

Section: Administrative	Behavioral Health Network	Original Date: 4/1/2010
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IV.T	Policy: Sliding Fee Policy	

I. PURPOSE OF THE POLICY

To provide financial relief to persons who require quality mental health and substance use services when they demonstrate an inability to pay. To ensure that due diligence is performed by BHN for all persons seeking financial assistance. To ensure that said policy is applied fairly and uniformly.

II. POLICY

It is the policy of BHN to perform due diligence at the time of intake for all persons seeking services when they present as uninsured or indigent. The due diligence process will begin at the time of intake and include periodic review of the individual's insurance eligibility and/or the person's ability to pay.

III. DEFINITIONS

Family Size - a group of two people or more (one of whom is head of household) related by birth, marriage or adoption and/or residing together. **Family** is limited to immediate family: spouse, partner, children/dependents (biological, foster, adoptive). Dependents must be **18 years** of age or younger.

Income – money income before taxes not including capital gains or noncash benefits (such as public housing, Medicaid, food stamps).

Indigent – a condition of having insufficient income to pay for adequate medical care without depriving oneself or one's dependents of food, clothing, shelter, or other living essentials.

Uninsured – any individual who does not have a contract with an insurer to cover health care costs.

IV. PROCEDURES

A. Determining a prospective person served's eligibility through evaluation of Financial Information. Persons who decline to offer this information are ineligible for a discount.

1. Eligibility for sliding fee discounts is determined by household income and family size alone. Eligibility will be renewed/reviewed at least annually. [Please note: eligibility for MA DPH/BSAS funds reimbursement does require establishing a person's residency in the Commonwealth of MA.]

2. A BHN representative will verify the following required documentation to support the due diligence process. Documentation shall include, but not be limited to, the following:
 - a. copies of insurance cards and insurance information
 - b. proof of income:
 - i. Filed current federal income tax return (Form 1040 or Form 1020) or W2; if not available,
 - ii. provide last two earnings statements (pay stubs)
 - iii. Public Assistance check stub/copy
 - iv. Social Security check stub or letter of award
 - v. Certification Letter from Medical Assistance or Department of Social Services
 - c. EVs system eligibility checks
 - d. collection of family size information
 - e. proof of address:
 - i. Current MA learner's permit, MA license, or MA ID card
 - ii. W-2 Form from current or previous year that displays residential address
 - iii. A utility bill (gas, electric, wired telephone, wired cable, or heating oil delivery bill) (no more than 60 days old) that contains the applicant's name and residential address
 - iv. Medicaid correspondence (dated within six months of application)
 - v. Cell phone, credit card, doctor, or hospital bill issued within the last 30 days
 - vi. First-class mail from any federal or state agency that displays residential address
 - vii. Form 1551
 - viii. Form 194

- B.** Information shall be gathered from the person served to assess the need for a sliding fee. The guideline for determination of a sliding fee shall be based on the most recent Federal Poverty Income Guidelines. See most recent sliding fee scale (Attachment A). The sliding fee process shall include:
 1. Household Income Worksheet (Attachment B) used to test the person served's financial status and ability to pay;
 2. Sliding Fee Contract (Attachment B) signed by the person served;
 3. BHN Sliding Fee Financial Agreement (Attachment C) signed by the person served.

- C.** Sliding fees shall be collected from persons served at the time of service. Collections of cash, check, money orders or credit cards will be accepted by BHN. Monthly bills will be generated to clients with unpaid sliding fees.

- D.** The following steps will be taken to update the person served's ability to pay for services and eligibility. Those steps include, but are not limited to:
 1. EVs checks through the EVs report prior to each scheduled service.
 2. A reassessment of each person served's financial status every 90 days, in conjunction with the review of the individual treatment plan, or sooner if evidence of changes in financial or income status is known.
 3. Verification of residency is documented in person served file, as state residency is a requirement for any funds reimbursement by MA DPH/BSAS.

ATTACHMENT A

Behavioral Health Network, Inc. Discounted/Sliding Fee Pay Classes 2020 Federal Poverty Guidelines for the 48 Contiguous States and DC

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent of Poverty

Federal Poverty Level Family Size	100%	133%	150%	200%	250%	300%	400%
1	\$12,760	\$16,971	\$19,140	\$25,520	\$31,900	\$38,280	\$51,040
2	\$17,240	\$22,929	\$25,860	\$34,480	\$43,100	\$51,720	\$68,960
3	\$21,720	\$28,888	\$32,580	\$42,660	\$54,300	\$65,160	\$86,880
4	\$26,200	\$34,846	\$39,300	\$52,400	\$65,500	\$78,600	\$104,800
5	\$30,680	\$40,804	\$46,020	\$61,360	\$76,700	\$92,040	\$122,720
6	\$35,160	\$46,763	\$52,740	\$70,320	\$87,900	\$105,480	\$140,640
7	\$39,640	\$52,721	\$59,460	\$79,280	\$99,100	\$118,920	\$158,560
8	\$44,120	\$58,680	\$66,180	\$88,240	\$110,300	\$132,360	\$176,480

Notes: The 2020 federal poverty guideline increases by \$5,600 for each additional family member.

Sliding Fee Scale Discount

100% 75% 63% 50% 38% 33% 0%

<https://aspe.hhs.gov/poverty-guidelines>

ATTACHMENT B

Behavioral Health Network SLIDING FEE CONTRACT

Name: _____

Carelogic ID: _____

Date: _____

WORKSHEET TO DETERMINE HOUSEHOLD INCOME FOR SLIDING FEE

HOUSEHOLD MEMBERS

PERSONAL INCOME

	<u>Name</u>	<u>DOB</u>	<u>Relationship</u>	<u>Salary & Wages</u>	<u>SSI/SSDI/TANF</u>	<u>Other Income</u>	<u>TOTAL INCOME</u>
1.	_____	_____	<u>SELF</u>	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____	_____	_____

TOTAL HOUSEHOLD INCOME

\$ _____ \$ _____ \$ _____ \$ _____

\$(_____)

Comments:

Total number of household members used to determine sliding fee _____

VERIFICATION OF INSURANCE AND INCOME STATUS

(Please circle one)

- Y / N I am employed full time.
- Y / N I am employed part time.
- Y / N I am currently unemployed and have no source of income.
- Y / N I am not currently covered by any health care insurance policy that would cover these services.
- Y / N I did not file an income tax return for the most recent year in which one was due.
- Y / N I am unable to provide any verification to this agency for the following reason:

_____.

- I agree to notify the Behavioral Health Network, Inc. in the event my financial or insurance circumstances change.

Person Served Signature

____/____/____
Date

Based upon the income information that I have provided to this agency, the following fee for each visit has been set for me. I understand and accept that it is my responsibility to pay the fee at the time of each session. I understand that in order to qualify for this reduced fee which is provided at least in part through funds from the Department of Public Health, I must submit the agreed upon proof of income to this agency. In the event that I do not submit acceptable proof of income to this agency, I may be held liable for the full cost of services provided.

\$_____ per Intake session \$_____ per Individual session

\$_____ per Group session \$_____ per Intensive Outpatient session

Person Served Signature

____/____/____
Date

Witness

____/____/____
Date

Slidingfee.doc
Revised 5/22/17



ATTACHMENT C

Behavioral Health Network Sliding Fee Financial Agreement

PAYMENT GUARANTEE

In consideration of the services rendered and to be rendered to the named person served by BEHAVIORAL HEALTH NETWORK, INC. ("BHN"), I expressly understand that I am responsible for payment of BHN fees based upon the agreed to sliding fee scale (attached) and agree to pay in full at time of service delivery using cash, check, money orders or credit card. _____ (Initial)

CHANGE IN STATUS

I understand that it is my obligation to notify BHN if a change in status for the person served occurs during the delivery of care. Status changes include but are not limited to insurance coverage activation, residency change outside Massachusetts, change in income, change in family size, etc. I understand that I must provide accurate information and documentation of income and family size any time BHN requests such information. I understand that I am eligible for the sliding fee only on condition that I make payments at time of service and failure to be current may jeopardize eligibility. _____ (Initial)

CLIENT RESPONSIBILITY

I understand that it is my responsibility to provide BHN with complete and accurate insurance information when it is obtained. To best serve me and my health needs, I must always provide a current copy of my card to BHN for my record. I understand that in order for BHN to set realistic treatment goals and priorities, it is important that they have current insurance information to evaluate what resources I have available to pay for my treatment. I understand that BHN will make a best effort to inform me of the anticipated fees involved as soon as this can be reasonably determined. I understand that BHN cannot guarantee my coverage and that I am ultimately responsible for payment of services rendered. _____ (Initial)

CANCELLATION POLICY

I understand that BHN respectfully requests a 24-hour notice of cancellation. I understand that if the person served has an emergency and cannot provide a 24-hour notice of cancellation, BHN must be notified as soon as possible. _____ (Initial)

I have read and understand the preceding information.

X _____
Name of Person Served (please print)

X _____
Signature of Person Served or person responsible for Person Served Date

X _____
Name of Person Responsible (please print)