, we will ask you to acknowledge your agreement to the above, as we acknowledge our agreement to you.

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's ***Notice of Privacy Practices*** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement.
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I have provided if requested.

WHAT YOU SHOULD KNOW ABOUT HIV AND AIDS

Pursuant to KRS214.620(4) we are required to provide written information on the HIV Virus.

What is AIDS?
AIDS is the Acquired Immune Deficiency Syndrome- A serious illness which makes the body unable to fight infection. A person with AIDS is susceptible to certain infections and cancers. When a person with AIDs cannot fight off infections, this person becomes ill. Most people with AIDs will die as a result of their infection.

What causes AIDS?
AIDS is caused by a virus called Human Immunodeficiency Virus or HIV.
HIV can be spread by:

- Sexual contact (oral, anal, or vaginal intercourse) with an infected person when blood semen or cervical/vaginal secretions are exchanged.
- Sharing a syringe /needle with someone who is infected.
- Receiving contaminated blood or blood products (very unlikely now because blood use for transfusions has been tested for HIV antibodies since March 1985).
- An infected mother passing HIV to her unborn child before or during childbirth, and possibly through breast-feeding.
- Receipt of transplant of infected tissue organs or artificial insemination from an infected donor.
- A needle stick or sharps injury in a healthcare setting involving an infected person.

You cannot get AIDS through casual contact, such as:

- Sharing food, utensils, or plates.
- Touching someone who is infected with HIV.
- Hugging or shaking hands.
- Donating blood (this has NEVER been a risk for contracting HIV).
- Using public restrooms.
- Being bitten by mosquitoes or any insects.

Treatment:

Early diagnosis of HIV infection is important! If you have been told you have HIV, you should get prompt medical treatment. Your doctor will help you determine the best treatment for you.

HIV antibody testing:

Free anonymous and confidential testing and counseling is available at every health department in Kentucky. After being infected with HIV, it takes between two weeks and six months before the test can detect the antibodies to the virus.

You should be tested if you:

- Have had sex with someone who has HIV.
- Have shared needles or syringes with someone who has HIV.
- Have had multiple sex partners or you have had sex with someone who has had multiple partners.
- Have had sex through prostitution (male or female).
- Have had sex with injecting drug users.
- Had a blood transfusion between 1978 and 1985.
- Are you a woman who is pregnant or desires to be pregnant and who wishes to reduce the chance of your baby getting HIV from you should be you infected.

Remember, you can't tell whether or not someone has HIV just by looking at them!

Assignments and Authorizations

CONSENT TO TREAT

I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of the Foothills Health & Wellness Center and its medical staff, or their designees, as may in their professional judgement be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such an examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

GUARANTEE OF PAYMENT

I agree to be responsible to Foothills Health & Wellness Center and/or their assigns for charges resulting from services rendered at the prevailing rate. I understand all bills are due in full upon demand. I also understand that payment plans are available upon request should I need assistance in making payments toward any outstanding balances. I realize that if payment is not received within 120 days, that I can be terminated from the clinic. Should I fail to honor this agreement, or any payment plan agreements, I agree to pay any collection costs or attorney fees resulting from the collection of our/my account.

ASSIGNMENT OF BENEFIT

I assign all rights and privileges and authorize payment directly to Foothills Health & Wellness Center, and/or their assignees for any claim filed on my behalf. I also understand that I am financially responsible for any charges not covered or paid by my insurance company.

NOTICE OF PRIVACY PRACTICES

Kentucky River Foothills Development Council, Inc. (KRFDC) recognizes and abides by the federally mandated Health Insurance Portability & Accountability Act, (HIPAA). KRFDC's Foothills Health & Wellness Center, as a health care provider, will strive to protect all patient information from outside requests for information, as well as

the protection of patient information from employees and staff by ensuring protocols are implemented to fully
comply with the HIPAA standards. Foothills Health & Wellness Center strongly encourages all patients to read the Notice of Privacy Practices. If you cannot understand the Notice of Privacy Practices, notify a member of our staff who will assist you.

CLIENT RIGHTS POLICY

All Clients of *Kentucky River Foothills Development Council's Foothills Health & Wellness Center* are guaranteed the following rights:

1. The right to be treated with consideration and respect for personal dignity, autonomy, and privacy.
2. The right to be informed of one's own condition, of proposed or current services, treatment, or therapies, and of alternatives.
3. The right to consent to or refuse any services, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal.
4. The right to a current, written treatment plan that addresses the provision of appropriate and adequate services, as available, either directly or by refusal.
5. The right to active and informed participation in establishment, review, and reassessment of the treatment plan.

6. The right to confidentiality of communications and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state, and federal statutes, unless release of information is specifically authorized by the client.
7. The right to be informed in advance of the reason(s) for discontinuation of service provision, and to be involved in planning for the consequences of that event.
8. The right to receive an explanation of the reason(s) for denial of services.
9. The right not to be discriminated against in the provision of services on the basis of religion, race, color, creed, sex, national origin, age, sexual orientation or disability.
10. The right to be fully informed of all rights.
11. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to services.
12. The right to be informed of my rights and protection with regards to confidentiality between the client and case manager.
13. I understand that according to KRS 620.030 my case manager has a legal and ethical obligation to report child abuse and neglect. I also understand that my case manager must report instances of threat of suicide or homicide.

I certify that I have reviewed and understand the aforementioned rights and have been given a copy of said rights for my personal records. Furthermore, I verify that I have received a copy of service complaint procedures, and fully understand my rights should I be dissatisfied with any service received or requested.

KRS 620.030-Any person who knows or has reasonable cause to believe that a child is dependent, neglected or abused shall immediately cause an oral or written report to be made to a local law enforcement agency or the Kentucky State Police; the Cabinet or its designated representative; the commonwealth's attorney; by telephone or otherwise