Target Population and Screening for Eligibility

Deciding who your clinic will serve and how you will determine eligibility for your clinic's services is a crucial step in the planning process. It is very important to accept the fact that your clinic will not be able to serve all the needs of the uninsured in your community. Being able to clearly state who you want to reach with your services helps the community understand who you are and where your program fits into the community's existing resources.

Many members of clinic planning teams struggle with the concept of limiting access to their clinic. In order to remain focused and deliver quality health care services, however, a target population must be defined, with the help of the Environmental Scan. Once the target population is determined, a written policy clearly defining the accepted criteria should be approved by the Board of Directors. You may want to consider starting with narrowly defined eligibility criteria and, if necessary, expand it later as the clinic grows in its abilities and resources.

Use a combination of factors to provide a clear description of who you are targeting for your services.

Some examples of criteria for eligibility used by clinics include:

- Income that falls at or below a percentage of Federal Poverty Guidelines. (The web address to find the most up to date guidelines: http://aspe.hhs.gov/poverty)
- Not enrolled in state or federal insurance programs (Medicaid/Medicare/CHIP)
- No private insurance
- High deductible private insurance (under-insured)
- Age limits
- A resident of the local community or of a specific zip code(s)
- Residency status

Once the eligibility criteria are agreed upon by the Planning Team, a member of this team should be assigned to develop the screening process to verify eligibility

for services at the clinic. It is useful to contact other charitable clinics in your area to discuss the screening methods they use.

You may find a broad range of options from clinics that may include:

- No requirement for written verification of a patient's income or residency status
- Federal tax return
- Payroll verification
- Social security card
- Statement from the employer verifying income
- Some clinics require a separate screening appointment before a patient can access clinic services
- Others allow one visit without verification, and then set a screening appointment to follow
- Some clinics "certify" patients for a set period of time, usually 6-12 months, and issue an eligibility card

You will need to determine which process will work best for your clinic, taking into consideration the resources available.

Regardless of the screening process, you will still encounter instances where a patient that has come to your clinic will not be eligible for care. This is a particularly difficult situation for clinic volunteers to face, so your planning team needs to provide training and offer procedures for handling these situations. For example, you may choose to have paid staff members or a member of the leadership team be involved when services must be denied. Recognize that there will be instances where exceptions are made to the eligibility criteria, but it is advisable to leave those decisions to staff or senior leadership and not to a volunteer screener.