Sliding Scale Fee Program Application Information & Instructions (01/04/21)

See Sliding Scale Fee Discount Program Policy and Procedure in your application packet for complete information on the program

1. RHS offers a sliding scale fee discount program to patients/clients/responsible party who are uninsured, are underinsured, need services not covered by insurance, have needs for cash pay only, or experiencing financial difficulty paying for RHS provided Behavioral Health Services.

2. Behavioral Health Services Include: Psychological Testing, Substance Use Disorder Treatment and Services, Community Mental Health Services (CBRS, Case Management, Family Support, Peer Support), Counseling/Therapy Services, and Psychiatric Medication Management.

3. Request or utilize an application provided by front office clerical staff members.

4. All applications are confidential

5. Fill out identifying information at the top of the application and complete Section A of the application **prior to receiving services at your first appointment**. The application includes family size, all forms of income, and deductions applicable to the income allowed by Idaho Behavioral Health Sliding Scale Fee Administrative Rules and incompliance with National Health Service Corps (NHSC) requirements.

6. If you are receiving crisis services at your first appointment the application is not required to be completed prior to receiving services, but should be completed as immediately feasible.

7. Assistance is available, as needed, from the front office or intake case manager to complete the application.

8. Sign the application. Your signature authorizes RHS access in confirming income and deductions as disclosed on the program application form.

9. Front office clerical staff will complete Section B and inform you of the discounted percentage (%) you are required to pay for your services at RHS pending verification of income and deductions. Clerical staff will provide a copy of the application at that time. You can request an additional copy of the application following completion of verification of income and deductions

10. To receive approval of your application you are required to provide verification of income and deduction (listed in Section C) to the front office clerical staff to receive a discount for services.

11. Verification of income and deductions is required to be submitted within two weeks of date of application. If verification is not received the you are required to begin the application process again and any services provided in the 2 week time period are not discounted and you are billed the remaining full rate balance.

12. RHS is unable to determine a discount without completion of the application. A discount cannot be applied until application and verification completion.

13. Providing false information on an application or false verification on an application can result in revoking the sliding scale fee discounts and the full balance of the account restored and payable immediately.

14. All alternative payment resources must be exhausted, including all third-party payment from insurance(s), Federal, and State Programs. If it appears you are eligible for Medicaid based on income a written denial of coverage by Medicaid may be required for verification.

15. Fee Determination is every 6 months and at patient/client request at change of income or deductions

16. A nominal fee of $5.00 is requested if it is determined your income is at or below 100% of poverty level, but does limit treatment at any time. This fee does not pose a barrier to receiving treatment if a patient/client is unable to meet financial obligations. The nominal fee is not considered a minimum fee or co-payment. It is RHS policy to provide essential services regardless of the patient's ability to pay.

17. If the services provided…
    - are for **<u>one time appointment</u>** or **a GAIN** the % payment the patient/client is responsible for is collected on day of service.
    - **require <u>more than one appointment</u> or require <u>on-going appointments</u>** the patient/client pays for services provided today at the next appointment.
18. RHS Family Medical Clinic does not offer sliding scale medical services. RHS has an agreement with the Community Family Clinic for sliding scale medical services. Individuals in need of sliding scale pay medical services are referred to the Community Family Clinic
    RHS Family Medical Clinic does not offer sliding scale medical services. RHS has an agreement with the Community Family Clinic for sliding scale medical services. Individuals in need of sliding scale pay medical services are referred to the Community Family Clinic – see website for locations and hours.

    https://communitycouncilofidaho.org/communityfamilyclinic/

    Idaho Falls 208-528-7655

    Blackfoot 208-782-0500

    Roberts 208-228-2000

RHS
Mental Health Solutions
Changing Lives Together
EST. 1998
Rehabilitative Health Services
PHONE: (208) 523-5319 FAX: (208) 523-5627
ADDRESS: 1675 Curlew Dr. Ammon, ID 83406

Addiction and Trauma
Recovery Services at RHS
EXPERIENCE. STRENGTH. HOPE.
PHONE: (208) 932-0668 FAX: (208) 932-0809
ADDRESS: 1675 Curlew Dr. Ammon, ID 83406

Sliding Scale Fee Discount Program Application

Financial Eligibility and Sliding Scale FEE DETERMINATION

Client Legal Name:	
Date of Birth:	
Social Security Number:	

Patient/Client/Responsible Party ***fee determination and financial responsibility*** for services not coved by third party liable resources *(uninsured),* other payment sources, or underinsured. **Fee redetermination is every 6 months, can be more often as requested by client/ parent/ guardian, and at minimum every 12 months**

Office use	
Date Initiated:	
Date Complete:	
☐ Initial Fee Determination	
☐ Fee Determination Update	
Line 15 (% of fee) _____	
☐ Denied (See reason Section B)	

DETERMINATION

INCOME AMOUNT *BELOW IS FOR THE INCOME MADE IN THE FULL PRIOR MONTH. (If you are paid or receive dividends every 3 months divide the income by 3 to arrive at 1 months income and so on.)*

DEDUCTIONS AMOUNTS *BELOW ARE FOR THE DEDUCTION TOTAL IN THE FULL PRIOR MONTH (If you have 1 time deduction within the calendar year divide it by 12 months and so on)*

Section A		
1. Do you have Insurance or 3rd Party Payer? ☐ YES ☐ NO If yes, see below		
☐ BPA ☐ Veterans Benefits	☐ Medicaid Number _____ ☐ Medicare Number _____	☐ Private Insurance (name) _____
2. Client requested form of payment for services : ☐ Insurance ☐ Cash pay only		
3. Number of People in Residence (family household size) - Persons related by blood, marriage, or adoption. Adult siblings, who are not claimed as dependents, and individuals receiving Supplemental Security Income (SSI) or Supplemental Security Disability Income (SSDI), and income from minor siblings **do not count towards household income.** Adults residing with one or more parents, relatives, or unrelated individuals shall constitute a separate family household as long as that adult is not claimed as a dependent of any parent, relative or unrelated individual for income tax purposes.		
4. Current Gross Income (prior to all tax) **for Residence** - Only that individual's income & the income of his or her spouse and dependent children (residing in the same household) shall be considered when establishing family household for purposes of calculating his or her ability to pay (IDAPA 16.07.01)		
Deductions from gross income to determine sliding fee scale		
5. State and Federal Tax Payments including FICA (social security)		

6. Court-Ordered Obligations - All financial payments which have been ordered by a court that may include victim's restitution, courts costs, and feeds, fines, supervision costs, drug court or mental health court fees, child support, alimony.	
7. Dependent Support - Financial payments the client or client parent pays to support another individual that does not live within the residence *(A dependent is an individual that relies on his/her family's income for over 50% of his/her financial support, including child support, elder care, and alimony.)*	
8. Child Care Payments - child care expenses for while client or parent of client is working	
9. Medical Expenses - Amount paid for insurance premiums, payments to doctors, & hospitals, medication, physical therapy, and dental.	
10. Transportation - Amount paid for car payments, gas, insurance, and public transportation	
11. Extraordinary rehabilitative expenses - Financial obligations as a result of the disability needs of the person receiving services. Monthly costs for items including, wheelchairs, adaptive equipment, medication, treatment, or therapy etc. not included in the medical payments deduction	
Deductions and Eligible Income Totals	
12. Total Deductions (Lines 5-11)	
13. Eligible Monthly Income Total Line 4 _____ – Line 12 _____ =	

- *I attest, the family size and income information shown above is correct.*
- *I attest, copies of pay stubs, documents, and other information verifying income or deductions that may be required for verification, are correct.*

Responsible Party Signature :		**Date:**	
Responsible Party PRINTED NAME:			

Section B	
Office Use **Sliding Scale Rate Determination**	
14. Eligible Yearly Income Line 13_____ X 12 months =	
15. Using Line 14 total… - Find where the income falls on the Cash Pay Sliding Fee Schedule within the family household size - Follow the column to the bottom of the page to find the % of Cost Sharing Responsibility of a Parent or Adult Service Recipient. - Enter the % (if the % is 0% then enter 0 % and $5.00 in the right hand column and in the Raintree Insurance comments)	
16. Sliding Scale Service Rate Formula Template RHS Rate for Service(s) provided x Line 15% (enter % as .05, .1, .15, .2 etc) =	Allowable Service Fee Rate
Service Name: GAIN **Procedure Code:** H0001 **RHS Service Fee Rate:** $240.00 x Line 15_____ =	
Service Name _____ **Procedure Code:** _____ **RHS Service Fee Rate** _____ x Line 15_____ =	

Service Name _____ **Procedure Code:** _____ **RHS Service Fee Rate** _____ x Line 15_____ =	
Service Name _____ **Procedure Code:** _____ **RHS Service Fee Rate** _____ x Line 15_____ =	
Service Name _____ **Procedure Code:** _____ **RHS Service Fee Rate** _____ x Line 15_____ =	

☐ **Application Approved** ☐ **Application Denied** (Document Reason Below)

Completed by (print name):		**Date:**	
Staff Signature:			

Section C

Office Use **Verification (attach copies)**

Identification/Address: ☐ Driver's license ☐ Utility Bill ☐ Employment ID
☐ Other _____ ☐ None – could not provide

☐ **Medicaid Letter of Denial** (if applicant appears eligible for Medicaid by income, but is not currently on Medicaid)

Income for the full prior month (Line 4.):

- ☐ Did not or could not provide
- ☐ Pay stubs or verification of employment income
  - ☐ Client or parent of client ☐ Additional residence parent ☐ Client Spouse ☐ Client's dependents
- ☐ Personal business
- ☐ Social security, pension, annuity, or veteran's benefits
- ☐ Alimony, child support, or military family allotments
- ☐ Rent, interest, dividend, and other income _____
- ☐ No income

Deductions

☐ **State or Federal Tax Payments** (Line 5.):

- ☐ Did not or could not provide – See Signed statement of income and deductions
- ☐ Pay stubs or verification of employment income
  - ☐ Client or parent of client ☐ Additional residence parent ☐ Client Spouse ☐ Client's dependents

☐ **Court Ordered Obligations** (Line 6.):

- ☐ Did not or could not provide – See Signed statement of income and deductions
- ☐ Statement or copy of court order of obligations

☐ **Dependent Support** (Line 7.):
- ☐ Did not or could not provide – See Signed statement of income and deductions
- ☐ Statement or copy of alimony or child support agreement
- ☐ Other _____

☐ **Child Care Payments** (Line 8.):
- ☐ Did not or could not provide – See Signed statement of income and deductions
- ☐ Receipts for child care

☐ **Medical Expenses** (Line 9.):
- ☐ Did not or could not provide – See Signed statement of income and deductions
- ☐ Receipts for medical expenses
- ☐ Medical/Dental Insurance bills
- ☐ Medication receipts

☐ **Transportation** (Line 10.):
- ☐ Did not or could not provide – See Signed statement of income and deductions
- ☐ Receipts for gas or public transportation
- ☐ Car payment or insurance bill

☐ **Extraordinary rehabilitative expenses** (Line 11.):
- ☐ Did not or could not provide – See Signed statement of income and deductions
- ☐ Receipt(s) for monthly costs for items such wheelchairs, adaptive equipment, medication, treatment, or therapy etc. which were not included in the medical payments deduction _____

Verified by (print name):		**Date:**	
Staff Signature:			

01/04/21

REHABILITATIVE HEALTH SERVICES and ADDICTION TRAUMA RECOVERY SERVICES AT RHS

Sliding Scale Fee Program Schedule Behavioral Health Services IDAPA 16.07.01.500, Federal Poverty Rates based on Household size 2020, AND NHSC

		Percentage of Poverty Level																		
99% & under ↓		100-109%	110-119%	120-129%	130-139%	140-149%	150-159%	160-169%	170-179%	180-189%	190-199%	200-209%	210-219%	220-229%	230-239%	240-249%	250-259%	260-269%	270-279%	280-289%	290-above
Fam Size ↓		**Income Amount based on Calculated Percentage of Poverty Level**																		
1	0	12,760	14,036	15,312	16,588	17,864	19,140	20,416	21,692	22,968	24,244	25,520	26,796	28,072	29,348	30,624	31,900	33,176	34,452	35,728	37,004
2	0	17,240	18,964	20,688	22.412	24,136	25,860	27,584	29,308	31,032	32,756	34,480	36,204	37,928	39,652	41.376	43,100	44,824	46,548	48,272	49,996
3	0	21,720	23,892	26,064	28,236	30,408	32,580	34,752	36,924	39,096	41,268	43,440	45,612	47,784	49,956	52,128	54,300	56,472	58,644	60,816	62,988
4	0	26,200	28,820	31,440	34,060	36,680	39,300	41,920	44,540	47,160	49,780	52,400	55,020	57,640	60,260	62,880	65,500	68,120	70,740	73,360	75,980
5	0	30,680	33,748	36,816	39,884	42,952	46,020	49,080	52,156	55,224	58,292	61,360	64,428	67,496	70,564	73,632	76,700	79,768	82,836	84,904	88,972
6	0	35,160	38,676	42,192	45,708	49,224	52,740	56,256	59,772	63,288	66,804	70,320	73,836	77,352	80,868	84,384	87,900	91,416	94,932	98,448	101,964
7	0	39,640	32,604	47,568	51,532	55,496	59,460	63,424	67,388	71,352	75,316	79,280	83,244	87,208	91,172	95,136	99,100	103,064	107,028	110,992	114,956
8	0	44,120	48,532	52,944	57,356	61,768	66,180	70,592	75,004	79,416	83,828	88,240	92,652	97,064	101,476	105,888	110,300	114,712	119,124	123,536	127,948
9 +	0	4,480	4,928	5,376	5,824	6,272	6,720	7,168	7,616	8,064	8,512	8,960	9,408	9,856	10,304	10,304	11,200	11,200	12,096	12,544	12,992
Percentage of Cost Sharing Responsibility of a Parent or Adult Services Recipient – (% of the service rate parent or recipient pays for services based on income)																					
	0 %	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	55%	60%	65%	70%	75%	80%	85%	90%	95%	100%

Rule and Guideline References: IDAPA Behavioral Health Sliding Fee Schedule 16.07.01 (.500) 3-20-20 – Optum Provider Manual/Contracts refer to and comply with all state and federal rules