Avita Community Partners
Finance & Accounting Procedures

# CLIENT BILLING & FEE COLLECTION

I. Purpose

The purpose of these procedures is to establish and describe practices to be utilized for the assessment, billing and collection of fees for services in accordance with Avita Community Partners (Avita) policy on "Billing & Fee Collection".

II. Persons Affected

These procedures apply to Finance Department and Service Operations Department staff members.

III. Procedures

A. General:

1. Charges: Charges for services received shall be assessed on a unit of service basis. The full charge is the amount billed to third party payers and clients who do not apply for or qualify for a reduction of fees. Access to copy of the Avita Service Charge Schedule is maintained in CareLogic with a copy located in the Avita Information System Public Folder for "Finance Department", subfolder for "Billing", "Reports/Charts".

2. Sliding Fees: In accordance with Georgia Department of Behavioral Health and Developmental Disabilities Policy, clients receiving behavioral health services funded by the State of Georgia (excepting pharmacy dispensing services, see Section "B" below), and who do not have third party insurance coverage (see definition of third-party coverage below), are eligible for a fee reduction based on net income. Clients shall be expected to pay for services based on their individual fee reduction as determined by the sliding fee scale. Every effort shall be made to address collection issues with clients and other responsible parties from a helpful, positive viewpoint. Access to a copy of the current Avita Sliding Fee Scale shall be maintained on the Avita Information System Public Folder for "Finance Department", subfolder for "Billing". A display of Avita offering a sliding fee scale is posted at each site prominently in lobby area.

3. Third-party coverage definition:
   a. Medicaid: Persons with Medicaid coverage are not eligible for a fee reduction. See procedures for "Medicaid Billing" for additional guidelines.

   b. Medicare: Persons with Medicare coverage may be eligible for a reduced fee for services not covered by Medicare, such as community-based services.


Original date issued: August 1, 1981
Review dates: 8/14/86, 10/15/90, 9/29/92, 6/15/94, 3/10/05, 10/10/06, 3/19/08, 6/23/09, 5/11/10, 5/17/11, 11/29/12, 7/2/13, 5/27/14, 3/19/15, 9/29/15

i. Requests for services not covered by Medicare (SCS covered services) will be reviewed on a case-by-case basis and may receive exception based services in accordance with medical necessity along with prior approval of BH Team Lead. Approval for these extra services will depend on the following:
   - severity of client need;
   - program capacity

ii. Approval for client to receive services not covered by Medicare (SCS covered services) will be communicated to client's Service Coordinator, site Business Manager, and Billing.

iii. An Application for Financial Assistance shall be completed by the client. Client co-pays for these services will be determined based on their eligibility for the sliding fee scale.

iv. A Client Registration for Services and treatment plan authorization are required to bill for any approved SCS services.

c. Commercial Insurance (examples: BCBS, Aetna, Cigna, Humana, United Healthcare, etc.): Services covered by commercial insurance, whether in-full or partial, or whether deductibles have been met, are not eligible for a fee reduction, regardless of the "in-network" or "out-of-network" status of Avita and/or Avita service provider's panel or credentialing status.

   i. Persons with Commercial Insurance may be eligible for a reduced fee for services not covered by their insurance, such as community-based services.

   ii. Requests for services not covered by the client insurance carrier will be reviewed on a case-by-case basis in accordance with medical necessity along with prior approval by the site BH Team Lead. Approval for these extra services will depend on the following:
      - severity of client need;
      - program capacity

   iii. Approval for client to receive services not covered by client insurance carrier will be communicated to client's Service Coordinator, site Business Manager, and Billing.

   iv. An Application for Financial Assistance shall be completed by the client. Client copays for these services will be determined based on their eligibility for the sliding fee scale.

   v. A Client Registration for Services and treatment plan authorization are required to bill these services.

d. Avita Contracts (examples: MH Court, Drug Court, VA Hospital, Employee Assistant Programs, etc.): Clients who fall within these contracts are pre-determined and/or direct referrals from outside entities.

i. These clients are not eligible for a fee reduction as these services are determined and paid according to each contract.
ii. Some contracts (i.e., VA Hospital) may include expanded services based on client need, i.e. community-based services, which would be covered by the contract as determined by the VA and Avita Utilization Manager per documented level of care. For other contracts, requests for services not covered by the contracts will be reviewed on a case-by-case basis and shall receive exception based services in accordance with medical necessity along with prior approval of BH Team Lead.
   - severity of client need;
   - program capacity.
iii. Approval for client to receive services outside of Avita contracts will be communicated to client's Service Coordinator, site Business Manager, and Billing.
iv. An Application for Financial Assistance shall be completed by the client. Client co-pays for these services will be determined based on their eligibility for the sliding fee scale.

v. A Client Registration for Services and treatment plan authorization are required to bill for any approved SCS services.

vi. Clients who are requesting an appointment for a Court Ordered Evaluation, will be scheduled as any other client requesting an assessment. Their financial information will be reviewed and processed as any other client, per Fee Collection Policy. An "administrative surcharge" fee of $50.00 will be expected from the client at first face-to-face contact (Intake Step One). This fee will be scheduled on the clinician's schedule for the first 1 minute of the service (similar to the Telemed fee).

4. Clients and/or other responsible parties shall be given the opportunity to apply for fee reduction at the time of intake and completion of the Avita "Application for Financial Assistance". In the event the client or responsible party elects not to apply for a fee reduction, the full fee is charged.

5. Clients, who are initially not approved for fee reduction, shall be provided the opportunity to apply for fee reduction at any time subsequent to admission to services whenever their financial circumstances changed.

6. Clients are asked to provide documentation of income and expenses per the DBHDD policy. In lieu of documentation, the client will be placed on sliding fee scale for 60 days. If at the end of the 60 days, if no documentation is provided, the cost of services is 100%.

B. Pharmacy Services:

1. Pharmacy service charges for clients who are eligible for DBHDD-funded services shall be limited to a $4.50 dispensing fee per prescription per month for medications prescribed by Avita physicians and physician extenders. The sliding fee schedule does not apply to the medication prescription dispensing fee.

2. Only clients who are eligible for DBHDDD-funded services (state contracted services) will receive medication based on the sliding fee scale. All others shall be charged full price, which includes acquisition and dispensing costs.

3. Fee Waiver Process – waiver to appeal for prescriptions if requested. Approval by Chief Operating Officer (COO) for 60 days (post on message board)

C. Certification of Applicable Fee Rate:

1. Client's financial information, including income and health insurance coverage, is documented on the "Application for Financial Assistance". All clients not covered by another funding source must be advised at this time of the requirement to pay for services as rendered.

2. Clients shall be certified at the applicable fee rate based on family size and gross family income less medical expenses in excess of 5% of their gross income. Verification of income including recent payroll check stubs, income tax report, or bank statement showing direct deposits, is required. If no verification of income is received within 60 days, the client will be placed on 100% payment until such time as documentation is provided. Exceptions approved by COO for 60 days (post on message board).
   a. For clients who request a reduction in fees using sliding fee scale: At the time of initial visit the Business Manager or designee will place an expiration date 60 days in the future on the SCS payer. At which time if the client has not verified income to substantiate the reduction in fees, the cost of services will then be 100%.

3. Program staff members responsible for completion of the phone intake screening shall be responsible for advising clients and/or other responsible parties of this requirement, along with the need for Social Security, Medicaid, Fee-For-Service (FFS), Medicare, and commercial insurance cards when intake appointments are scheduled.
   a. For unscheduled, walk-in face-to-face intake assessments, the client and/or other responsible party shall be advised to bring required documentation (verification of income including recent payroll check stubs, income tax report, or bank statement showing direct deposits) to next appointment at which time eligibility for fee reduction, if applied for, may be determined.

   b. Advise client that in 60 days the cost of services will be 100% if income is not verified to substantiate the reduction in fees.

4. Client's financial information on the "Application for Financial Assistance" shall be updated at least annually or sooner if client circumstances change. Applicable fee reductions shall be recertified with verification of income annually.

5. Clients presenting as dangerous to themselves or others shall be served on an emergency basis regardless of fee payment.

6. Clients shall be asked to inform local administrative support staff members of any change in income status. This obligation is indicated on the "Application for Financial Assistance", and acknowledged by the client or responsible party at the time "Application" is made and signed.

7. Direct service staff members shall be expected to inform the Business Manager and designee of any changes in client's income, third-party payer, employment or disability status.

D. Definitions for Schedule of Fee Reduction:

1. Ability to pay: A person is determined to have an ability to pay using their adjusted income and applying that to the income levels found on the sliding fee scale based on the Federal Poverty Guidelines adopted by DBHDD of Georgia. Individuals whose adjusted income is at or below the poverty level for their family size is determined not to have an ability to pay for services; and, therefore, is not required to pay a fee. For individuals and families their ability to pay is based on their gross income, reduced by adjusted income (allowable expenses), family size and the percentage of the full charge payment as indicated on the sliding fee scale.

2. Gross Monthly Income: Verified monthly income from client, spouse, legal guardian, dependents, or family (as defined below) in the form of wages, SSI, unemployment compensation, disability, cash income, TANF, veterans benefits, child support, alimony, Social Security, retirement/pension funds, trust fund payments, stock dividends, rental income, or other regularly scheduled income reportable on Federal and/or State Income Tax Returns.

3. Adjusted Monthly Income: The gross monthly income minus the total allowable deductions. The allowable deductions are in the form of verified child support payments, alimony payments, monthly child care payments necessary to work, or monthly medical expenses in excess of 5% of gross income, i.e., medicine, dental (braces, dentures), medical supplies (diabetes), oxygen, or any debt or obligation to any medical provider including pharmacy for which the client is responsible.

4. Family: A family is an inter-reliant unit of people. For purposes of determining the number of family members living in a family unit to establish ability to pay, one uses the same logic applied in determining a dependent when completing a federal tax return. If a person is determined

to need the financial support of the inter-reliant unit to live and could meet the test to be claimed as a dependent on someone's tax return, then they are a part of that person's family and should be included when determining the family size. Adult children living at home, but not claimed as a dependent on the family's tax return must be considered a family of one.

5. Number of dependents: Number of dependents (identified in the family) claimed on the client's financial application.

6. Verification: The collection and verification of information contained in the "Application for Financial Assistance".

7. Client Notification of Fee: The notification process used to inform the client of their responsibility for payment for services, the amount or percentage they are expected to pay and the rates for services.

8. Collection: Agencies may use a process in which payment is requested, but not required, at time of services. Services (particularly crisis services) may not be denied due to lack of payment at the time of appointment. Continued non-payment for services and payments that are more than 90 days delinquent will be considered refusal to pay and the organization may take action in accordance with policy. The client will be notified of the organization's policy and their right to request a review of any such action.

9. Review: A process requested by the client based on the percentage of change (or request to adjust percentage) determined by the organization and the collection of outstanding payments. The impending termination of services to a client for refusal to pay triggers an automatic review of the client's circumstances. The review will include an administrative as well as a clinical review (conducted by the site's Team Lead) to assure the client's ability to comprehend the actions and the client is not dangerous to self or others.
   a. An "Appeal of Client Fee" form must be completed and submitted to the COO for all services including pharmacy if a determination is made to reduce client's percentage. When appeals are approved, the COO or her/his designee should notify the Business Manager and Billing Manager of the new fee rate reduction amounts.

10. Clinical Exception: A clinical exception is identified when it has been determined that payment from the client is impractical due to the client's current mental status, comprehension or level of functioning and payment is thereby adjusted, suspended, or waved as determined by the Team Lead. This will be documented in the client's ECR through a Memorandum to Chart, and by email to notify the Service Coordinator, Business Manager, and Billing Manager.

11. Crisis: An individual is determined to be in crisis when:

a. The individual is experiencing a behavioral or psychiatric crisis which could potentially endanger the safety of either the individual or others; or

b. The individual is experiencing hallucinations, delusions, disorientation, generalized confusion or unusual or dangerous behaviors; or

c. The individual is experiencing a substance withdrawal crisis.

12. Refusal to Pay: A person is determined to refuse to pay for services when:
    a. It has been determined that they have the ability to pay the minimal charge and refuse to pay part or all of the charge for services based on his/her adjusted income being applied to the sliding fee scale; and

    b. They have the mental and emotional acuity to understand payment is expected and understand the consequences of not paying, but refuse to pay their individual outstanding debt and the account is at least 90 days in arrears.

13. Accounts Receivables: Accounts on which no payment has been made in over 90 days should be considered delinquent. This will require an administrative and clinical review by the Team Lead.

E. Medicaid, Medicare, Peachcare, and Commercial Insurance Billing:
    1. Staff should make every effort to bill and collect reimbursement of fees for services from third party payers, including Medicaid, Medicare, Peachcare, TriCare, VA Contracts and limited commercial insurance companies.

    2. Effective October 1, 2011 Avita will only bill commercial insurance for clients who are active to services on September 30, 2011, or is an Avita existing State Contract Eligible client who later purchases Commercial Insurance to comply with the Affordable Care and Portability Act.
        a. Commercial insurance-covered clients should be scheduled for services by provider staff covered by the commercial insurance plan (e.g. appropriately licensed).

    3. Each of these clients who are covered by commercial insurance shall be required to sign the certification authorizing the release of information and the assignment of benefits. A copy of the insured client's insurance membership identification card must accompany the "Commercial Insurance Assignment of Benefits" Form.

    4. Upon signing the "Commercial Insurance Assignment of Benefits" Form and designating Avita as having the right to receive the health care insurance payment, the client or other responsible party shall be required to pay 100% of all charges not covered by insurance. An adjustment shall be made if one of the following occurs:

a. If the amount paid by the insurance company and the amount paid by the client and/or other responsible party exceeds the total charge, that amount shall be refunded to the client and/or responsible party, or applied as a credit balance.

b. Regardless of the insurance payment, the client and/or other responsible party's responsibility shall not exceed the client's liability as defined by the insurance company.

5. If a client refuses or fails to sign the "Commercial Insurance Assignment of Benefits" form, the client will be charged 100% for all services payable at the time of the service. Failure to sign this form does not allow Avita to bill a third party.

F. Point of Service Fees and Co-Payment Collections:

1. Sliding fee payments: For clients authorized for reduced fees, payment shall be requested at time of each visit.

2. Co-payments: For clients receiving Medicare or commercial insurance-covered services that have co-payment requirements, co-pays are requested at time of each visit.

3. Full-fee payments: For clients who do not apply for or who are not eligible for reduced fees, payment of the full fee charge is expected at time of each visit.

G. Past Due Accounts:

1. The Business Manager (and/or designees) and clinicians must make every effort to assure that clients or the legally responsible person(s) are aware of and understand their responsibility to pay for services and the amount, their right to request an adjustment, and their right to request a review of actions taken by the organization with regard to their payment and/or continuation of services as a result of payment or lack of payment.
   a. The client or responsible party is clearly informed of the expectations for payment of services, the billing procedures, payment options, and the amount of payments per service.

   b. Clients wishing to establish a regular payment plan can negotiate monthly payments with Business Manager and/or Billing staff. Once a monthly payment amount is agreed upon, a message is entered on the client's alerts in their ECR. This should be activated to be visible to front desk, clinician, billing, etc.

2. Clients who refuse or fail to provide information concerning their financial status or third party payers and for whom there is no indication that this action is related to the individual's clinical status, after 60 days of the initiation of services the client must be charged the full charge using the rates as established by the organization until the client and/or responsible party provide the required information. At that time, if the individual does

not pay, they may be considered as refusing to pay for services. If the client's ability to produce this documentation is impaired by his/her mental illness/SA issues and/or client's risk of psychiatric hospitalization, incarceration, or significant deterioration in health will be impacted, then the provider extends this time period until such time as the client can produce this information. This action is subject to an automatic administrative and clinical review as defined by this policy.

3. If a client is determined to have the ability to pay and the capacity to understand what it means to refuse to pay for services and refuses to pay, an administrative and clinical review of the circumstances must be conducted prior to denial for any services.
   a. The administrative review will include consulting with the client about any change in financial status including loss of employment, changes in income, family crisis, the birth of a new child, and so forth. If appropriate, a re-determination of the client's ability to pay is conducted. The client must be given the opportunity to pay any new amount before any action may be initiated toward the denial of services. The administrative review must be concluded within 30 calendar days of the client's refusal to pay.

   b. After the administrative review, a clinical review must be conducted by the site's Team Lead, as a licensed provider of the organization, in conjunction with the service coordinator to determine mental and diagnostic status or other factors that might contribute to non-payment and/or dangerous to self or others. The client will be notified of the review and may choose to participate.

   c. If the clinical review finds the client is dangerous to self or others, is in crisis, or requires inpatient level of care, or if discontinuing services will result in crisis or inpatient care, then services must continue.

   d. If the clinical review finds the client is not dangerous to self or others, not in crisis, not requiring inpatient level of care, nor displaying diminished acuity, the client may be denied services based on refusal to pay if there is no clinical reason to continue services.

   e. Clients who at admission are dangerous to themselves or others, in crisis, or at risk of inpatient care must be served regardless of ability to pay status or their payment history with the organization.

   f. If it is determined by the site's Team Lead, along with the COO, that services are denied due to clinical or administrative findings as specified in these guidelines, the client must be notified in writing by the COO within five (5) days of the review decision. Notification of termination of service(s) as well as dates of the administrative and clinical reviews, and the reason(s) for the action must be communicated through face-to-face contact with the client and/or confirmed by mail with a certified return receipt requested. The

written notification mailed to the client will include the statement that the client may receive services if he/she agrees to pay the assessed rate or provide the information needed to assess their ability to pay for services (this can include a payback schedule over time) or if the client experiences an acute crisis.

i. The site's Team Lead will notify the following staff of the decision to terminate services: Service Coordinator, who will complete discharge summary; Business Manager (or designee) who will close out program(s) in Program History.
ii. A message will be placed on the client's ECR message board, by the Business Manager, to appear when accessing client's ECR record for all viewers, i.e. Front Desk, Billing, Clinician, etc. stating: Terminated from Services (date) – may be seen if agrees to pay bill or if client is in crisis.

g. The decision-making process associated with the termination of services must be thoroughly documented in the client's ECR by the Team Lead. This must include the findings of the administrative and clinical reviews and a scanned copy of the written notice of termination of services.
   i. Documentation for the administrative review is completed by the Business Manager and/or COO (ECR Memo to Chart).
   ii. Documentation for the clinical review is completed by the Team Lead (ECR Memo to Chart).

h. The returned certified receipt as signed by the client or responsible party will be scanned in to the ECR with the original kept in the addendum paper chart.

4. All past due accounts shall be written off after 12 months unless an active payment plan has been agreed to.

H. Appeals: Appeal for change of fee reduction rate and reduction to minimum or zero fees may be requested when clients and/or guardians are not able to pay. When such hardship conditions are determined to exist, an "Appeal of Client Fee" form must be completed and submitted to the COO for all services including pharmacy. Verification of clients' and/or guardians' income and expenses must accompany each appeal. When appeals are approved, the COO or her/his designee should notify the Business Manager, along with the Billing Manager, of the new fee rate reduction amounts.

I. Schedules and Forms: Current copies of fee schedules referenced in these procedures shall be accessible in the Electronic Client Record (ECR) and also attached to this procedure along with the Application for Financial Assistance Form.

## IV. Responsibilities

A. Implementation: The COO, Chief Financial Officer and their designees are responsible for ensuring implementation of these procedures.

B. Review and update: The Chief Financial Officer is responsible for review and update of these procedures on an as needed and annual basis.

Approved: Victor Bonura Date: 09/30/2015
Chief Financial Officer

**Avita Community Partners Behavioral Health Sliding Fee Scale for Community Based Services**

**100%**

**FEE SCALE** Scale adopted on FPG dated January 22, 2015 Fee Scale

| 100% of the Federal Poverty Guidelines 2015 | | | FAMILY SIZE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Adjusted Monthly Income | | | | | | | | | | | |
| Low | to | High | Percentage of Rate to be Charged to the Client for Services Received | | | | | | | | |
| $ - | to | $ 981 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 982 | to | $ 1,329 | 5% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 1,330 | to | $ 1,677 | 10% | 5% | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 1,678 | to | $ 2,025 | 20% | 10% | 5% | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 2,026 | to | $ 2,373 | 30% | 20% | 10% | 5% | 0 | 0 | 0 | 0 | 0 |
| $ 2,374 | to | $ 2,721 | 40% | 30% | 20% | 10% | 5% | 0 | 0 | 0 | 0 |
| $ 2,722 | to | $ 3,069 | 50% | 40% | 30% | 20% | 10% | 5% | 0 | 0 | 0 |
| $ 3,070 | to | $ 3,417 | 60% | 50% | 40% | 30% | 20% | 10% | 5% | 0 | 0 |
| $ 3,418 | to | $ 3,765 | 70% | 60% | 50% | 40% | 30% | 20% | 10% | 5% | 0 |
| $ 3,766 | to | $ 4,113 | 80% | 70% | 60% | 50% | 40% | 30% | 20% | 10% | 5% |
| $ 4,114 | to | $ 4,461 | 100% | 80% | 70% | 60% | 50% | 40% | 30% | 20% | 10% |
| $ 4,462 | to | $ 4,809 | 100% | 90% | 80% | 70% | 60% | 50% | 40% | 30% | 20% |
| $ 4,810 | to | $ 5,157 | 100% | 100% | 90% | 80% | 70% | 60% | 50% | 40% | 30% |
| $ 5,158 | to | $ 5,505 | 100% | 100% | 100% | 90% | 80% | 70% | 60% | 50% | 40% |
| $ 5,506 | to | $ 5,853 | 100% | 100% | 100% | 100% | 90% | 80% | 70% | 60% | 50% |
| $ 5,854 | to | $ 6,201 | 100% | 100% | 100% | 100% | 100% | 90% | 80% | 70% | 60% |
| $ 6,202 | to | $ 6,549 | 100% | 100% | 100% | 100% | 100% | 100% | 90% | 80% | 70% |
| $ 6,550 | to | $ 6,897 | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 90% | 80% |
| $ 6,898 | to | $ 7,245 | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 90% |
| $ 7,246 | and | higher | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

**Avita Community Partners Behavioral Health Sliding Fee Scale for Community Based Services**

**200%**

**FEE SCALE** Scale adopted on FPG dated January 22, 2015 Fee Scale

| 200% of the Federal Poverty Guidelines 2015 | | | FAMILY SIZE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Adjusted Monthly Income | | | | | | | | | | | |
| Low | to | High | Percentage of Rate to be Charged to the Client for Services Received | | | | | | | | |
| $ - | to | $ 1,962 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 1,963 | to | $ 2,656 | 5% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 2,657 | to | $ 3,350 | 10% | 5% | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 3,351 | to | $ 4,044 | 20% | 10% | 5% | 0 | 0 | 0 | 0 | 0 | 0 |
| $ 4,045 | to | $ 4,738 | 30% | 20% | 10% | 5% | 0 | 0 | 0 | 0 | 0 |
| $ 4,739 | to | $ 5,432 | 40% | 30% | 20% | 10% | 5% | 0 | 0 | 0 | 0 |
| $ 5,433 | to | $ 6,126 | 50% | 40% | 30% | 20% | 10% | 5% | 0 | 0 | 0 |
| $ 6,127 | to | $ 6,820 | 60% | 50% | 40% | 30% | 20% | 10% | 5% | 0 | 0 |
| $ 6,821 | to | $ 7,514 | 70% | 60% | 50% | 40% | 30% | 20% | 10% | 5% | 0 |
| $ 7,515 | to | $ 8,208 | 80% | 70% | 60% | 50% | 40% | 30% | 20% | 10% | 5% |
| $ 8,209 | to | $ 8,902 | 100% | 80% | 70% | 60% | 50% | 40% | 30% | 20% | 10% |
| $ 8,903 | to | $ 9,596 | 100% | 90% | 80% | 70% | 60% | 50% | 40% | 30% | 20% |
| $ 9,597 | to | $ 10,290 | 100% | 100% | 90% | 80% | 70% | 60% | 50% | 40% | 30% |
| $ 10,291 | to | $ 10,984 | 100% | 100% | 100% | 90% | 80% | 70% | 60% | 50% | 40% |
| $ 10,985 | to | $ 11,678 | 100% | 100% | 100% | 100% | 90% | 80% | 70% | 60% | 50% |
| $ 11,679 | to | $ 12,372 | 100% | 100% | 100% | 100% | 100% | 90% | 80% | 70% | 60% |
| $ 12,373 | to | $ 13,066 | 100% | 100% | 100% | 100% | 100% | 100% | 90% | 80% | 70% |
| $ 13,067 | to | $ 13,760 | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 90% | 80% |
| $ 13,761 | to | $ 14,454 | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 90% |
| $ 14,455 | and | higher | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

# Application for Financial Assistance for Community Behavioral Health Services

**Today's Date:** _____

If you need help in completing this form or if you have questions about this form a staff member will be happy to assist you.

Payment for services is expected. If you do not have health insurance, you can complete this form in order to determine if you qualify for state financial assistance in paying for your services. In order to qualify for this assistance, you will also need to provide proof of income such as copies of recent pay stubs or your most recent tax return.

In order for us to bill your health insurance company, Medicaid or Medicare, you will need to provide proof of your insurance, including the group number and policy number. You will be responsible for any co-payments or deductibles required by your insurance policy.

This application will be considered without regard to race, color, gender, age, handicap, religion, national origin, sexual orientation or political belief. Failure to provide accurate information may result in you being charged the full charge or in the denial of services.

Name: _____ (Last) _____ (First) _____ (Middle Initial)

CID #_____
(to be completed by the Provider Organization)

Address: _____

City, State & ZIP: _____

Phone Number: Home: (____)_____ Work: (____)_____

Social Security Number: _____-_____-_____

**Method of Payment:**

1. Self Pay ❑ 2. Medicaid ❑ #: _____ 3. Medicare ❑ #: _____
4. Insurance ❑ Company: _____

   Group Number: _____ Policy Number: _____

   Is pre-certification required? ❑ Yes ❑ No Verification of coverage complete? ❑ Yes ❑ No
5. Secondary Insurance ❑ Company: _____

   Group Number: _____ Policy Number: _____

   Is pre-certification required? ❑ Yes ❑ No Verification of coverage complete? ❑ Yes ❑ No
6. Currently in Jail? ❑ Yes ❑ No County/City: _____
7. Employed ❑ Employer: _____ Unemployed ❑ Retired ❑

   TANF ❑ SSI ❑ Social Security ❑
8. If unemployed, date of last employment: __/__/____ Previous Place of employment: _____

_____ Did you have insurance coverage? ❑ Yes ❑ No If Yes, Name of the

Insurance Company: _____

Group Number: _____ Policy Number: _____

**Income: (Combined Family/Guardian)**

1. Are you claimed as a dependent on someone's Federal or State income tax? ❑ Yes ❑ No
   If yes, what is the relationship? Parent ❑ Other Relative ❑ Legal Guardian ❑ Other ❑.
   If yes to above, the following questions apply to the household income. If the answer to the above is no, then report only the income of those individuals reported on your last tax return.

| | **Initial** | **Update** | **Update** | **Update** |
|---|---|---|---|---|
| **Dates of Application Reviews** | Date: | Date: | Date: | Date: |
| | **Amount** | **Amount** | **Amount** | **Amount** |
| **Monthly Income from Wages** | | | | |
| Individual Gross Wages | $ | $ | $ | $ |
| Spouse Gross Wages | $ | $ | $ | $ |
| (18 years of age or younger or as a dependent on income tax) Legal Guardian 1 Gross Wages | $ | $ | $ | $ |
| Legal Guardian 2 Gross Wages | $ | $ | $ | $ |
| **Monthly Income from Other Sources** | | | | |
| **SSI** | $ | $ | $ | $ |
| **TANF** | $ | $ | $ | $ |
| **V.A.** | $ | $ | $ | $ |
| **Child Support** | $ | $ | $ | $ |
| **Alimony** | $ | $ | $ | $ |

| | | | | |
|---|---|---|---|---|
| **Social Security** | $ | $ | $ | $ |
| **Retirement/Pension payments** | $ | $ | $ | $ |
| **Trust Fund payments** | $ | $ | $ | $ |
| **Other regularly scheduled payments** | $ | $ | $ | $ |
| **Total Monthly Income** | $ | $ | $ | $ |
| **Allowable Monthly Deductions**<br>It may not be necessary to fill out the following section.<br>You are welcome to discuss this with a staff member at this point. | | | | |
| **Child Support** | $ | $ | $ | $ |
| **Alimony** | $ | $ | $ | $ |
| **Monthly Child Care Payments necessary to work** | $ | $ | $ | $ |
| **Monthly non-court ordered Child Support Payments** | $ | $ | $ | $ |
| **Monthly Medical Expenses in excess of 5% of gross income** | $ | $ | $ | $ |
| **Total Allowable Deductions** | $ | $ | $ | $ |
| | | | | |
| **Adjusted Monthly Income** (Total Monthly Income Minus Total Allowable Deductions) | $ | $ | $ | $ |
| **Number of Family Members** (Including Self) | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Based on this information and the attached fee scale, the determined charge(s) for my services are listed below:**

| Service | Individual Fee Amount Per Established Period |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

- I affirm that the statements above are true and accurately reflect my current financial circumstances.
- I understand that I am responsible for payment for services provided to my dependents or myself.
- I understand that the organization may ask me for additional information to assist in making a final determination of my ability to pay.
- I further understand that the organization may verify the information provided and give my consent for the verification by signing this application.
- I understand that my financial status will be reviewed annually or as circumstances change.
- I also understand that I have the option to review the decision by following the review process.

**Signature of Individual or Representative**
(If a minor, parent/guardian's signature)

**Date**