Client Compensation Procedure

Background: Health Care for the Homeless ("the Agency") recognizes the organization benefits from client contributions in its advocacy, programmatic development, and narrative. We acknowledge the value of client expertise and time. The Client Compensation Procedure is guided by the directive to create a culture of respect and inclusion, as detailed in the Racial Equity Guiding Principles, the REI Action Plan and the 2022-2025 Strategic Plan.

PURPOSE: To outline the required steps when referring clients for activities where they will receive stipends or an honorarium.

SCOPE
This procedure applies to the staff who support clients engaged in compensable activities.

PROCEDURE

I. Ensuring the activity is a qualifying event

A. The staff member must first consult the Client Compensation Policy.
B. The staff member should then complete the first page of the Client Compensation Agreement (CCA, see Attachment A) and share this with the Senior Client Relations Manager (SCRM) to ensure the event qualifies for client compensation.

II. Recruiting client participation

A. Once the event is approved, the staff member introduces the availability of compensation to clients.
B. Client selection considerations:
    i. Alignment with activity (i.e., opportunities for oral testimony will prioritize those with experience relevant to a particular bill; Diabetes Workgroup will prioritize clients living with diabetes, etc.)
    ii. In some cases, a brief interview process may be part of the decision process.
    iii. First-time participants will be given priority to encourage inclusion of multiple perspectives.
C. The staff member will complete, review, and obtain client signature using the following forms. Once signed, the staff member will give the client a copy and email the following forms to the SCRM:
    i. CCA (this form should also be emailed to the Accounting Manager)
    ii. Client Interview Permission, Photo and Video Release Form (Attachment B) only if the qualifying activity includes the client sharing their personal story for use in

Agency media. (This form will be centrally stored by the Communications department.)

III. Client Engagement

1. The staff member will maintain flexibility with location as interviews may be in-person or virtual.
2. The staff member will carefully document the time spent with the client for total payment (in 15- minute increments).

IV. Client Payment

A. At the conclusion of the event, the staff member will alert (preferably by email or via Microsoft Teams) both the SCRM and Accounting Manager that payment is due to the client.
B. Good faith effort on the part of all involved staff members will be made to get payment to the client within 48 hours after the conclusion of their participation (typically petty cash).
C. The client, SCRM, and a Finance representative will sign and date the receipt for any compensation administered.
D. Finance is responsible for storing petty cash receipts.
E. Interoffice signature envelopes will be utilized when funds are not directly handed to the client from Finance. All hands that touch the envelope are required to sign it.
F. SCRM and Finance will maintain a shared tracking sheet to keep up with client participants, total amount, and type of payments made to individuals.

V. 1099 Form Reporting

A. The Agency is required to issue 1099 forms to taxpayers who have received at least $600 or more in non-employment income during the tax year. This information is included in the CCA.
B. The staff member must discuss in detail with clients who receive SSI/SSDI as it will be reported as income and could affect their benefits.
C. The SCRM will track cumulative client payments and will notify clients or the referring staff member when the client is nearing the $600 mark. Clients who are nearing the $600 mark and agree to continue receiving payments will have to sign a W-9 prior to receiving their next stipend/honorarium.

REVIEW CYCLE

This procedure will be reviewed every two years to remain compliant and up to date with the Agency needs and expectations.

Signed by: Keiren Havens

Date: 8/28/2023
Position: Chief Strategy Officer
Reviewed every two years

See also Compensation Policy

Attachment A
Attachment B

Client Compensation Agreement

Health Care for the Homeless ("the Agency") recognizes that the organization benefits from client contributions. By sharing testimony, expertise, and time, clients help advance Agency goals in advocacy, development, delivery of services, and more. To acknowledge the value of client contributions, the Agency will provide a monetary stipend or honorarium for the following qualified activities. (Please refer to the Client Compensation Policy and Procedure for more details.)

IF stipend activity (please check one)

___ Participating in Performance Improvement (or other workgroup)
___ Leading/co-leading client support group
___ Captaining/co-captaining a lobby day group
___ Providing oral testimony in Annapolis
___ Presenting at National Health Care for the Homeless Conference
___ Relationship-building and decision-making activities
___ Other _____

IF honorarium activity (please check one)

___ Interviewing for written/video piece for the Agency
___ Writing a story or other content piece for Agency publication
___ Submitting written/oral testimony for legislative advocacy
___ Presenting as part of a clinic tour
___ Serving as a Team (Co)Captain at Lobby Day
___ Third-party referral (e.g., news site) to speak about HCH services or advocacy priorities
___ Speaking at a one-time event as an Agency representative that does not require pre-event preparation
___ Other _____

__ Check if travel reimbursement will be required. # of tokens (if return round-trip): _____

__ Other travel reimbursement requested. Please explain what is needed: _____

Provide relevant details below:

Event	Date(s)	Estimated Hours	Location	Type of Service

Client Name: _____

Date of Birth: _____

Address: _____

Telephone: _____ Email: _____

I agree to participate in the agency activity as specified above. I understand that at any time before or during the activity, I can decide not to participate. I understand that no longer participating may end future payments for that activity. This will in no way prevent me from taking part in future activities. My participation will have no effect on my care at the agency.

If you feel that your care has been affected by ending your participation, please call the Agency complaint line, 443-703-1414, or go to www.hchmd.org/client-feedback.

Signature (Client)	Printed Name	Date
Signature (Staff)	Printed Name	Date

RECEIPT

1099 Form Reporting

I understand that the Agency is required to report and issue 1099 forms to taxpayers who receive $600 or more in non-employment income during the tax year. I understand that if I receive SSI/SSDI, my benefits could be affected if the total amount for the tax year reaches $600. If an individual reaches $600 total for the year, they will be notified by staff.

I am receiving a payment of $_____ for ___ hours/days of my participation in the above qualifying agency activity. In addition, I am receiving _____ for related transportation.

Client Signature	Printed Name	Date
Approved by	Printed Name	Date

Expense Coding

Invoice Period	Fund	GL Code	Grant Code	Dept	Amount
		5593		13	

Acuerdo de compensación de los clientes

Health Care for the Homeless ("la Agencia") reconoce que la organización se beneficia de las contribuciones de los clientes. Al compartir testimonio, experiencia y tiempo, los clientes ayudan a avanzar en los objetivos de la Agencia en promoción, desarrollo, prestación de servicios y más. Para reconocer el valor de las contribuciones de los clientes, la Agencia proporcionará un estipendio monetario u honorarios para las siguientes actividades calificadas. (Consulte con la política y el procedimiento de compensación de los clientes para obtener más detalles.)

SI es una actividad de estipendio (marque uno) ___ Participar en la Mejora del Rendimiento (u otro grupo de trabajo) ___ Líder/co-líder del grupo de apoyo al cliente ___ Capitán/co-capitán de un grupo del día de lobby ("Lobby Day") ___ Testimonio oral en Annapolis ___ Presentar a la Conferencia Nacional de Health Care for the Homeless ___ Actividades de establecimiento de relaciones y adopción de decisiones ___ Otro: _____
SI es una actividad del honorario (marque uno) ___ Entrevistar para pieza escrita / video para la Agencia ___ Escribir una historia u otra pieza de contenido para la publicación de la Agencia ___ Presentar de testimonios escritos/orales para la defensa legislativa ___ Presentar como parte de un tour por la clínica ___ Sirviendo como (Co)Capitán del Equipo en el día de lobby ("Lobby Day") ___ Referencias a terceros (p. ej. sitio de noticias) para hablar sobre las metas de defensa legislativa o los servicios de HCH ___ Hablar en un evento único como representante de la Agencia, sin preparación previa al evento ___ Otro: _____

__ Marque si se requerirá reembolso de viaje. # de vales/tokens (Si regresa ida y vuelta): _____

__ Otros reembolsos de viaje solicitados. Explica lo que se necesita: _____

Llena detalles relevantes a continuación:

Evento	Fecha(s)	Horas estimadas	Ubicación	Tipo de servicio

Nombre del cliente: _____

Fecha de naci.: _____

Dirección: _____

Teléfono: _____ E-mail: _____

Acepto participar en la actividad de la Agencia como se especifica anteriormente. Entiendo que en cualquier momento antes o durante la actividad, puedo decidir no participar. Entiendo que dejar de participar puede poner fin a los pagos futuros por esa actividad. Esto de ninguna manera me impedirá participar en futuras actividades. Mi participación no tendrá ningún efecto en mi atención en la Agencia.

Si cree que su atención se ha visto afectada por terminar su participación, llame a la línea de quejas de la Agencia, 443-703-1414, a visita www.hchmd.org/client-feedback.

Firma (Cliente)	Nombre en letra de molde	Fecha de hoy
Firma (Empleado)	Nombre en letra de molde	Fecha de hoy

RECEIPT

1099 Form Reporting

Entiendo que la Agencia está obligada a informar y emitir formularios 1099 a los contribuyentes que reciben $600 o más en ingresos no laborales durante el año tributario. Entiendo que si recibo SSI/SSDI, Mis beneficios podrían verse afectados si el monto total para el año tributario alcanza los $600. Si una persona alcanza un total de $600 para el año, será notificado por el personal.

Estoy recibiendo un pago de $_____ for ___ horas/días de mi participación en la actividad de Agencia como se especifica anteriormente. Además, estoy recibiendo _____ para transporte relacionado.

Firma (Cliente)	Nombre en letra de molde	Fecha de hoy
Aprobado por	Nombre en letra de molde	Fecha de hoy

Expense Coding

Invoice Period	Fund	GL Code	Grant Code	Dept	Amount
		5593		13	

Client Story Release Form

Client Name: _____

Address: _____

Telephone: _____ Email: _____

Health Care for the Homeless thanks you for your willingness to share your story. Your story helps us spread the word about the work we do, and enables us to serve more people.

We take your privacy very seriously. Please let us know how we may use your personal (and health) information below:

Types of Activity (please initial):

You agree to be interviewed, provide details about your health care and/or have photographs, audio or video recordings made of you (referred to herein as "Your Story"), to be used by Health Care for the Homeless in:

_____ ☐ Brochures, newsletters, fundraising materials and/or other publications

_____ ☐ Website(s) and/or social media sites

_____ ☐ Stories in the media (e.g., newspaper, TV, radio, magazine and online publications)

_____ ☐ Other: _____

You agree to:

_____ ☐ Allow Health Care for the Homeless to speak with your providers regarding your health care for the purpose of telling Your Story.

If there is specific information (arrest history, medical conditions, family information, etc.) that you do <u>not</u> want Health Care for the Homeless to use, please write it here: _____

_____

_____

You understand that:

- If you do not sign this form, Health Care for the Homeless will not disclose Your Story.

- Health Care for the Homeless will have one year from the date of your signature to print or publish Your Story.
- You may cancel this release at any time. Simply send your request in writing to the Health Care for the Homeless Communications Department, 421 Fallsway, Baltimore, MD 21202.
- Cancellation does not affect any uses or disclosures of your information that have already occurred, but will prohibit the future use of Your Story.
- Once Your Story is disclosed as authorized, it is no longer protected by federal or state privacy laws, and could be re-disclosed by the person receiving it.

You further understand that:

- You will not receive any payment for the use of Your Story.
- Health Care for the Homeless will have full editorial control over Your Story.
- Health Care for the Homeless has the right not to use Your Story.
- Your Story should contain no information that violates a right of another person(s).

Signature

I have read this form, and all of my questions have been answered. My signature means that I understand and accept all of the above conditions, and approve the use and disclosure of my images and personal health information by Health Care for the Homeless. I am entitled to receive a copy of my signed form.

_____	_____	_____
Signature (Client)	Printed name	Date

If authorized by a representative:

I, _____, am the (check which applies)

☐ Parent with Parental Rights

☐ Registered Kinship Care Relative

☐ Court Appointed Guardian

Address: _____ Phone: _____

_____	_____	_____
Signature (Representative)	Printed name	Date

**This release is compliant with HIPAA authorization requirements as of February 2019*

Formulario de consentimiento para compartir la historia del cliente

Nombre del cliente: _____

Dirección: _____

Teléfono: _____ Correo electrónico: _____

Health Care for the Homeless agradece su buena voluntad para compartir su historia. Esto nos ayuda a correr la voz sobre el trabajo que hacemos y a ayudar a más personas.

Nos tomamos muy en serio su privacidad. Háganos saber cómo podemos usar su información personal (y de salud) a continuación:

Tipos de actividades (escriba las iniciales):

Usted acepta ser entrevistado, dar detalles sobre su atención médica, fotografiarse, hacer grabaciones de audio o video (a las que se hace referencia en este documento como "Su historia") para que Health Care for the Homeless las utilice en lo siguiente:

_____ ☐ Folletos, boletines informativos, materiales para recaudar fondos u otras publicaciones.

_____ ☐ Sitios web o redes sociales.

_____ ☐ Historias en los medios de comunicación (por ejemplo, periódicos, televisión, radio, revistas y publicaciones en línea).

_____ ☐ Otro: _____

Usted acepta lo siguiente:

_____ ☐ Permitir que Health Care for the Homeless hable con sus proveedores de salud sobre su atención médica para que nos cuenten Su historia.

Si no quiere que Health Care for the Homeless use cierta información (antecedentes de arrestos, afecciones médicas, información familiar, etc.), especifíquelo aquí: _____

_____

_____

Usted entiende lo siguiente:

- Si no firma este formulario de consentimiento, Health Care for the Homeless no revelará Su historia.
- El consentimiento para compartir Su historia es voluntario. Su tratamiento (y la elegibilidad para el tratamiento) no se verá afectado, independientemente de que firme o no.

- Health Care for the Homeless tendrá un año a partir de la fecha en que firme para imprimir o publicar Su historia.
- Usted puede cancelar este consentimiento en cualquier momento. Solo tiene que enviar la solicitud por escrito a Health Care for the Homeless Communications Department, 421 Fallsway, Baltimore, MD 21202.
- La cancelación no tendrá efecto en ningún uso o divulgación que ya se haya hecho, sino que prohibirá el uso futuro de Su historia.
- Una vez autorizada la divulgación de Su historia, ya no estará amparada por las leyes de privacidad federales ni estatales, y la persona que la recibe puede volver a divulgarla.

Además, entiende lo siguiente:

- No recibirá ningún pago por el uso de Su historia.
- Health Care for the Homeless tendrá el control editorial total sobre Su historia.
- Health Care for the Homeless tiene el derecho de no usar Su historia.
- Su historia no debe contener información que viole el derecho de otra persona.

Firma

He leído este formulario de consentimiento y me han respondido todas mis preguntas. Con mi firma doy fe que entiendo y acepto todas las condiciones arriba mencionadas y doy mi consentimiento a Health Care for the Homeless para que use y divulgue mis imágenes e información de salud personal. Tengo derecho de recibir una copia de este formulario firmado.

_____	_____	_____
Firma (cliente)	Nombre en letra de molde	Fecha

Si es un representante autorizado:

Yo, _____, soy (marque la opción correspondiente)

☐ padre/madre con derechos parentales

☐ pariente registrado con familiar a cargo

☐ tutor designado por un juzgado

Dirección: _____ Teléfono: _____

_____	_____	_____
Firma (representante)	Nombre en letra de molde	Fecha

** Este formulario cumple con los requisitos de autorización de la Ley de Responsabilidad y Portabilidad del Seguro Médico (HIPAA) desde febrero de 2019.*