Status Active PolicyStat ID 12725123

Kedren Community Health Center

Origination	12/2020	Owner	John Griffith: President/ CEO
Last Approved	03/2022	Area	Finance
Last Revised	03/2022		
Next Review	03/2024		

Fair Pricing Policy

POLICY: FAIR PRICING POLICY

It is the policy of Kedren Acute Psychiatric Hospital & Community Mental Health Center ("KAPH&CMHC") to have a Sliding Fee Discount Program that is provided to all eligible patients with incomes at or below 400% of the current federal poverty guidelines, based solely on household size and income, and no other criteria. This policy is intended to adjust charges based on the patient's ability to pay in order to address financial barriers to care.

PURPOSE:

To assure the establishment of a sliding fee scale in conformity with federal poverty guidelines and requirements based upon patient's income and household size, whether the patient is insured or uninsured and to ensure KAPH&CMHC has a sliding fee discount program that applies to all patients for all services provided by the KAPH&CMHC for which there are distinct fees.

DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

A. **Family (Household) size: Using the Census Bureau definition, a group of two or more people who reside together and are related by birth, marriage, or adoption, or legally recognized domestic partner.**

B. **Family Income: Family is determined using the Census Bureau definition, which uses the**

following income when computing Federal Poverty Guidelines:

- **Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.**
- **Capital gains or losses, noncash benefits (such as food stamps and housing subsidies), and tax credits do not count (determined on a before-tax basis).**
- **If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).**

A. **Uninsured: The patient has no level of insurance or third-party assistance to assist with meeting their payment obligations.**

B. **Underinsured: The patient has some level of insurance or third-party assistance but still has out-of-pocket expenses that exceed their financial abilities.**

C. **Sliding Fee Application Form: The document used in the collection of information used to determine eligibility for the applicable fee according to the sliding fee scale.**

D. **Eligibility period: is one year from the time the sliding fee funding form is approved or sooner if there is a change in family size or income. The patient is required to notify the health center of any such changes.**

E. **The Sliding fee discount is structured to ensure that patient charges are adjusted based on ability to pay. The nominal charge(s) is less than the fee that would be paid by patients in the first sliding fee discount pay level above 100% of FPG.**

F. **Federal Poverty Guidelines (FPG) and Levels are updated and published in the Federal Register annually.**

G. **The current FPG are those which are always used in the calculations for all of the discount pay levels.**

H. **Nominal amount is a flat fee charged for patients at or below 100% of Federal Poverty Level. The nominal amount is determined in a manner that ensures it is nominal from the patient's perspective and is not a barrier to care and it does not reflect the true cost of the service being provided.**

I. **Setting the flat nominal charge(s) for patients at a level that would be nominal from the perspective of the patient will occur using in one or more of the following methods: a) based on input from patient board members, b) patient surveys, c) advisory committees, d) review of co-pay amount(s) associated with Medicare and Medicaid for patients with comparable incomes e)utilization rates by sliding fee discount levels/tiers, collection rates by sliding fee discount levels, etc.**

J. **Sliding fee scale is updated annually once the federal poverty levels are published and is approved by the Board of Directors. KCCC will also update all electronic systems and those patient information forms affected by the change in the Federal Poverty Level.**

K. **Sliding fee discount program evaluation occurs at a minimum once every three years or more often if deemed necessary.**

L. **Self-Declaration is allowed for patients that do not have any proof of income.**

M. **The Kedren Community Health Center Board of Directors approves the sliding fee discount program.**

N. **Patients with third party coverage may also be eligible for sliding fee discount program since eligibility is based on income and family size and no other criteria. Accordingly, a patient who has third party coverage and is eligible for sliding fee discount will pay the lower of the nominal flat amount/sliding fee discount charge or their deductible, co-pay, share of cost, etc.**

O. **Services Covered include all services provided by the Kedren Community Health Center's KAPH&CMHC.**

P. **There shall be at least three sliding fee levels between 100% and 400% of the FPL.**

Q. **Acceptable forms of proof of income include: a recent (within 15 months) W-2 forms or the most recent pay stub(s) (within 2 months), most current income tax return (modified adjusted gross income (MAGI) amount. Additional verification includes unemployment letter, letter from parent or caretaker or employer, or other income from domestic partner or spouse, social security earnings, other retirement or VA benefits, child support, court orders, welfare checks, workman's compensation checks, etc. and self-declaration.**

R. **The KAPH&CMHC will collect data to evaluate the effectiveness of its Sliding Fee Discount program at least once every three years.**

PROCEDURES:

1. **Establishing Discounts. The KAPH&CMHC has established a sliding fee schedule for all eligible patients whose annual individual or family incomes do not exceed 400% of the most current Federal Poverty Guidelines.**

2. **Publicizing Discounts. The KAPH&CMHC will inform all patients of the availability of discounts through such means as notifications on intake forms, notices in public spaces, etc.**

3. **Eligibility Documentation assistance. The Enrollment Specialist or other assigned staff will assist patients in completing a sliding fee discount application and will collect relevant income verification documentation from patients. Whenever possible, completion of the sliding fee discount application and collection of income verification documentation will occur prior to the KAPH&CMHC rendering behavioral healthcare services to the patient, or as soon thereafter as is reasonable, but always prior to the application of the discount.**

   Under no circumstances will services be withheld or denied on account of delay of the eligibility documentation process. New Sliding Fee discount funding applications and collections of income verification documentation will be required of patients on an annual basis or more frequently (e.g., upon change in the patient's income status or change is family size). Copies of all income verification forms, and documentation will be added to the patient's electronic health record.

4. **Application of Discounts. Patients who have completed an application and have submitted income verification documentation, and who have been found based on their application and income verification documentation to be eligible for a discount will be charged in accordance with the sliding fee scale or nominal fee as applicable.**

5. **Collections. The KAPH&CMHC will make a reasonable effort to collect all charges for health**

care services rendered, regardless of whether discounted charges or standard changes are applied. A reasonable effort may include, but is not limited to, issuance of a bill to the patient or responsible party and follow-up with subsequent billing, collection letters, and telephone calls. The telephone calls will include three attempts to collect fees and documented in the Electronic Health record. A patient's refusal to pay does not equate to an inability to pay.

6. **No Denial of Services for Inability to Pay. Regardless of whether a patient qualifies for a discount, if a patient would be denied services due to inability to pay, then charges will be waived or reduced to the extent necessary to ensure that such patient receives health care services based on hardship criteria. This determination will be conducted on a case-by-case basis based on an individualized determination of need and the hardship situation. Administrative judgements for waiving or reducing payments may be made for the hardship situations or other unforeseen circumstances that would impede the patient's ability to pay and must be properly documented and sent to the Clinic Manager for approval.**
    a. **. Patient must provide a written statement for the basis for their hardship request.**
    b. **. Hardship situations include for example, sudden loss of employment, residence, or family member, natural disaster, catastrophic illness of the patient or family member, loss of insurance coverage, and or other contributory circumstances consistent with a financial hardship.**
    c. **. Waiver or reduction of payment determination will be made at the time that the written request is submitted, and the validity period will be for that one encounter only.**
    d. **. The assigned staff person will review and prepare the waiver/reduction form for the Clinic Manager's approval and once approval is obtained will contact the patient with the determination. CFO may approve in the absence of the CEO.**

Health Center shall ensure that patients are informed about availability of the Sliding Fee Discount Program (SFDP)

1. **New patients requesting appointments or other services are informed of the availability of the sliding fee discount program. At the time of all telephonic appointment scheduling, all patients requiring documentation to qualify for the SFDP will be informed of the required documents.**
2. **An informational brochure/handout about the discount program is given to each new patient at the time of initial registration.**
3. **The KCCC shall post a notice about the Sliding Fee Discount Program at the reception area/ intake desk and with Enrollment Specialist and/or other assigned staff. All shall provide reminders to patients regarding the availability of the sliding fee through printed messages on billing statements and other means.**
4. **Sliding Fee Discount Program will be provided in language and literacy level that accommodates KCCC's patients served.**

Decline to be Assessed (Refusal to Participate):

a. **Some patients may choose not to provide information that the KAPH&CMHC requires for assessing income and family size, even after being informed that they may qualify for sliding fee discount.**

b. **These patients are considered by KAPH&CMHC as declining to be assessed for eligibility for sliding fee discounts. As long as KAPH&CMHC has followed its policies and procedures and the patient declines to be considered for the SFDP, KAPH&CMHC may consider the patient ineligible for such discounts.**

KAPH&CMHC shall maintain a uniform process for accessing and re-assessing for the sliding fee discount program applications and will verify patient eligibility no less than annually.

1. **As part of the registration process, patients are asked their income and family size and if they are interested in financial assistance in paying for health services. If so, patients given the sliding fee application and are assesses for eligibility for the sliding fee discount program.**
2. **Patients applying for the Sliding Fee Discount Program are asked to provide a government issued photo identification card, household size and written verification of monthly income.**
3. **Temporary eligibility will be granted for those patients who have stated that they have written verification of monthly income but did not bring it to the appointment. Patients will be expected to bring verification of monthly income to the clinic at their next visit. The patient will be asked to sign the Affidavit of Income/No Income form until verification is brought in.**
4. **If a patient qualifies for the Sliding Fee Discount Program or receives temporary eligibility, the appropriate sliding scale discount shall be granted. To determine the sliding scale appropriate for each qualified patient, the total household income and family size shall be compared to the sliding fee scale chart.**
5. **For insured sliding fee patients, the out-of-pocket expense a patient incurs, who is eligible for a discount, is not the lower of their eligible sliding fee discount or out of pocket expense.**
6. **Patients applying for the Sliding Fee Discount Program will be informed that they are obligated to contact KAPH&CMHC if their income or household status changes at their next visit. Patients will be asked to verify their income annually for the sliding fee to apply.**

KAPH&CMHC will maintain uniform minimum payment terms for Sliding Fee Discount Program Services.

1. **KAPH&CMHC will request a nominal fee from patients at or under 100% of the federal poverty guidelines**
2. **Sliding fee discounts apply to patient visits and related procedures.**

3. **When a sliding fee scale patient is in need of other services not provided directly by the KAPH&CMHC, the patient is responsible for paying for the service in accord with the discount provided in the sliding fee schedule.**

KCCC shall maintain consistent expectations for payment on outstanding balances and clearly communicate these expectations.

1. **KAPH&CMHC shall request and expect payment at the time of visit. Patients that cannot make their payment at the time of service will be asked to bring payment to the next visit.**
2. **KAPH&CMHC's sliding fee patient accounts are handled in a manner consistent with payment and collection policies. See separate billing and collections policies. After days with no activity on an account, KAPH&CMHC's billing department will work with patients to establish payment plans.**
3. **The sliding fee scale is available to insured patients with payment responsibilities, who meet the income requirements, the patient will be charged no more than the discounted pay level for which she/he is eligible.**
4. **For patients without revenue (income) at the time of visit, or cannot make payment for nominal services, labs, or medication, KAPH&CMHC will make every effort to facilitate care on behalf of the patient, despite their immediate inability to pay. The CEO or his/her designee will have discretion over financial decisions most beneficial to the patient, including adjusting payments.**

Attachments

A - Kedren Community Health Center, Inc. Sliding Fee Scale 2022.pdf

B - Notification of Kedren's Payment Assistance Program for Patients and the Public English and Spanish Versions.pdf

C - Client Face Sheet and Payor Financial Info 11172022162124-0001.pdf

D - Uniform Patient Fee Scale.pdf

E - Completing the PFI Form - MH 281 Supplement A - 1 pages 5 - 26.pdf

F - Completion of the PFI for Medi-Cal Beneficiaries pgs 27- 41.pdf

G - Medi-Cal Share of Cost (SOC) 42 - 50.pdf

Approval Signatures

Step Description	Approver	Date
	Maureen Sabino: Chief Financial Officer	03/2022
	John Griffith: President/ CEO	03/2022

Kedren Community Care Clinic
Sliding Fee Scale 2022

Refer to Federal Register 1/21/2022

Effective Date: 03/01/2022

The Kedren Community Health Center, Inc sliding fee discount schedule is used to determine the discount a patient will receive on their total charges for services. The scale below shows monthly income.

These fees and discounts apply to medical and behavioral health services provided directly by Kedren Community Health Center, Inc.

	A		B		C		D		No Discount	
Persons in Family/ Household	**<=100% FPG**		**101%-133% FPG**		**134%-166% FPG**		**167%-400% FPG**		**401%> FPG**	
1	$ -	$ 1,133	$ 1,134	$ 1,506	$ 1,507	$ 1,880	$ 1,881	$ 4,530	$ 4,531	+
2	$ -	$ 1,526	$ 1,527	$ 2,029	$ 2,030	$ 2,533	$ 2,534	$ 6,103	$ 6,104	+
3	$ -	$ 1,919	$ 1,920	$ 2,552	$ 2,553	$ 3,186	$ 3,187	$ 7,677	$ 7,678	+
4	$ -	$ 2,313	$ 2,314	$ 3,076	$ 3,077	$ 3,839	$ 3,840	$ 9,250	$ 9,251	+
5	$ -	$ 2,706	$ 2,707	$ 3,599	$ 3,600	$ 4,492	$ 4,493	$ 10,823	$ 10,824	+
6	$ -	$ 3,099	$ 3,100	$ 4,122	$ 4,123	$ 5,145	$ 5,146	$ 12,397	$ 12,398	+
7	$ -	$ 3,493	$ 3,494	$ 4,645	$ 4,646	$ 5,798	$ 5,799	$ 13,970	$ 13,971	+
8	$ -	$ 3,886	$ 3,887	$ 5,168	$ 5,169	$ 6,450	$ 6,451	$ 15,543	$ 15,544	+
Payment:										
Medical	**$10** *Nominal Charge*		**25%**		**50%**		**75%**		**100%**	

For families/households with more than 8 persons, add $393.33 for each additional person.

Discount Schedule based on 2022 Federal Poverty Guidelines found at https://aspe.hhs.gov/sites/default/files/documents/4b515876c4674466423975826ac57583/Guidelines-2022.pdf

No one will be turned away for lack of ability to pay.

IMPORTANT INFORMATION NOTICE

Notification of Kedren's Payment Assistance Program for Patients and the Public

Information about patient payment assistance available through Kedren includes a toll-free contact number (855) 808-4580, disseminated by various means, including, without limitation, the publication of notices in patient bills, and by posting notices in waiting rooms, admitting and registration department, hospital business offices and patient financial services offices that are located at all of Kedren's locations (Kedren Hospital and Outpatient Clinics), and at public places as Kedren may elect. Information shall also be included on facility website and with the Conditions of Admission form. Such information shall be provided in the primary languages spoken by the populations served by Kedren. Referral of patients for payment assistance may be made by any member of Kedren's staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for payment assistance may be made by the patients, or a family member, a close friend or associate of the patient, subject to applicable privacy laws.

For more information please contact:

Javier Arellano
Services Coordinator
(323) 802-0361
j_arellano@kedren.org

OR

Hilda Rodriguez
Revenue Manager
(323) 802-0264
h_rodriguez@kedren.org

Revised 11/8/2022

AVISO DE INFORMACIÓN IMPORTANTE

Notificación de Programa de Asistencia de Pago de Kedren Para Pacientes y el Publico

La información sobre la asistencia de pago del paciente disponible a través de Kedren incluye un numero de contacto gratuito (855) 808-4580, diseminada por diversos medios, incluida, entre otras, la publicación de avisos en las facturas de los pacientes y mediante la publicación de avisos en las salas de espera, el departamento de admisión y registro, las oficinas comerciales del hospital y las oficinas de servicios financieros para pacientes que se encuentran en todas las ubicaciones de Kedren (Kedren Hospital y clínicas ambulatorias), y en lugares públicos que Kedren elija. La información también se incluirá en el sitio web de la instalación y con el formulario de Condiciones de Admisión. Dicha información se proporcionará en los idiomas principales hablados por las poblaciones atendidas por Kedren. Cualquier membro del personal o del personal médico de Kedren, incluidos médicos, enfermeros, asesores financieros, trabajadores sociales, administradores de casos, capellanes y patrocinadores religiosos, puede derivar pacientes para asistencia con el pago. Los pacientes, o un miembro de la familia, un amigo cercano o un asociado del paciente pueden realizar una solicitud de asistencia de pago, sujeto a las leyes de privacidad aplicables.

Para mas información, favor de contactar a:

Javier Arellano
Coordinador de Servicios
(323) 802-0361
j_arellano@kedren.org

O

Hilda Rodriguez
Gestora de Ingresos
(323) 802-0264
h_rodriguez@kedren.org

MH 224A
Revised 10/29/09

CLIENT FACE SHEET

Note: Shaded/Bolded fields must be completed on individuals prior to Triage.
The remainder of the fields must be completed prior to opening an Episode.

***See Client Face Sheet Codes Table for a listing of codes/definitions for the field.**
**** Field is NOT entered into the IS; information gathering only.**

CLIENT DATA			CLIENT I.D.#
Last Name:			
First Name:		**Middle Name:**	
AKA/Maiden Last Name:			
AKA First Name:		**Middle Name:**	
SSN:	**Mother's Maiden Name:**		
Gender: Male ☐ Female ☐ Other ☐ Unknown ☐		**DOB:**	**Age:**
English Speaking: Yes ☐ No ☐	***Primary Lang:**	***Preferred Lang:**	***Ethnicity:**
***If Hispanic, Indicate Origin:**	***If American Indian/Alaska Native, Indicate Tribe:**		
***Education Level :**	***Level of Care:**	***Conservatorship:**	
***Handicap:**	***Marital Status:**	***APR:**	**Veteran: Yes ☐ No ☐**
***Living Arrangement:**	***Employment Status:**	**Date of Death:**	
****Are there children in the home? Yes ☐ No ☐**	****Dependent(s) in the home? Yes ☐ No ☐**		
****Insurance: Medi-Cal ☐ Medicare ☐ Indigent ☐ Private/Other ☐ Unknown ☐**			
CLIENT ADDRESS			
Transient/Homeless: Yes ☐ No ☐	***Time Homeless:**		
Address:			
Second Line:			
City:	***State:**	Zip:	***County:**
Phone (Home):	****(Cell)**		**(Work)**
Address Memo:			
EMERGENCY CONTACTS	DO NOT CONTACT EMERGENCY CONTACTS EXCEPT IN EMERGENCY SITUATIONS WHICH HAVE BEEN CLEARLY DOCUMENTED		
Name:			*Contact Type:
Address:	City:	*State:	Zip:
Relationship:	Phone:	Email:	
Name:			*Contact Type:
Address:	City:	*State:	Zip:
Relationship:	Phone:	Email:	
Complete only if the Client's Child is enrolled in FSP			
Child's Name:			Contact Type: **Child Enrolled in FSP**
Address:	City:	State:	Zip:
DMH I.D.#	Phone:	Email:	
SFPR and PRIMARY CONTACT			
SFPR Name:			Provider Number:
Primary Contact Name:			Provider Number:
BIRTH INFORMATION			
Indicate Client Birth Name (If different than the name listed in Client Data)			
Last Name:	First Name:		Middle Name:
Birth County:	Birth State:	Birth Country (If born outside US):	
Mother's First Name:			

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

CLIENT FACE SHEET

Please return to: Kedren Community Health Center, Inc.
4211 S. Avalon Blvd., Los Angeles, CA 90011
Attn: Hilda Rodriguez (H_Rodriguez@kedren.org)

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH

PAYOR FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1	CLIENT NAME		SS #	CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	SPOUSE NAME

THIRD PARTY INFORMATION

3 ☐ NO THIRD PARTY PAYOR

4	MEDI-CAL ☐ YES ☐ NO	MEDI-CAL COUNTY CODE /AID CODE/ CLAIM #		MEDI-CAL PENDING ☐ YES ☐ NO REFERRED FOR ELIGIBILITY ☐ YES ☐ NO			DATE REFERRED
5	SHARE OF COST ☐ YES ☐ NO	SOC AMT $	SSI PENDING ☐ YES ☐ NO	SSI APPLICATION DATE	IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON		
6	MEDI-CAL HMO ☐ YES ☐ NO	CALWORKS ☐ YES ☐ NO	AB3632 ☐ YES ☐ NO	GROW ☐ YES ☐ NO	HEALTHY FAMILIES ☐ YES ☐ NO	HEALTHY FAMILIES CIN #	OTHER FUNDING
7	MEDICARE ☐ YES ☐ NO	MEDI-GAP ☐ YES ☐ NO	CHAMPUS ☐ YES ☐ NO	VET/ADM ☐ YES ☐ NO	PRIVATE INS ☐ YES ☐ NO	HMO ☐ YES ☐ NO	CLAIM #
8	NAME OF CARRIER			GROUP/POLICY/ID #		NAME OF INSURED	
9	CARRIER ADDRESS					ASSIGNMENT/RELEASE OF INFORMATION OBTAINED ☐ YES ☐ NO	

PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10	NAME OF PAYOR	RELATION TO CLIENT	DOB	MARITAL STATUS ☐M ☐S ☐D ☐W ☐SP	PAYOR CDI/CAL ID
11	ADDRESS	CITY	STATE	ZIP CODE	TEL #
12	SOURCE OF INCOME ☐ SALARY ☐ SELF EMPLOYED ☐ UNEMPLOYMENT INSURANCE ☐ DISABILITY INSURANCE ☐ SSI ☐ GR ☐ VA ☐ Other Public Assistance ☐ IN-KIND ☐ UNKNOWN ☐ OTHER:				PAYOR SS #
13	EMPLOYER	POSITION			IF NOT EMPLOYED DATE LAST WORKED
14	EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
15	SPOUSE	ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #
16	SPOUSE'S EMPLOYER	POSITION			IF NOT EMPLOYED, DATE LAST WORKED
17	SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
18	NEAREST RELATIVE/RELATIONSHIP	ADDRESS (Include City, State & Zip Code)			TEL #

UMDAP LIABILITY DETERMINATION

19 LIQUID ASSETS		20 ALLOWABLE EXPENSES		21 ADJUSTED MONTHLY INCOME	
Savings	$	Court ordered obligations paid monthly	$	Gross Monthly Family Income	
Checking Accounts	$	Monthly child care payments (necessary for employment)	$	Self/Payor	$
IRA, CD, Market value of stocks, bonds and mutual funds	$	Monthly dependent support payments	$	Spouse	$
TOTAL LIQUID ASSETS	$	Monthly medical expense payments	$	Other	$
Less Asset Allowance	$	Monthly mandated deductions from gross income for retirement plans, (Do not include Social Security)	$	TOTAL	$
Net Asset Valuation	$	**Total Allowable Expenses**	$	Add monthly asset valuation	$
Monthly Asset Valuation (Divide Net Asset by 12)	$	VERIFICATION OBTAINED ☐ YES ☐ NO		TOTAL	$
VERIFICATION OBTAINED ☐ YES ☐ NO				Subtract total expenses	$
				Adjusted Monthly Income	$
				VERIFICATION OBTAINED ☐ YES ☐ NO	

22	Number Dependent on Adjusted Monthly Income	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD FROM TO	Payment Plan $ per month for months.
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)			

OTHER

24	PRIOR MH TREATMENT (Only applicable to current Annual Charge Period) ☐ YES ☐ NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE	REASON ADJUSTED	
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER		PROVIDER NAME AND NUMBER	
27	I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON		DATE	

MH 281 Rev. 04/03/2006

Please return to: Kedren Community Health Center, Inc.
4211 S. Avalon Blvd., Los Angeles, CA 90011
Attn: Hilda Rodriguez (H_Rodriguez@kedren.org)

Uniform Patient Fee Schedule
Community Mental Health Services
Attachment C to DMH Notice 98-13
Effective October 1, 1989

Monthly Adjusted Gross Income*	Persons Dependent on Income Annual Deductibles					Monthly Adjusted Gross Income*	Persons Dependent on Income Annual Deductibles				
	1	2	3	4	5 or more		1	2	3	4	5 or more
	Medi-Cal Eligible Area**					1950 – 1999	1029	926	833	750	675
0 – 569	37	33	30	27	24	2000 – 2049	1142	1028	925	833	750
570 – 599	40	36	32	29	26	2050 – 2099	1268	1141	1027	924	932
600 – 649	45	40	36	32	29	2100 – 2149	1407	1266	1139	1025	923
650 – 699	50	45	41	37	33	2150 – 2199	1562	1406	1265	1139	1025
700 – 749	56	50	45	41	37	2200 – 2249	1734	1561	1405	1265	1139
750 – 799	63	57	51	46	41	2250 – 2299	1925	1733	1560	1404	1264
800 – 849	71	64	58	52	47	2300 – 2349	2136	1922	1730	1557	1401
850 – 899	79	71	64	58	52	2350 – 2399	2371	2134	1921	1729	1556
900 – 949	89	80	72	65	49	2400 – 2449	2632	2369	2132	1919	1727
950 – 999	99	90	80	72	65	2450 – 2499	2922	2630	2367	2130	1917
1000 - 1049	111	100	90	81	73	2500 – 2599	3275	2948	2653	2388	2149
1050 – 1099	125	112	101	91	82	2600 – 2699	3482	3134	2821	2359	2285
1100 – 1149	140	126	113	102	92	2700 – 2799	3695	3326	2993	2694	2425
1150 – 1199	156	140	126	113	102	2800 – 2899	3915	3524	3172	2855	2570
1200 – 1249	177	159	143	129	116	2900 – 2999	4139	3725	3353	3018	2716
1250 – 1299	200	180	162	146	131	3000 – 3099	4370	3933	3540	2186	2867
1300 – 1349	226	203	183	165	149	3100 – 3199	4607	4146	3731	3358	3022
1350 – 1399	255	230	207	186	167	3200 – 3299	4850	4365	3929	3536	3182
1400 – 1449	288	259	233	210	189	3300 – 3399	5099	4589	4130	3717	3345
1450 – 1499	326	293	264	238	214	3400 – 3499	5458	4912	4421	3979	3581
1500 – 1549	368	331	298	268	241	3500 – 3599	5830	5247	4722	4250	3825
1550 – 1599	416	374	337	303	273	3600 – 3699	6214	5593	5036	4532	4079
1600 – 1649	470	423	281	343	309	3700 – 3799	6610	5949	5354	4819	4337
1650 – 1699	531	478	430	387	348	3800 – 3899	7018	6316	5684	5116	4604
1700 – 1749	600	540	486	437	393	3900 – 3999	7438	6694	6025	5423	4881
1750 – 1799	678	610	549	494	445	4000 – 4099	7870	7083	6375	5738	5164
1800 – 1849	752	677	609	548	493	4100 – 4199	8314	7483	6735	6062	5456
1850 – 1899	835	752	677	609	548	Above $4200 add $400 for each $100 additional income.					
1900 - 1949	927	834	751	676	608						

*Monthly Gross Income after adjustment for allowable expenses and asset determination from computation made on the financial intake form.

**Medi-Cal eligible. The shaded Medi-Cal eligible area identifies income levels presumed eligible if client meets Medi-Cal eligibility requirements. (see back page)

The above information was provided by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

10/20/89

Quick Reference

Medi-Cal Eligibility

All clients with monthly income at or below the Medi-Cal Family Budget Unit (MFBU) and have assets at or below the asset allowance area are presumed eligible if they meet aid eligibility requirements.

Maintenance need levels by Medi-Cal Family Budget Unit (MFBU) are:

MFBU				
	1 - $602	3 - $934	6 - $1,417	9 - $1,825
	2 - $750	4 - $1,100	7 - $1,550	10 - $1,959
	2 - $934 (Adults)	5 - $1,259	8 - $1,692	

Asset allowances for 1989 are:

Persons			
	1 - 2000	4 - 3300	7 - 3750
	2 - 3000	5 - 3450	8 - 3900
	3 - 3150	6 - 3600	9 - 4050

Aid categories commonly found in community mental health are:

Refugee: First 18 months in the U.S.	**Disabled**: Meeting federal definition of disability
Aged: 65 years of age and over	**AFDC**: Aid to Family with Dependent Children

Medi-Cal Share-of-Cost

Persons with an extended treatment prognosis who are within a few hundred dollars of asset allowance and maintenance need levels may be eligible for Medi-Cal with a share-of-cost and/or real or personal property spend down.

For Example: A single 70-year old man would be eligible for Medi-Cal except that his income is too high. He has a $1000 medical bill. He meets the low asset levels, but his income from retirement is $1000 per month. His income is $1000 minus the standard $20 disregard and the $24.90 payment for the Medicare Part B, leaving a "net" of $955.10. His "share-of-cost" for Medi-Call is $955.10 minus $602 ("need level") or $353.10. Medi-Cal will pay the remainder of the $1000 medical bill for that month and other months when he obligates the share of cost. He has to submit a Medi-Cal form MC-177 each month he obligates a share of cost above $353.10. His eligibility will be predetermined by Social Services each year.

All persons with property and income within a few hundred dollars of the Medi-Cal limits and are expected to have substantial treatment cost must be referred to Social Services for eligibility determination. Persons on Medi-Cal, SSI or have incomes in the shaded area do not have an annual deductible.

COMPLETING THE PATIENT FINANCIAL INFORMATION (PFI) FORM - MH 281

SUPPLEMENT A-1

The PFI is used to capture client/payor financial information in order to determine a client's ability to pay. It is also used to identify and document third party payor sources for billing purposes. All information recorded on the PFI is confidential (Welfare and Institutions Code, Section 5328).

- **A PFI must be completed for each client treated in the County Mental Health Care System.**

A provider should always request a photocopy of a PHI completed at another facility. A signed **Authorization For Request Or Use/Disclosure Of Protected Health Insurance Information (PHI) MH 602** is not required if the purpose of the request is for billing; however, non-directly operated programs may require an authorization based on their interpretation of the Privacy regulation. If an authorization is requested, the form may be accessed at http://dmhweb/dmhpolicy/docs/500_01_att1.pdf. ***Supplement A-9 (A) & A-9 (B)***

Each provider should provide a photocopy of the PFI when requested. In lieu of obtaining a photocopy of a current PFI, a provider may complete a PFI with the information obtained from the Integrated System (IS), retaining the current annual UMDAP liability period and indicating on the PFI that the information was obtained from the IS. Subsequent providers must accept the UMDAP liability sliding scale fee established by a previous provider for the remainder of the UMDAP liability period, however all information must be confirmed by the client that it is still current.

The following provides detailed instructions for the completion of the PFI.

TEXT APPEARING IN THIS TYPEFACE INDICATES THE ACTUAL WORDING AS IT APPEARS ON THE PFI.

CLIENT INFORMATION

Line 1

CLIENT NAME Enter the client's first, middle, and last name.
SS # Enter the client's Social Security Number.
CLIENT ID # Enter the client's Integrated System (IS) identification number.

Line 2

MAIDEN NAME Enter the client's surname that she had when not yet married.
DOB Enter the client's date of birth – month, date, and year.
MARITAL STATUS Circle the applicable marital status. ***M*** - Married ***S*** - Single ***D*** - Divorced ***W*** - Widowed ***SP*** - Separated
SPOUSE NAME Enter the name of the client's spouse if applicable.

THIRD PARTY INFORMATION

All clients must be questioned as to their eligibility for Medi-Cal and third party payor benefits and providers should ensure benefits are maximized. Welfare and Institutions Code Section 5872 states that participating counties shall collect reimbursement for services from fees paid by private or public third party payors.

Line 3

NO THIRD PARTY PAYOR ☐

This box is to be used only when no other third party payor has been identified. Third party payor is defined as a company or organization that may provide benefits toward treatment costs.

Line 4

MEDI-CAL (☐ YES ☐ NO)

Check the applicable box to indicate the client's Medi-Cal beneficiary status. Medi-Cal is the state's version of Medicaid, a publicly financed national health insurance program that provides comprehensive care to low-income individuals and families. [See **Completion of PFI for Medi-Cal Beneficiaries** following the PFI instructions.]

MEDI-CAL COUNTY CODE/AID CODE/CLAIM #

Enter the client's County Code, Medi-Cal Aid Code, and Medi-Cal Beneficiary Identification Card (BIC) number, or Medi-Cal Client Index Number (CIN). The county and aid codes are provided when proof of Medi-Cal eligibility is obtained. It would be appropriate to enter the BIC Issue Date here also. [See **Medi-Cal Proof of Eligibility** following the PFI instructions.]

MEDI-CAL PENDING (☐ YES ☐ NO)

Check the appropriate box to indicate whether a Medi-Cal application is pending through the Department of Public Social Services (DPSS).

REFERRED FOR ELIGIBILITY (☐ YES ☐ NO)

Check the appropriate box to indicate whether the client was referred to DPSS to apply for Medi-Cal benefits. [See the **Medi-Cal Eligibility Guidelines** following the PFI instructions.]

DATE REFERRED

Enter the date when the client was referred to DPSS.

Line 5

SHARE OF COST (☐ YES ☐ NO)

Check the appropriate box to indicate whether or not the client has a Medi-Cal Share of Cost (SOC). SOC is a term that refers to the amount of health care expenses a recipient must accumulate each month before Medi-Cal begins to offer assistance. [See **Medi-Cal Share of Cost (SOC)** following the PFI instructions.]

SOC AMT

Indicate the dollar amount of the Medi-Cal SOC, if applicable.

SSI PENDING (☐ YES ☐ NO)

Check the appropriate box to indicate whether a Supplemental Security Income (SSI) application is pending through Social Security Administration. SSI is a national program for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled.

SSI APPLICATION DATE

Enter the date of client's application for SSI.

IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON

If the client appeared eligible for Medi-Cal benefits and was not referred to DPSS, indicate the reason why. In addition, if the client appears eligible for SSI and an application was not completed, indicate why.

Line 6

MEDI-CAL HMO (☐ YES ☐ NO)

Check the applicable box to indicate if the client has Medi-Cal assigned to an HMO. If ***YES***, all services provided are to be billed to Short-Doyle/Medi-Cal through the IS.

CALWORKS (☐ YES ☐ NO)

Check the applicable box to indicate if the client is a CalWORKs beneficiary. CalWORKs is California's welfare-to-work program that provides temporary financial assistance and employment focused services to families with minor children that have income and property below State maximum limits for their family size. [See **Completion of PFI for CalWORKs Clients** following the PFI instructions.]

AB3632 (☐ YES ☐ NO)

Check the applicable box to indicate if the client is covered under the AB3632 program. AB3632 is a legislatively mandated program that requires Severely Emotionally Disturbed (SED) children who are referred by the public school districts to County Mental Health Departments be served regardless of available funding. [See **Completion of PFI for AB3632 Clients** following the PFI instructions.]

GROW (☐ YES ☐ NO)

Check the applicable box to indicate if the client is a participant of the GROW Program. GROW is a program that provides employment and training services to help employable General Relief (GR) participants obtain jobs and achieve self-sufficiency. [See **Completion of PFI for GROW Clients** following the PFI instructions.]

HEALTHY FAMILIES (☐ YES ☐ NO)

Check the applicable box to indicate if the client has coverage under the Healthy Families program. Healthy Families is California's Federally Funded Children's Health Insurance Program that provides affordable, low cost, comprehensive Medical, Dental, and Vision coverage for children who do not have insurance and do not qualify for no-cost Medi-Cal.

HEALTHY FAMILIES CLIENT INDEX # (CIN)

The Healthy Families Client Index Number (CIN) is a unique number assigned to a client by the Medi-Cal Eligibility Data System (MEDS). You must have access to MEDS to obtain the CIN.

Client Index Number (CIN) = 9NNNNNNNA

(N = numeric and A = character)

OTHER FUNDING

Enter any other funding that is not specifically identified on the PFI.

Line 7

MEDICARE (☐ YES ☐ NO)

Check the applicable box to indicate if the client is eligible for Medicare benefits. Medicare is a Federal Health Insurance Program for people {1} who have attained the age of 65 or over or {2} has received SSD for two years or more. To clarify who is eligible for treatment when Medicare benefits have been assigned to an HMO, refer to DMH Policy 401.7 Medicare Prepaid Health Care Treatment and Billing.

MEDI-GAP (☐ YES ☐ NO) Check the applicable box to indicate whether or not the client is covered by Medi-Gap insurance. Medi-Gap is a private insurance policy purchased to supplement Medicare benefits. Medi-Gap pays for some of the items that Medicare does not cover such as deductible, co-payment, prescription drugs, and dental.
CHAMPUS (☐ YES ☐ NO) Check the applicable box to indicate whether or not the client is covered by CHAMPUS. CHAMPUS is insurance for retired service personnel, their dependents, and the dependents of active duty service personnel.
VET/ADM (☐ YES ☐ NO) Check the applicable box to indicate if the client is a veteran. Veterans should obtain all medical care at Veterans Administration (VET/ADM) facilities. Refer to DMH Policy 401.4 Procedures for Screening Veterans and Referring Veterans to the U.S. Department of Veterans Affairs regarding exceptional instances such as emergency care when providers may treat veterans and bill the VET/ADM (VA) the actual cost of the services provided.
PRIVATE INS (☐ YES ☐ NO) Check the applicable box to indicate whether or not the client is covered by an indemnity, private, or group health / medical insurance policy.
HMO (☐ YES ☐ NO) Check the applicable box to indicate whether or not the client is covered by a private insurance Health Maintenance Organization (HMO). To clarify who is eligible for treatment, refer to DMH Policy 401.8 Private Prepaid Health Care Treatment and Billing.
CLAIM NUMBER Enter the client's Health Insurance Claim (HIC) number.

Line 8

NAME OF CARRIER Enter the name of the insurance policy carrier.
GROUP/POLICY/ID # Enter any applicable identification numbers.
NAME OF INSURED Enter the name of the insured or subscriber. Verify that it corresponds to the group or policy identification number listed in the ***GROUP/POLICY/ID #*** field.

NOTE: In the event the client is eligible for additional third party coverage, attach an additional sheet of paper detailing the required information.

Line 9

CARRIER ADDRESS Enter the insurance company's address.
ASSIGNMENT/RELEASE OF INFORMATION OBTAINED (☐ YES ☐ NO) Check the applicable box to indicate whether the Assignment/Release of Information was completed, signed, and dated. (See **Insurance Authorization and Assignment of Benefits *Supplement A-4*** for private insurance beneficiaries or **Lifetime Extended Signature Authorization *Supplement A-5*** for Medicare beneficiaries).

PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)

Line 10

NAME OF PAYOR Enter the client's or responsible person's first, middle, and last name.
RELATION TO CLIENT Enter the payor relationship to client.
DOB Enter the payor date of birth - month, date, and year.
MARITAL STATUS Circle the applicable marital status of the payor. ***M*** - Married ***S*** - Single ***D*** - Divorced ***W*** - Widowed ***SP*** - Separated
PAYOR CDL/CAL ID Enter the payor California Drivers License or California Identification Number. (This information is not required in the event of a conservator or foster parent).

Line 11

ADDRESS ***CITY*** ***STATE*** ***ZIP CODE*** Enter the payor residence street address, City, State, and Zip Code. (A post office box is not acceptable as a residence address).
TEL # Enter the telephone number (include area code) where payor may be reached. When necessary, this can be the telephone number of a neighbor or relative where the payor regularly receives messages.

Line 12

SOURCE OF INCOME

Identify how the payor is financially supported.

- ☐ ***SALARY***
- ☐ ***SELF EMPLOYED***
- ☐ ***UNEMPLOYMENT INSURANCE***
- ☐ ***DISABILITY INSURANCE***
- ☐ ***SSI***

  Supplemental Security Income (SSI) / State supplementary payments (SSP)
- ☐ ***GR***

  General Relief
- ☐ ***VA***

  Veterans Administration
- ☐ ***OTHER PUBLIC ASSISTANCE***
- ☐ ***IN-KIND***

  In-Kind is used to identify when a client receives room and board from another person without incurring a financial liability.
- ☐ ***UNKNOWN***
- ☐ ***OTHER***

  Clarification must be provided when other is identified as the source of financial support.

PAYOR SS #

Enter the payor Social Security Number.

Line 13

EMPLOYER

Enter the payor employer name. (This information is not required in the event of a conservator or foster parent.)

POSITION

Enter the payor payroll title or occupation.

IF NOT EMPLOYED, DATE LAST WORKED

If the payor is no longer employed, indicate the last date worked.

Line 14

EMPLOYER'S ADDRESS Enter the payor employer street address, City, State, and Zip Code.
TEL # Enter the payor employer telephone number (include area code).

Line 15

SPOUSE Enter the payor spouse name.
ADDRESS Enter the payor spouse residence address, City, State, and Zip Code if different from payor. If the address is the same indicate *"Same as payor".*
SPOUSE'S SS # Enter the payor spouse Social Security Number.

Line 16

SPOUSE'S EMPLOYER Enter the payor spouse employer name. (This information is not required in the event of a conservator or foster parent.)
POSITION Enter the payor spouse payroll title or occupation.
IF NOT EMPLOYED, DATE LAST WORKED If the payor spouse is no longer employed, indicate the last date worked.

Line 17

SPOUSE EMPLOYER'S ADDRESS Enter the payor spouse employer street address, City, State, and Zip Code.
TEL # Enter the payor spouse employer telephone number (include area code).

Line 18

NEAREST RELATIVE/RELATIONSHIP Enter the name of the nearest relative of the client including the relative's relationship.
ADDRESS Enter the client relative residence address, City, State, and Zip Code.
TEL # Enter the client relative telephone number (include area code).

UMDAP LIABILITY DETERMINATION

Line 19

LIQUID ASSETS		
Savings	$	(1)
Checking Accounts	$	(1)
IRA, CD, Market value of Stocks, bonds and mutual funds.	$	(1)
TOTAL LIQUID ASSETS	$	(1)
Less Asset Allowance	$	(2)
Net Asset Valuation	$	(3)
Monthly Asset Valuation (Divide Net Asset by 12)	$	(4)
(5) VERIFICATION OBTAINED ☐ YES ☐ NO		

(1)	Enter the combined total of liquid assets (those easily converted into cash) of the client/payor and the client/payor's spouse. You are not limited to those identified on the PFI. Liquid assets also include deferred compensation plans, trust funds, etc.
(2)	Subtract the asset allowance amount. The asset allowance is the dollar amount of liquid assets (savings, stocks and bonds, etc.) a family is allowed to retain without it being added into their income for purposes of determining their annual liability. The asset allowance can be determined by using the chart found on the **Quick Reference. *Supplement A-2*** *(The chart identified in this training guide indicates the asset allowances for 1989. This is the most current chart issued by the State of California Department of Mental Health and is still in use. When an update becomes available, it will be issued to all providers).*
(3)	Enter the ***NET ASSET VALUATION*** amount (the total liquid asset amount less the asset allowance amount).
(4)	The ***MONTHLY ASSET VALUATION*** amount is determined by dividing the Net Asset Valuation amount by twelve (12). The amount entered here is to be carried forward to Line 21 - ***ADJUSTED MONTHLY INCOME***, and entered on the line identified as ***ADD MONTHLY ASSET VALUATION***.

(5)	***VERIFICATION OBTAINED (☐ YES ☐ NO)*** Providers are to ask for verification or to directly verify any financial statement made by a client or payor. In making any inquiry to sources other than client or payor, care must be exercised to insure confidentiality requirements, Welfare and Institutions Code, Section 5328. *If verification is not attached or available in the client's financial folder, the client is to be charged the actual cost for services.*

See the following examples:

Example # 1 would include the Asset Allowance for a family of 4. Using this example there would be no additional dollar amount added to the Adjusted Monthly Income amount.

LIQUID ASSETS		
Savings	$	1500
Checking Accounts	$	985
IRA, CD, Market value of Stocks, bonds and mutual funds.	$	0
TOTAL LIQUID ASSETS	$	2485
Less Asset Allowance	$	3300
Net Asset Valuation	$	0
Monthly Asset Valuation (Divide Net Asset by 12)	$	0
(5) VERIFICATION OBTAINED	X YES ☐ NO	

Example # 2 would include the Asset Allowance for one person. Using this example there would be an additional $625 added to the Adjusted Monthly Income amount.

LIQUID ASSETS		
Savings	$	1500
Checking Accounts	$	1000
IRA, CD, Market value of Stocks, bonds and mutual funds.	$	7000
TOTAL LIQUID ASSETS	$	9500
Less Asset Allowance	$	2000
Net Asset Valuation	$	7500
Monthly Asset Valuation (Divide Net Asset by 12)	$	625
(5) VERIFICATION OBTAINED	X YES	☐ NO

Line 20

ALLOWABLE EXPENSES		
Court ordered obligations paid monthly	$	(1)
Monthly child care payments (necessary for employment)	$	(2)
Monthly dependent support payments	$	(3)
Monthly medical expense payments	$	(4)
Monthly mandated deductions from gross income for retirement plans (Do not include Social Security)	$	(5)
Total Allowable Expenses	$	(6)
(7) VERIFICATION OBTAINED ☐ YES ☐ NO		

(1)	Monthly obligations include Court ordered child support and alimony obligations that are to be verified with a copy of the certified court order and receipts or canceled checks verifying payment.
(2)	Monthly child care payments (necessary for employment) are to be verified with receipts or canceled checks.
(3)	Monthly dependent support payments to qualified dependents are for children, spouse, or parents. The deduction is not allowed when the same person or persons are claimed as UMDAP dependents and are to be verified with receipts or canceled checks.
(4)	Monthly medical expense payments include all health, medical and dental premiums as well as expenses and regular monthly payments, i.e., installments on a hospital or dental bill. Payments are to be verified with invoices, receipts, or canceled checks.
(5)	Monthly mandated deductions from income for retirement plans are those that are required as a condition of employment and are not elective. ***DO NOT INCLUDE SOCIAL SECURITY*** payments *[identified as FICA (Federal Insurance Contribution Act) on paycheck stubs]*, because they have been used as a consideration in determining the sliding scale fee schedule. Verification of deductions is available from paycheck stubs.

(6)	The total expense amount entered here is to be carried forward to Line 21 - ***ADJUSTED MONTHLY INCOME***, and entered on the line identified as ***SUBTRACT TOTAL EXPENSES***.
(7)	***VERIFICATION OBTAINED (☐ YES ☐ NO)*** All allowable expenses must be substantiated. If verification is not attached or available in the client's financial folder, do not include the expense in the determination of the client/payor's annual UMDAP liability.

Line 21

ADJUSTED MONTHLY INCOME		
Gross Monthly Family Income		
Self/Payor	$	(1)
Spouse	$	(2)
Other	$	(3)
TOTAL	$	(4)
Add monthly asset valuation	$	(5)
TOTAL	$	(6)
Subtract total expenses	$	(7)
Adjusted Monthly Income	$	(8)
(9) VERIFICATION OBTAINED ☐ YES ☐ NO		

(1)	Enter the client/payor's gross monthly income.
(2)	Enter the client/payor's spouse gross monthly income.
(3)	Enter any additional monthly income such as child or spousal support received or income from a part-time or second job.
(4)	Enter the total monthly income identified above.
(5)	The amount identified on this line is to be added to the total monthly income amount. *(See Section 19 - **LIQUID ASSETS** for information regarding the determination of the **MONTHLY ASSET VALUATION**).*
(6)	Enter the ***TOTAL*** monthly income plus the ***MONTHLY ASSET VALUATION***.
(7)	***SUBTRACT TOTAL EXPENSES*** The amount identified on this line is to be subtracted from the combined totals of the monthly income plus the monthly asset valuation. *(See Section 20 - **ALLOWABLE EXPENSES** for information regarding the determination of monthly allowable expenses).*
(8)	**ADJUSTED MONTHLY INCOME** Enter the balance of the following equation: Total Gross Monthly Income Plus → Monthly Asset Valuation Minus → Total Expenses *Equals* → ***ADJUSTED MONTHLY INCOME***
(9)	***VERIFICATION OBTAINED (☐ YES ☐ NO)*** If verification is not attached or available in the client's financial folder, the client must be charged the actual cost for services.

Line 22

NUMBER DEPENDENT ON ADJUSTED MONTHLY INCOME

Enter the number of dependents applicable to the adjusted monthly income. Dependents are those persons claimable as exemptions on the client/payor's Federal Income Tax Return. Child support that is paid, but does not qualify client/payor to claim the child as a dependent may be claimed in Section 20 - ***ALLOWABLE EXPENSES***. The child support must be court ordered and verification of payment must be provided.

ANNUAL LIABILITY

Enter the amount of the annual liability. The annual liability is determined by using the adjusted monthly income amount and the number dependent on the adjusted monthly income. The **Uniform Patient Fee Schedule *Supplement A-3*** provides the annual UMDAP liability based on income and number of dependents. [The **Uniform Patient Fee Schedule** is dated 1989. This is the correct fee schedule that all providers are to use. **No provider is allowed to develop or use any other sliding scale fee schedule.**]

The shaded Medi-Cal Eligible Area on the Uniform Patient Fee Schedule identifies income levels presumed eligible if the client meets Medi-Cal eligibility requirements. Client/payor income levels falling into the shaded Medi-Cal eligible area are to be assessed an annual UMDAP liability of zero. If the client meets the Medi-Cal eligibility requirements, the client is to be referred to the Department of Public Social Services (DPSS) to apply for Medi-Cal benefits. [See **Medi-Cal Eligibility Requirements** following the PFI instructions.]

ANNUAL CHARGE PERIOD: FROM_____ TO_____

The annual liability period runs from the date of the client's first visit (regardless of when the PFI is completed or of an adjustment) until the last day of the eleventh subsequent month. For example; the client was admitted to a mental health facility on October 22, 2007, therefore the UMDAP annual charge period would be 10/22/07 through 9/30/08.

There can be only ***one*** annual UMDAP liability period regardless of the number of providers of service within the county or State of California in which a client is treated. Subsequent providers must accept the UMDAP liability sliding scale fee established by a previous provider for the remainder of the UMDAP liability period. When a client is admitted to a program, staff is instructed to check the IS for an existing UMDAP

Date. In the event there is a current UMDAP Date, the provider is to complete a blank PFI with the information obtained from the IS, retaining the current annual UMDAP liability period and indicating that the information was obtained from the IS. The client must confirm all financial information. A provider may request a photocopy of a PFI completed at another facility and the previous provider is to immediately provide it upon request.

The UMDAP liability period is a twelve-month period that constitutes a client's fiscal year. The UMDAP liability sliding scale fee must be reevaluated for every twelve-month period. There is only one circumstance that would warrant a change in the annual charge period. If a provider fails to financially screen a client and later discovers that a PFI was completed at another facility, the provider may contact that facility requesting that the annual charge period be changed to include their dates of service. **The facility that originated the PFI is the only provider that is authorized to change the annual charge period**.

PAYMENT PLAN $____ PER MONTH FOR_____ MONTHS

Enter the amount and duration of the monthly payment the client/payor has agreed to make towards the Annual Liability as stated on the **Financial Obligation Agreement *Supplement A-8.*** The Financial Obligation Agreement is required whenever a client/payor has been determined to have an annual liability. Payment plans should allow the client/payor to pay off their debt in the shortest time possible. The payment plan should rarely exceed the anticipated length of treatment, and under no circumstances should the plan exceed one year.

Line 23

PROVIDER OF FINANCIAL INFORMATION

Enter the name and complete street address of the person providing the financial information if other than the client or responsible person.

OTHER

Line 24

PRIOR MH TREATMENT (☐ YES ☐ NO) ***(Applicable to the current Annual Charge Period only)*** Enter Yes or No as to whether the client has prior mental health treatment with a current Annual Charge Period.
WHERE Identify the provider's name where the prior mental health treatment occurred.
FROM Enter the "From" date of the annual charge period.
TO Enter the "To" date of the annual charge period.
PRESENT ANNUAL LIABILITY BALANCE Enter the dollar amount of any outstanding UMDAP liability balance. A subsequent provider may collect any balance of a client's UMDAP liability not incurred in services at the provider that completed the financial screening. A provider may request information regarding the remaining portion of a client's UMDAP liability by completing a **Request for Annual Liability Balance *Supplement A-10.***

For Example:

Provider A completed the financial screening on May 9, 2007 and determined the client's annual UMDAP liability at $300. The client was provided services in the amount of $100 on May 9, 2007 and services in the amount of $50 on May 24, 2007. No other services were provided to the client during the month of May 2007. Provider A is required to collect payment from the client in the amount of $150 for services delivered during the month of May 2007.

May 9, 2007 through April 30, 2008 is the Annual Liability Period.

Annual UMDAP Liability Amount		$300
Minus actual cost of services	-	$150
Annual UMDAP Liability Balance		$150

The client did not receive services during the month of June or July 2007.

On August 12, 2007 the client receives services in the amount of $75 from Provider B. Provider B is required to collect payment from the client in the amount of $75 for services delivered during the month of August 2007.

Annual UMDAP Liability Balance		$150
Minus actual cost of services	-	$ 75
Annual UMDAP Liability Balance		$ 75

The client has a remaining balance of $75. This means the client may be seen at Provider A or B or at a completely different provider. If the client were seen again at any provider within the current Annual UMDAP Liability Period, that provider would collect the $75 remaining of the UMDAP Liability amount as long as the client incurred $75 in actual charges for services rendered.

Line 25

ANNUAL LIABILITY ADJUSTED BY Enter the name of the person changing the UMDAP liability amount or payment plan during an Annual Liability Period. [See **Liability Adjustment** and/or **Therapeutic Fee Adjustment (TFA)** following the PFI instructions.]
DATE Enter the date when the adjustment was made.
REASON ADJUSTED Enter the reason the adjustment in the UMDAP liability amount or payment plan was made. Any verification or documentation must be kept in the client's financial folder.
ANNUAL LIABILITY ADJUSTMENT APPROVED BY Enter the name of the person who approved the change in the UMDAP liability amount or payment plan. [Please note: If the change in the UMDAP liability amount was implemented due to a TFA, Program Head approval is required.]
DATE Enter the date when the Annual Liability Adjustment approval was given.

Line 26

SIGNATURE OF INTERVIEWER The person who completed the PFI during a financial interview with the client/payor is to enter their signature. The financial interviewers' signature signifies that an explanation of the UMDAP liability was provided.
PROVIDER NAME AND NUMBER Enter the name and provider number of the mental health facility where the PFI was completed.

Line 27

I AFFIRM THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I AGREE TO THE PAYMENT PLAN AS STATED ON LINE 22. ***SIGNATURE OF CLIENT OR RESPONSIBLE PERSON*** The client/payor shall be asked to sign as affirmation that the statements made are true and correct and that they agree to the payment plan agreement.
DATE The client or responsible person is to enter the date that they are signing the PFI.

COMPLETION OF THE PFI FOR MEDI-CAL BENEFICIARIES

Providers are required to complete the PFI form for **all** clients during the financial screening interview. However, the UMDAP process that occurs during a client's financial screening may be waived for full-scope Medi-Cal beneficiaries with no share-of-cost. Full-scope Medi-Cal beneficiaries are eligible to receive the full package of benefits offered by the State of California. Benefits include non-emergency services, dental care, and pharmaceuticals. Medi-Cal beneficiaries with limitations on the scope and duration of some services are not included in the waiver. Those beneficiaries must be financially screened to determine if they will have an UMDAP liability.

The following information must be completed on the PFI for full-scope Medi-Cal beneficiaries:

Line 1

CLIENT NAME
SS #
CLIENT ID #

Line 2

DOB

Line 4

MEDI-CAL (☐ YES ☐ NO)
MEDI-CAL COUNTY CODE/AID CODE/CLAIM #

Line 21

ADJUSTED MONTHLY INCOME The **Adjusted Monthly Income** for full-scope Medi-Cal beneficiaries will be the dollar amount the beneficiary receives as cash aid.

Line 22

ANNUAL LIABILITY The **Annual Liability** will always be zero for full-scope Medi-Cal beneficiaries.
ANNUAL CHARGE PERIOD (FROM __ TO __)

Line 26

SIGNATURE OF INTERVIEWER
PROVIDER NAME AND NUMBER

Line 27

SIGNATURE OF CLIENT OR RESPONSIBLE PERSON
DATE

***Note:** If a client is identified as being Medi-Cal eligible only after meeting their Medi-Cal share-of-cost, technically they are not Medi-Cal eligible and must interface with the UMDAP process.

COMPLETION OF THE PFI FOR CALWORKS CLIENTS

The Medi-Cal program **Cal**ifornia **W**ork **O**pportunities and **R**esponsibilities to **K**ids (CalWORKs) replaced Medi-Cal TANF (Temporary Assistance for Needy Families) that provides cash benefits to poor individuals and their children. CalWORKs makes welfare a temporary source of assistance by putting a five-year lifetime limit on receipt of benefits. **All clients identified as CalWORKs are full-scope Medi-Cal beneficiaries.** Therefore, completion of the PFI meets the same requirements as identified in the Section **Completion of the PFI for Medi-Cal Beneficiaries** but must also include:

Line 6

CALWORKS (☐ YES ☐ NO)

The Department of Public Social Services (DPSS) will reimburse 100% of the cost for delivering services to CalWORKs beneficiaries. Mental health services provided to CalWORKs beneficiaries are entered into the IS and identified as such. A unit of service report based on the CalWORKs identified services is generated by the Financial Services Bureau and is used to invoice DPSS. Those services are not claimed to Short-Doyle/Medi-Cal for reimbursement.

COMPLETION OF THE PFI FOR GROW CLIENTS

GROW is a program administered by The Department of Public Social Services (DPSS) that provides General Relief (GR) participants with employment and training services to help those individuals obtain a job and become self-sufficient. The Department of Mental Health (DMH) provides clinical assessments and treatment services to GROW participants with an emotional or mental disorder that would otherwise limit or impair their ability to become and remain employed.

GROW participants are not Medi-Cal beneficiaries; however DPSS will reimburse DMH 100% of the cost for delivering services to GROW participants. Mental health services provided to GROW participants are entered into the IS and identified as such. A unit of service report based on the GROW services is generated by the Financial Services Bureau and used to invoice DPSS.

Although GROW participants are not Medi-Cal beneficiaries, completion of the PFI meets the same requirements as identified in the Section **Completion of the PFI for Medi-Cal Beneficiaries** but must also include:

Line 6

GROW (☐ YES ☐ NO)

COMPLETION OF THE PFI FOR AB 3632 CLIENTS

Because Federal and State education laws require that all disabled students receive the services they need as part of a "free, appropriate public education", all services under **AB 3632** must be provided at no cost to the student or his/her parents. The courts have ruled that if public agencies bill parents' private insurance for these educationally mandated services, it constitutes a "cost" to the parents, which is in violation of the law. This same scenario is true when an AB 3632 client has Medi-Cal with a Share of Cost (SOC).

This means that providers should NOT bill private insurance before they bill Medi-Cal if the client is AB 3632. In addition, claims should not be billed to Medi-Cal for those clients who are AB 3632 AND who have Medi-Cal with a SOC, unless of course, SOC is cleared. Please note that the SOC amount may not be collected from the client or parents.

The following information must be completed on the PFI for AB 3632 clients:

Line 1

CLIENT NAME
SS #
CLIENT ID #

Line 2

DOB

Line 4

MEDI-CAL (☐ YES ☐ NO)
MEDI-CAL COUNTY CODE/AID CODE/CLAIM #

Line 6

AB3632 (☐ YES ☐ NO)

Line 22

ANNUAL LIABILITY The **Annual Liability** will always be zero for AB 3632 clients.
ANNUAL CHARGE PERIOD (FROM __ TO __)

Line 26

SIGNATURE OF INTERVIEWER
PROVIDER NAME AND NUMBER

Line 27

SIGNATURE OF CLIENT OR RESPONSIBLE PERSON
DATE

The PFI should have written or stamped on it the following notation which describes the parent's exempt status:

Pursuant to Public Law 94-142, services are provided at no charge to the parent or adult pupil, and in accordance with Section 7582 of the Government Code, are exempt from financial eligibility requirements.

COMPLETION OF THE PFI FOR HOMELESS CLIENTS

Providers are required to complete the PFI form for **all** clients during the financial screening interview; however, the State Department of Mental Health only requires specific information be completed for clients that are identified as "Homeless".

The following information must be completed on the PFI for Homeless clients in addition to any additional information if known or applicable:

Line 1

CLIENT NAME
SS #
CLIENT ID #

Line 2

DOB

Line 11

ADDRESS *CITY* *STATE* *ZIP CODE* In place of an address insert the word "TRANSIENT" or "HOMELESS".

Line 12

SOURCE OF INCOME Identify how the payor is financially supported. ☐ *GR* General Relief (If applicable)

Line 21

ADJUSTED MONTHLY INCOME The **Adjusted Monthly Income** for Homeless clients would be the amount received as General relief if applicable.

Line 22

ANNUAL LIABILITY The **Annual Liability** will always be zero for Homeless clients.
ANNUAL CHARGE PERIOD (FROM __ TO __)

Line 26

SIGNATURE OF INTERVIEWER
PROVIDER NAME AND NUMBER

Line 27

SIGNATURE OF CLIENT OR RESPONSIBLE PERSON
DATE

REEVALUATION

The client is to be financially reevaluated on an annual basis. The **Reevaluation Follow-Up Letter *Supplement A-7*** may be used to facilitate the reevaluation process. Telephone reevaluations are acceptable, however missing information and verification of income and expenses are still required. Client/payor signature is to be obtained during the next visit. Client/payors that have not been reevaluated are responsible for the actual cost of care until the reevaluation is completed.

The UMDAP liability period, for a client who is still in treatment, is continuous regardless of when the PFI is completed. The reevaluation date to be recorded on the PFI shall be from the first day of the month to the end of the eleventh succeeding month. For example, the original UMDAP liability period was 10/22/07 through 9/30/08; then the reevaluation date will be 10/1/08 through 9/30/09.

DISTRIBUTION

The PFI is a three-part carbonless form that, once completed, is to be distributed as follows:

- ***FINANCIAL FOLDER*** - white copy
- ***CLINIC*** (Medical chart) - yellow copy
- ***CLIENT*** (Payor/responsible person) - blue copy

VERIFICATION

Verification of Social Security Number, employment, current address, liquid assets, allowable expenses, and income is ***mandatory***. Copies of verification should be attached to the PFI or placed in the client's financial folder. Until verification is received, the client/payor is responsible for the actual cost of care.

Examples of sources available for verification of income are: pay stub, tax return form, or bank statements showing direct deposits.

In making inquiries to sources other than the client or payor, care must be exercised to maintain confidentiality. Letterhead stationary that identifies you as a mental health provider ***must not*** be used.

FINANCIAL OBLIGATION AGREEMENT

A **Financial Obligation Agreement** ***Supplement A-8*** is a written agreement between the client/payor and the provider, and is required whenever a client/payor has been determined to have an annual liability. This agreement must detail the maximum liability amount and the monthly payment amounts. The agreement ***must*** be signed by the client/payor and acknowledged by a provider representative.

Payment plans should allow the client/payor to pay off their debt in the shortest time possible. The payment plan should rarely exceed the anticipated length of treatment, and under no circumstances should the plan exceed one year.

LIABILITY ADJUSTMENT

An annual UMDAP liability amount may be adjusted when properly supported by additional financial data justifying such change. At any time during the liability period, an adjustment may be made for the time remaining in the period. Reasons for such action may be for any significant change in a person's financial circumstances, such as becoming employed or no longer working. Since a client/payor is responsible for prompt notification of a change in financial circumstances, an adjustment cannot be retroactive, but is effective on the date of notification. Verification and documentation supporting the adjustment must be kept in the client's financial folder.

NOTE: Be aware that once a client has incurred services that equal or exceed the amount of the annual liability, an adjustment to lower the annual liability cannot be made.

THERAPEUTIC FEE ADJUSTMENT (TFA)

It is the policy of the Department of Mental Health to allow UMDAP liability fee adjustments for ***therapeutic value only***. No other basis or rationale for fee adjustments will be accepted.

When, in the opinion of the therapist, a client's treatment would benefit by an increase or decrease in the annual liability, a therapeutic fee adjustment is indicated. Program Head approval is required for all therapeutic fee adjustments. A therapeutic fee adjustment may ***not*** be initiated by the financial screener.

Refer to the DMH Policy 404.3 Therapeutic Fee Adjustments, regarding the requirements and procedures for initiating a therapeutic fee adjustment.

Insurance Authorization and Assignment of Benefits

Due to confidentiality laws, prior to billing an insurance company for services rendered, the provider must have the client's permission to release information. Additionally, unless the client has paid their bill in full, they must agree to assign their benefits to the provider rendering the services if they expect the provider to process the paperwork.

To meet this requirement the **Insurance Authorization and Assignment of Benefits** ***Supplement A-4*** is to be signed and dated by all insurance beneficiaries. The authorization allows providers to submit insurance claims for reimbursement without obtaining original beneficiary signatures on each claim form and it is valid for an extended period of time. Enter "Signature on File" where client signature is requested on the insurance claim form and the original signed **Insurance Authorization and Assignment of Benefits** is to be maintained in the client's financial folder. If a client refuses to sign this form, the signed claim form from their insurance company is acceptable if it contains both a release and an assignment.

Lifetime Extended Signature Authorization

The **Lifetime Extended Signature Authorization** ***Supplement A-5*** is a statement to permit payment of Medicare benefits to a supplier or physician. The authorization is to be completed, signed, and dated by the client. The original is to be maintained in the client's financial folder.

All electronic claims *require* a **Lifetime Extended Signature Authorization**. If you do not have the signed form in the client's financial folder, you must bill the claim manually using the Medicare Claim Form CMS 1500 which must contain the beneficiary's signature.

FINANCIAL FOLDERS

Providers are required to maintain a financial folder for each client receiving services at their facility. The financial folder should contain all financial information regarding the client and a detailed history of contacts and conversations with the client/payor, third party payors, or other persons providing financial information. The following are examples of the type of information that is to be filed in the financial folder:

- Patient Financial Information Form ***Supplement A-1***
- Insurance Authorization and Assignment of Benefits ***Supplement A-4***
- Lifetime Extended Signature Authorization ***Supplement A-5***
- Department of Public Social Services/Social Security Admin. Referral Card ***Supplement A-6***
- Reevaluation Follow-Up Letter ***Supplement A-7***
- Financial Obligation Agreement ***Supplement A-8***
- Authorization for Request or Use/Disclosure of Protected Health Insurance Information (PHI) ***Supplement A-9 (A) and A-9 (B)***
- Request for Annual Liability Balance ***Supplement A-10***
- Verification of employment, income, allowable expenses, and assets.
- Photocopy of identification, Social Security Card, paycheck stubs, health insurance cards.
- Copies of any correspondence to or from the client/payor.
- Photocopy of the clients Benefit Identification Card (BIC).

FINANCIAL RECORD RETENTION

Accounting records and supporting documents must be retained for four years after the closing of the fiscal year or until such time as the audit has been settled for the fiscal year. This includes proof of Medi-Cal eligibility for each beneficiary receiving service, financial documents received during the financial screening process, and all reports available from the Integrated System (IS) or other financial reports.

DMH Policy Manual

The Los Angeles County Department of Mental Health Policy Manual should be accessed regarding specific policies addressed in this manual. Each provider should have a copy of the policy manual in your facility that is distributed through the Program Support Bureau.

MEDI-CAL ELIGIBILITY GUIDELINES

What is Medi-Cal?

- Health care coverage for qualifying persons who live in California, who have income and resources below established limits

Who can get Medi-Cal?

- Persons 65 or older
- Persons who are under 21 years of age
- Certain adults between 21 and 65 years of age, if they have minor children living with them
- Persons who are blind or disabled
- Pregnant women
- Persons receiving nursing home care
- Certain Refugees, Asylees, Cuban/Haitian Entrants

Do I have to be a U.S. citizen to get Medi-Cal?

- No, documented and undocumented aliens may be eligible for Medi-Cal. Some persons may receive pregnancy related and emergency services only; others are eligible for full Medi-Cal benefits depending on their alien status

Anyone falling into these categories must be referred to their local DPSS office to apply. The client is to be provided with a completed **DPSS/SSA Referral Card *Supplement A-6*** when referred to DPSS.

MEDI-CAL SHARE OF COST (SOC)

Medi-Cal offers health care coverage to individuals and families who have incomes too high to qualify for welfare, but too low to cover health care costs. Medi-Cal requires some of these recipients to contribute to their health care by paying a share of the cost of the services they receive.

Share of cost (SOC) is a term that refers to the amount of health care expenses a recipient must accumulate each month before Medi-Cal begins to offer assistance. Once a recipient's health care expenses reach a predetermined amount; Medi-Cal will pay for any additional covered expenses for that month. SOC is an amount that is owed or obligated to the provider of health care services, not to the state. However, Short-Doyle/Medi-Cal providers are to collect the amount of the SOC or the amount of the annual liability, whichever is less.

A client is not Medi-Cal eligible until the SOC has been met and cleared through the Medi-Cal Host computer (Point of Service (POS) Device, the Automated Eligibility Verification system (AEVS), the Medi-Cal Web site or on the Internet at www.medi-cal.ca.gov. Once SOC has been cleared and certified, an Eligibility Verification Confirmation (EVC) number will be given by the Medi-Cal Host computer to show the recipient is eligible for Medi-Cal.

SOC cannot be cleared unless services are provided. SOC is to be cleared as soon as the service is provided. The dollar amount that is cleared for SOC is the actual number of minutes multiplied by your rate for the service that was provided. The SOC or deductible is what the client must pay or obligate to pay for services before any additional services, delivered in the same month, may be billed to Medi-Cal. The State Department of Mental Health instruction directs Short-Doyle/Medi-Cal providers to bill the client the amount of the monthly SOC or the amount of the annual liability, whichever is less, **therefore it is necessary to apply UMDAP during the financial screening of a SOC client to determine their annual liability.**

MEDI-CAL PROOF OF ELIGIBILITY

Providers must verify Medi-Cal eligibility every month for each recipient prior to claiming their services for Medi-Cal reimbursement. Eligibility verified at the first of the month is valid for the entire month of service. The Medi-Cal Eligibility Verification System allows Medi-Cal providers on-line access to Medi-Cal eligibility information. Providers may access Medi-Cal eligibility information through the Integrated System (IS), a Point of Service (POS) device, the telephone Automated Eligibility Verification System (AEVS), the Medi-Cal Eligibility Data System (MEDS) Online POS Inquiry (MOPI) screen or the Medi-Cal Web site at www.medi-cal.ca.gov.

Regardless of which method is used to determine eligibility, only the Eligibility Verification Confirmation (EVC) number that is provided for eligible recipients is VERIFICATION that an inquiry was received by the State of California and eligibility information was transmitted to the provider. The white plastic Benefits Identification Card produced by a Medi-Cal recipient is not proof of Medi-Cal eligibility.

NOTE: Receipt of an EVC number does not guarantee claim payment. Providers should carefully review all information returned with the eligibility response to ensure that their services are covered under the recipient eligibility. Information includes any unmet share of cost amount, health plan enrollment, benefits coverage and lists any other health coverage the patient may have.

GLOSSARY OF TERMS

AB3632 Synonymous with Special Education Pupils (SEP).
Ability to Pay A client or responsible person's ability to pay toward the actual cost of care as determined by the State Department of Mental Health sliding scale fee schedule. The ability to pay is increased to the extent that third party benefits are available or paid.
Actual Cost of Care The actual cost of delivering services to the client. The cost is determined by a provisional billing rate, a negotiated rate, or a cost reimbursement rate.
Adjusted Gross Income The total family monthly income plus the value of the assets less allowable deductions.
AEVS The telephone Automated Eligibility Verification System used to obtain Medi-Cal eligibility information.
Allowable Deductions Court ordered obligations paid monthly, monthly dependent support payments, monthly child care payments necessary for employment, monthly medical expenses, and mandatory deductions from gross monthly income for retirement plans.
Annual Charge Period Synonymous with Annual Liability Period.
Annual Liability Amount The annual liability amount applies to services extended to the client and dependent family members and is determined by using the adjusted monthly income amount and the number dependent on the adjusted monthly income.
Annual Liability Period The annual liability period runs from the date of the client's first visit and the subsequent eleven calendar months, and each 12-month period thereafter during which the client continues to receive services. (Admissions and/or readmissions during the 12-month period do not change the sliding scale fee period.)

BIC Benefits Identification Card. Medi-Cal beneficiaries are issued a white plastic identification card by DPSS. The card is not a guarantor of eligibility.
Cal ID California Identification Number issued by the State of California.
CalWORKs The Medi-Cal program **Cal**ifornia **W**ork **O**pportunities and **R**esponsibilities to **K**ids (CalWORKs).
CDL California Drivers License Number
CHAMPUS Civilian Health and Medical Program of the Uniformed Armed Services. Insurance for retired service personnel, their dependents, and the dependents of active duty service personnel.
CIN Client Index Number. The CIN is a unique number assigned to a client by the Medi-Cal Eligibility Data System (MEDS).
Client/Consumer A recipient of services, synonymous with patient.
Court Ordered Obligations Obligations upon which a court has made a decision and a written order of liability has been issued. Such liabilities paid on a monthly basis can be allowed as a deduction from monthly gross income as long as the amount is currently being paid.
Dependents Those persons within a family unit dependent upon the payor's income for support as well as members outside the family group that payor claims as dependents when filing income tax.
DPSS Los Angeles County Department of Public Social Services.
EVC Eligibility Verification Confirmation Number. The EVC number is provided for eligible recipients and is VERIFICATION that an inquiry was received by the State of California and eligibility information was transmitted to the provider.
Family Unit Payor and his/her dependents.
FCC

Full cost of care synonymous with actual cost of care.
FICA Federal Insurance Contributions Act.
GR General Relief
Gross Income Total family income before allowances for taxes and other deductions. For self-employed persons, it is the total income after business expenses have been deducted.
GROW GROW is a program administered by The Department of Public Social Services (DPSS) that provides General Relief (GR) participants with employment and training services to help those individuals obtain a job and become self-sufficient.
Healthy Families Program Healthy Families is the California name for the federally funded State Children's Health Insurance Program that provides affordable, low cost, comprehensive medical, dental, and vision coverage for children and youth one year old up to their 19th birthday who reside in the State of California and who qualify as a U.S. Citizen, National, or Qualified Alien.
HIC Health Insurance Claim Number
HMO Health Maintenance Organization. A managed care plan.
Homeless A client who does not have an address, also identified as "Transient".
In-Kind In-Kind is used to identify when a client receives room and board from another person without incurring a financial liability.
GR General Relief
Gross Income Total family income before allowances for taxes and other deductions. For self-employed persons, it is the total income after business expenses have been deducted.

GROW GROW is a program administered by The Department of Public Social Services (DPSS) that provides General Relief (GR) participants with employment and training services to help those individuals obtain a job and become self-sufficient.
Healthy Families Program Healthy Families is the California name for the federally funded State Children's Health Insurance Program that provides affordable, low cost, comprehensive medical, dental, and vision coverage for children and youth one year old up to their 19th birthday who reside in the State of California and who qualify as a U.S. Citizen, National, or Qualified Alien.
HIC Health Insurance Claim Number
HMO Health Maintenance Organization. A managed care plan.
Homeless A client who does not have an address, also identified as "Transient".
In-Kind In-Kind is used to identify when a client receives room and board from another person without incurring a financial liability.
Liability Adjustment An annual UMDAP liability amount may be adjusted when properly supported by additional financial data justifying such change. Reasons for such action may be for any significant change in a person's financial circumstances, such as becoming employed or no longer working.
Liquid Assets Any possessions easily converted into cash, such as IRAs, 401Ks, or savings bonds.
Managed Care A term coined originally to refer to the prepaid health care sector (e.g., HMOs and PHPs). In general, the term refers to a means of providing health care services within a defined network of health care providers who are given the responsibility to manage and provide quality cost-effective health care.

Medi-Cal California's medical assistance program for eligible low-income persons to pay for needed medical care.
Medicare A Federal Health Insurance Program for people 1) who have attained the age of 65 or over, or 2) have received SSD for two years or more.
Medi-Gap Insurance companies which contract with a Medicare carrier that allows the carrier to directly crossover your claims to an insurance company.
MEDS The Medi-Cal Eligibility Data System maintained by DPSS.
Monthly Child Care Payment The monthly expense to a family for necessary child care as a result of a parent working.
Monthly Dependent Support Payment The monthly expense to a family for dependent support. This can be for children, spouse, or parents. The deduction is not allowed when the same person or persons are claimed as UMDAP dependents.
Monthly Mandated Deductions for Retirement Plans The amount deducted monthly from gross income for a retirement plan that is a condition of employment and is not elective. Social Security payments are not deducted because they have been used as a consideration in determining the sliding scale fee.
Monthly Medical Expense Payments The amount of the families' monthly income that is being paid for medical expenses.
MOPI The Medi-Cal Eligibility Data System (MEDS) Online Point Of Service (POS) Inquiry (MOPI) screen used to obtain Medi-Cal eligibility information.
Payor Person legally responsible for payment of client's bills.
PFI Patient Financial Information Form.

PHP Prepaid Health Plan. A managed care plan.
POS Point of Service (POS) device used to obtain Medi-Cal eligibility information.
Responsible Person Client, the spouse of a married client, the parents of a minor, or a guardian or conservator of a client's estate.
SED Severely Emotionally Disturbed.
SEP Special Education Pupils.
Sliding Scale Fee The determined amount the client is expected to pay for all services received during a 12-month period exclusive of third party payors.
SOC Share of Cost.
SSA Social Security Administration.
SSDI Social Security Disability Income. Workers qualify for disability income when they cannot work or are diagnosed with a condition that is expected to last for a year or result in death. A spouse of a disabled worker is entitled to benefits at age 62, (including some divorced spouses) or at any age, if they have children less than 16 years of age. A widow(er) at any age with children under age 18. A child including adopted or stepchild may receive monthly benefits. Normally, children's benefits may continue indefinitely or start at any age if the child has a severe physical or mental disorder that began before age 22 and keeps the child (or adult child) from gainful employment.
SSI Supplemental Security Income. A national program for the purpose of providing supplemental security income to individuals who have attained age 65 or are blind or disabled.

SSP State supplementary payments (SSP) are any payments made by a State to a recipient of supplemental security income (SSI) benefits, if the payments are made as a complement to the Federal benefit amount, thereby increasing the amount of income available to the recipient to meet his/her needs.
TFA Therapeutic Fee Adjustment.
Third Party Payor A payor other than a client or responsible person, who is legally liable for all or part of the cost of patient care.
UMDAP Uniform Method of Determining Ability to Pay.
VET/ADM Veterans Administration

KEDREN COMMUNITY HEALTH CENTER, INC.

6. PATIENT ACCOUNTING

BILLING AND COLLECTION

Patient Billing Communication

Policy: Relevant billing and collection policies are communicated to patients through either verbal or written means.

Purpose: To improve client relations and decrease confusion.

Procedures:

1. All new patients receive a written summary of relevant billing and collection policies; a verbal summary is given when appropriate.
2. When major revisions in policies occur, these changes are mailed to all active patients with an outstanding balance. A sign is posted in the waiting room stating that the practice is following a new collection policy (when this occurs).
3. Upon patient request, the practice provides a complete copy of the financial policies, including the fee schedule.
4. Sliding fee policy notice is located in each waiting room area and each patient is assessed for eligibility based on income and family size. KEDREN assists all patients without any payor source determine if they are eligible for any third- party coverage and Sliding fee discounts program (Sliding fee applies to all patients with or without insurance- criteria is only for eligibility is only income and family size). See KEDREN's sliding Fee Discount Program P & P.
5. No patient is denied service due to inability to pay. Payment plans are also offered to all patients who have a balance and can-not pay at the time of service. See Payment Plan.
6. Hardship waiver for reduced or full waiver of payment is also available, see separate Hardship Waiver Policy.

6.1 PATIENT ACCOUNTING

BILLING AND COLLECTION

Claims Submission and Cash Patient Collections

Policy: KEDREN will take steps to ensure all services are billed and collected and that efficient management of resources and maximization of revenues including progressive collection procedures.

Purpose: To maximize collection of patient revenues.

Procedures:

1. All patients are billed timely through the ECW practice management system.
2. The practice is to bill daily or weekly and in no event less than monthly (30 days from date of service).
3. The first billing notice is a statement for accounts 0 - 30 days past due.
4. The second billing notice (accounts 30-days past due) is a statement which includes a message that the account is past due.
5. The third billing notice (accounts 60-days past due), for accounts that have balances of $5.00 or less, is a statement which requests payment immediately. If there is no response, the practice ceases written billing and collection efforts. The appropriate staff member writes-off account balances equal to or less than $5.00 after 120 days.
6. The third billing notice (accounts 60-days past due) for accounts that have balances of greater than $25.00 includes a letter, which notes the amount that is now seriously past due, and a statement.
7. The fourth billing notice (accounts 90-days past due) includes a letter which notifies the patient that they may be send to collections.
8. The practice allows each provider to review the list of patients prior to sending the fourth letter to make special arrangements for medical care for appropriate patients.
9. The practice assures that patients with past due amounts of varying ages receive only one customized letter per billing cycle.
10. The billing cycle is not suspended unless the patient pays his/her past due balance in full or enters into a formal payment arrangement.
11. If an insurance payment is not received 120 days after insurance claim is filed, the patient may be held responsible for the charges.
12. Patients who may have out of pocket costs will be asked to sign an ABN or Treatment plan before the service is provided.

6.2 PATIENT ACCOUNTING

BILLING AND COLLECTION

Revenue Cycle Maximization

Policy: KEDREN will seek to maximize reimbursement through billing, charging and coding accurately.

Purpose: To maximize the revenue cycle.

Procedures:

1. KEDREN generates encounters timely and reconciles the encounter count to the patient visits. No encounters are to be maintained open for more than 72 hours.
2. KEDREN enters all encounters in the practice management/billing system (ECW) timely.
3. KEDREN's has a two-level claim scrubbing (editing and verification) process. The first level is an in-house built claim editing system and the second is through a third party who performs a second edit and verification process and then submitters the claims (third party billing vendor)
4. Month outstanding AR balance reports are run and all unpaid claims over 30 days are followed up by either a call or resubmission as deemed appropriate.
5. Month denied claim are reviewed and corrected and resubmitted for payment. Claims are re-filed within two weeks of receiving a denial. KEDREN's COO and Senior Accountant/Financial Analyst are tracking the denied claims monthly. All denied claims are worked and resubmitted to ensure reimbursement is maximized.
6. The encounter forms are reviewed annually typically in December in order to reflect changes in CPT codes effective in January of each year. The practice updates its encounter forms on an annual basis for sooner if deemed necessary. All changes are made in the practice management system.

6.3 PATIENT ACCOUNTING

BILLING AND COLLECTION

Credit Balances

Policy: To review credit balances and ensure they are truly overpayments and not incorrect postings or other system errors. Patient credit balances are limited to a dollar maximum determined by the CEO for all patients except those covered by Medicare. Medicare credit balances are reviewed quarterly and processed in accordance with the Medicare Credit Quarterly report requirements.

Purpose: To accurately reflect revenues and receivable balances and to comply with all government regulations.

Procedures:

1. Credit balances are reviewed by the COO or Senior Accountant/Financial Analyst for appropriateness.
2. Accounts with less than $l0 in credit balance are not issued a refund. The credit is applied to outstanding balances unless otherwise requested.
3. Accounts with greater than $l0 in credit balance are issued a refund check at the end of the month within which the balance was determined and requested by the patient or insurance carrier.
4. Medicare patients with a credit balance on their account of any amount are issued a refund check by the end of the month in which the balance was determined.
5. Patient Accounting staff will provide copies of each patient's account on which a credit balance is due to the Accounting Staff for processing.
6. Medicare Credit reports are generated quarterly and any overpayments from Medicare are refunded immediately.
7. Medi-Cal overpayments identified will be processed through the Medi-Cal track back system, in order to ensure that duplicate payment does not occur. Medi-Cal will take back the funds directly through subsequent RA's to KEDREN.

6.4 PATIENT ACCOUNTING
BILLING AND COLLECTION
Charge Master (Fee Schedule)

Policy: KEDREN maintains one fee schedule, which is reviewed at least once every three years and looked at annually and if necessary, updated by the COO/CFO/CEO once approved by the board. The fee schedule/charge master is designed to reflect closely the Center's total costs and to reflect reasonable and customary charges for the Center's service area (prevailing rates).

Purpose: To maximize revenues and to treat all the patients equally.

Procedures:

1. KEDREN's fee schedule is reviewed and revised at least once every three years and if necessary, more often. The Center will also review current charges in its market and ensures that charges are comparable. In addition, the Center maintains fees which are above Medicare and Medicaid fee schedule amounts. Determination of Fee schedule based on health center costs and locally prevailing rates. As much as possible, fees reflect the cost of providing care.
2. The COO/ Senior Accountant/Financial Analyst with the CEO's approval may make minor changes to the fee schedule if a need is determined prior to the annual review. These would have to be considered minor such as incorporating new CPT codes etc. and would not require board approval
3. All services listed on the fee schedule/charge master are coded correctly, based on the current edition of CPT codes.
4. KEDREN may also use a consultant to perform a detail review of the charge master to determine the Center's cost per RVU and evaluate if the charge master reflects the center's cost as required by HRSA.
5. KEDREN's Charge Master will be approved by the Board of Directors.

6.5 PATIENT ACCOUNTING
BILLING AND COLLECTION
Patient Responsibility

Policy: It is an expectation that patients will pay amounts they are responsible for at the time of the visit. However, if a patient cannot pay, KEDREN will offer a payment plan to all patients (see separate policy for payment plan).

Purpose: To maximize revenues and ensure no patient is denied care due to inability to pay.

Procedures:

1. At the time of the patient visit the staff will make every effort to collect the appropriate payment from the patient or work with the patient to establish a payment plan.
2. The COO/ Senior Accountant/Financial Analyst approves all payment plans. CEO may also approve a payment plan with a patient if the COO/ Senior Accountant/Financial Analyst is not available or the payment term is longer than 6 months. See separate section on payment plans.
3. KEDREN staff members discuss financial matters with patients in a way that ensures privacy.
4. For billing and collection purposes, the receptionist obtains or verifies telephone, address and insurance information for each patient at each visit. The receptionist explains that payment is expected at the conclusion of their visit.
5. If a patient expresses difficulty in paying the entire amount owed, the receptionist tries to obtain a partial payment before offering to arrange a payment plan. The patient is referred to the COO/ Senior Accountant/Financial Analyst for payment arrangements, who is authorized to approve all payment plans. See separate policy
6. If a patient does not have primary care insurance, staff referrers patient to an eligibility outreach staff to help the patient obtain coverage they may be eligible for. In addition, all patients are assessed for KEDREN's sliding fee program.

6.6 PATIENT ACCOUNTING

BILLING AND COLLECTION

Never Refuse Patient Care and Hardship Waiver or reduction in Fees

Policy: Staff will never refuse services to a patient who presents with a condition that could be a life-threatening emergency regardless of the patient's financial status with KEDREN.

Purpose: To prioritize patient care and limit liability and ensure no patient is denied care due to inability to pay.

Procedures:

1. All patients needing care will be seen by KEDREN regardless of their ability to pay.
2. The CEO or assignee has the authority to waive or reduce the payment to the patient, on a case-by-case basis, based on an individualized determination, in cases where it is determined that the charge represents a barrier to care and is due to a hardship. See below.
3. The patient will be triaged as deemed appropriate by medical staff/provider.
4. Patients will be evaluated to determine if they qualify for any third-party coverage and the patient will be evaluated for KEDREN's sliding fee discount.
5. Payment arrangement can be made for patient having a life-threatening emergency and with no form of payment on that day.
6. Front desk protocols are in place for identifying those patients who need to see a nurse/provider for triage purposes.
7. Nurse/Provider triage protocols are in place for identifying those patients having life-threatening emergency.
8. If a patient cannot pay due to hardship reasons (they may write a letter to the COO and CEO describing their situation and request a waiver or reduction in their payment).
9. The criteria for hardship waiver or reduction of fees may be one of the following and will be determined on a case by case basis and must be approved by the COO and CEO:

   Loss of job, death in the family, loss of home, hospitalization, or extensive health issues/costs, etc.

KEDREN MEDICAL SERVICES

Hardship Waiver/Reduction of Payment Approval/Denial Letter

Date: _____ MR#_____

Dear: _____

Thank you for providing a Hardship letter documenting your hard ship situation.

- At this time, we have determined you are not edibility for waiver
- At this time, we have determined you are eligible for a
- 1) a full waiver of charges or
- 2) a reduction/discount of _____% of full charges.

The Waiver/Reduction is approved for the Following Period _____ to _____ (and cannot exceed one year) and only applies to services provided by ACH and does not include medically unnecessary, optional, or cosmetic services.

Should your circumstance change and you need to speak to our enrollment specialist or Billing Manager, please do not hesitate to contact our office. Thank you for choosing KEDREN and entrusting us with your health care.

Prepared & reviewed by: _____ (COO/Billing): Date: _____

Approved by:

CEO or COO signature: _____ Date: _____

6.7 PATIENT ACCOUNTING
BILLING AND COLLECTION
Never Refuse Patient Care

Policy: Outstanding patient accounts are followed-up according to an established collection procedure.

Purpose: To maximize revenues.

Procedures:

1. Patient account balances more than 120 days past due are written off as uncollectible with the approval of the CEO or his/her designee.
2. Patients with account balances more than 120 days past due, who make no arrangements to pay on their account, will have their accounts flagged as “bad debt” and will be required to make a payment on their account before they are seen, unless they present with a life-threatening emergency.
3. Staff will make every effort to identify patients who may be eligible for third party coverage and KEDREN Sliding Fee Discount Program
4. Uncollectible accounts are indicated with specific codes for easy identification if reinstatement becomes necessary.
5. If the patient makes arrangements or begins to make payments on the unpaid amount, the written-off amount is reinstated, and medical services are provided.
6. The practice has a system for reviewing past due accounts to identify patients eligible for payment arrangements.
7. Those patients who are not receptive to the practice's attempts to assist them in paying their medical bills are subject to the practice's usual collection efforts.

6.8 PATIENT ACCOUNTING

BILLING AND COLLECTION

Contracting with Third Party Payors

Policy: KEDREN will make all efforts to contract with third party payors and is a Medicare and Medical provider.

Purpose: To ensure that the Center's patient can be seen, and their coverage is excepted as form of payment. COO makes sure that the Center is contracted and credentialed with the majority payors for which patients have coverage.

Procedures:

1. COO makes sure KEDREN is contracted with Medicare
2. COO makes sure KEDREN is contracted with Medi-Cal
3. COO makes sure KEDREN is contracted with any other public program that would benefit the Center's patients.
4. Any new payor's that currently are not contracted will be brought to the attention of the CEO and an evaluation will be performed to determine if a contract is needed.

6.9 PATIENT ACCOUNTING

BILLING AND COLLECTION

Sliding Fee Program & Patient Accounts

Policy: KEDREN offers a Sliding Fee Scale Program (the KEDREN Sliding Fee Program) to all patients. The Sliding Fee Policy is approved by the Board of Directors and staff is trained on KEDREN's sliding fee process.

Purpose: To meet federal requirements and ensure access to care to all eligible patients.

Procedures:

1. Staff is trained on KEDREN's sliding fee program and process.
2. Sliding Fee notices are posted in the waiting areas in both English and Spanish
3. Only patients with income below 200% of the current federal poverty guidelines will be eligible to participate in the KEDREN sliding fee program (eligibility criteria are only income and family size). Patient at or below 100% of the Federal poverty level will only be charges a nominal amount which is flat and does not reflect the true cost of the services.
4. The KEDREN Discount Plan is updated each year based on revisions to the federal poverty guidelines and is submitted to the Board of Directors for approval.
5. Patients, who qualify for the sliding fee program, will have their account balances adjusted for all amounts except the nominal fee/discount amount based on KEDREN's sliding fee discount scale.
6. Refer to KEDREN's Sliding Fee Policy for specific detail.

6.10 PATIENT ACCOUNTING

BILLING AND COLLECTION

Patient Account Payment (plan) Arrangements

Policy: KEDREN will offer a Payment Plan to All patients who are unable to pay their account balances on the day of service.

Purpose: To maximize collections and to by assisting patients having financial difficulties.

Procedures:

1. The patient is allowed up to six months to pay off the account. Payment arrangements are determined by the amount of the patient's bill (usually the higher of the total bill divided by six or $5 per month at a minimum). Special arrangements are made for patients who cannot pay off the account in six months.
2. The patient signs a contract (payment plan), stating the amount owed and the amount to be paid each month until the account is cleared.
3. If the patient visits the practice for additional care during the Payment Plan cycle, the appropriate staff person adds the new charges to the current balance. This total is then used to calculate new monthly payments (new total divided by six). An amended contract is signed.
4. All future bills sent to the patient reflect the Payment Plan monthly payments as stated in the signed contract. If the patient falls behind in making Payment Plan payments, the patient is subject to the routine collection process.
5. Patient accounts are flagged to easily identify patients on Payment Plans.
6. All payment plans must be approved by the either the COO or Senior Accountant/Financial Analyst and payment plans longer than 6 months must be approved by both the COO and the CEO.
7. Patients, who become delinquent in their payment arrangements, maybe subject to routine collection efforts.
8. Any payment plans longer than 6 months require the CEO approval.

KEDREN
Payment Plan Agreement

Patient's Name: _____ Date: _____
MR#:_____ Balance Owed: _____

The above-named patient (or guarantor) agrees to make monthly payments on the balance of this account. Payments will be made on or before the _____ day of each month.

Failure to meet this obligation will make the agreement null and void and the practice will then reserve the right to make a "Demand for Payment" on the remaining balance.
Minimum monthly payment agreed upon: $_____
The account will be paid in full on or before: _____ Date: _____
Signature (Patient/Guarantor): _____ Date: _____

Signature (Authorized Employee): _____ Date: _____

Supervisor approval (when required): _____ Date: _____

ALL FURTHER CHARGES WILL BE PAID AT THE TIME OF SERVICE

Pre-Authorized Use of Credit Card I authorize (KEDREN) to keep my signature on file and to charge my Visa / Mastercard for (this is maintained in the HIPPA Secured Practice Management System):

Balance of charges not paid by insurance within 90 days and not to exceed $_____ for: this visit only. all visits this year.

Recurring charges (on-going treatments or payment plan) of $_____ every_____
_____from to_____ (frequency) (date) (date)

I assign my insurance benefits to the provider listed above. I understand that this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider (your credit card information is kept in our secure practice management system).

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____ City_____

State_____ Zip_____ Credit Card Account #:_____

Expiration Date: _____ CVS#_____

Cardholder Signature_____ Date_____

6.11 PATIENT ACCOUNTING
BILLING AND COLLECTION
Other Charges- NSF & Medical Records

Policy: Fees are collected for non-patient care services.

Purpose: To cover non-patient costs incurred by KEDREN due non-sufficient funds (NSF) checks being issued by patients to the Center.

Procedures:

1. The charge for returned checks is $25.00 each. Additional checks are not accepted until the returned check(s) and related fee(s) have been paid.
2. KEDREN reserves the right to not accept any personal checks from patients with an NSF history.
3. The charge for medical records copying for attorneys, etc. (non-patients) is the greater of $5.00 or $0.35 per page.
4. All medical records requests by third party besides the patient must be prepaid before they are released and must include a signed patient release form.

6.12 PATIENT ACCOUNTING
BILLING AND COLLECTION
Coding (CPT and ICD codes)

Policy: Coding practices are reviewed annually.

Purpose: To maximize revenues.

Procedures:

1. KEDREN purchases up-to-date copies of CPT and ICD coding books.
2. A profile of each provider's coding practices is performed annually or as needed. This information is shared with the profiled provider.
3. Medical records, claim forms, and encounter forms are reviewed to ascertain whether all of the documentation is consistent. This documentation must match for auditing, reimbursement and medical-legal purposes. Inconsistent documentation is reviewed with the provider and relevant office staff.
4. KEDREN's ECW system is ICD10 compliant.