ATTACHMENT 2

FORM	100-P	Butler County Mental Health & Addiction Recovery Services Board
		Individual/Family Care Subsidy Application

PURPOSE of FORM 100:
To establish guidelines and specific procedures for the assessment of consumer
fees and appropriate billing to the Butler County Mental Health & Addiction Recovery
Services (BCMHARS) Board for services to consumers whose adjusted monthly
income and number of dependents fall within the approved fee scale.
This is referred to as co-pay and is reflected as a component of the Butler County plan.

To establish guidelines and specific procedures for making exceptions to the fee
scale.

To assure all consumers are given the same treatment in applying the system fee
scale.

CALCULATION OF CONSUMER FEES

Determine Family Gross Monthly Income. Gross Monthly Income total must be
entered on Form 100. Photocopies of income verification shall be
attached to the Form 100. Assure all consumer income is assessed
and calculated just as it would be for federal income tax, including items listed in section C.

Financial Party
A financial party is the person responsible to pay for the services. The financial party
is the person(s) that the household size and income is used to determine the sliding fee.

Allowable Adjustments.
Co-pays may be waived for the following reasons:
1. A consumer who has been clinically determined to be a danger to self or others.
2. An extreme or disruptive family situation that creates ununsual financial hardship
or unusual circumstances in the household.

THIRD PARTY PAYMENTS
It is understood that any available third party payer, such as the consumer's
workplace or insurance, will be billed first for services. If the consumer is eligible
by income for a Board subsidy (qualifies via the sliding fee scale and fee scale worksheet)
then any remaining unpaid portion of the services up to the agreed rate may be billed
to the Board. The Board is payor of last resort as identified in the Contract.

See more information in the instructions tab as to how sliding fee and insurance billings
work in combination of one another.

Rev. 6/6/18 **ATTACHMENT 2**

FORM 100

Butler County Mental Health & Addiction Recovery Services Board

Individual/Family Care Subsidy Application

Section A.

			Client's county of residence*	Client's Date of birth
Does consumer have Medicaid?	☐ Yes ☐ No	If yes, obtain copy of card		
Does consumer have Medicare Part B insurance?	☐ Yes ☐ No	If yes, obtain copy of card		/ /
Does consumer have other health insurance?	☐ Yes ☐ No	If yes, obtain copy of card	Insurance effective date	/ /

Name of other health insurance coverage is?

Consumer's first name and initial	Consumer's Last name	Consumer's social security No.

Section B. Financial Party

Financial Party's (who is responsible to pay for the requested services? - Use responsible party's information to determine sliding fee)

Financial party's and/or consumer's first name and initial,	Last name	Financial party social security No.
If a joint or family application, spouses first name and initial	Last name	Spouse's social security No.

Home address	Apt. No.	TAX FILING STATUS
City, town, or post office, state, and ZIP code.		☐ Single ☐ Married

Calculation of Family Size Exemptions	Yourself, enter 1	Spouse, enter 1	Enter number of dependents reported to IRS	Total Exemptions
	+	+	+	=

For this application, your family size shall match your exemptions claimed on IRS form 1040 or 1040EZ tax return.

Section C. Income of Financial Party

Family size is equal to Total Exemptions from Section B. Report your family's income below.

1 Wages, salaries, tips, etc. from Form 100-1 (Income Worksheet).	$	**Agency Office Use Only**
2 Taxable interest, investment earnings, dividends	$	GOSH Reporting:
3 Alimony Received	$	Family size
4 Business income	$	# __________
5 Pension / retirement / VA pension / Military pay	$	Adjusted gross
6 Rental real estate income	$	monthly income
7 Farm income	$	$ __________
8 Trust fund income	$	Client's sliding fee
9 Unemployment compensation / TANF/DA	$	co-pay percentage
10 Social Security benefits /SSDI/SSI/ VA disability/........................	$	__________%
11 Child support income	$	INSURANCE CO-PAY
12 Worker's compensation benefits	$	$_________ per visit
13 Other (List ___________________________________)	$	REMINDER
14 Exclusions from Form 100-3 (Exclusion Worksheet)...................	$ (-)	UPDATE GOSH MEMBER
Adjusted Gross Monthly Income Total	$	ENROLLMENT SCREEN

Is Adjusted Gross Monthly Income zero dollars, enter zero for the answer and see below.

Subsidy schedules:

<u>Zero Income section.</u> If Adjusted Gross Monthly Income totals Zero, check this box and complete Form 100-2 (Zero Income Self-Declaration Form)
Also, a Medicaid denial is required

☐ Sliding Fee 200%

Staple documentation to Form 100 for all items entered above.

Income Verification Attached?

Additional Comments:

Section D. Signatures

To the best of my knowledge, the statements on this application are accurate, true and complete.

______________________________ ______________________________

Financial Party's signature Date

I have examined this application and have verified the documents and statements.
To the best of my knowledge, they are accurate, true and complete.

______________________________ ______________________________

Agency staff signature Date

Form 100 must be updated when changes occur or at least annually.

All sections of this Form 100 must be complete and accurate. To be considered complete and accurate, this Form 100 should be able to be verified by the Board examiner using the attached supporting documentation.

FORM 100-1

Butler County Mental Health & Addiction Recovery Services Board

Individual/Family Care Subsidy Application

Income Worksheet

If the documentation is already at monthly - do not complete this form.
This worksheet is provided to assist in calculating the **monthly** income that is to be entered onto Form 100 under Section C, Row 1 (Wages, salaries, tips, etc.).

People typically are paid once a week, once every two weeks, or twice a month.
Select the appropriate option to calculate the Financial Party's gross pay and fill in the boxes.
(Only one calculation is needed per paystub).

Provide this **monthly** income calculation for every paystub of every working member of the Financial Party's family.
Use additional copies of this form if necessary.

Name on paystub: ______________________ **Date of paystub:** ______________________

Monthly Income Calulation

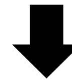
Weekly Gross Pay	weekly pay box	**multiplied by 52, divided by 12 =**	
		OR	
Every 2 Weeks Gross Pay	every 2 weeks $	**multiplied by 26, divided by 12 =**	$
		OR	
Twice a Month Gross Pay	twice a month $	**multiplied by 24, divided by 12 =**	$

Name on paystub: ______________________ **Date of paystub:** ______________________

Monthly Income Calulation

Weekly Gross Pay	weekly pay box $	**multiplied by 52, divided by 12 =**	$
		OR	
Every 2 Weeks Gross Pay	every 2 weeks	**multiplied by 26, divided by 12 =**	
		OR	
Twice a Month Gross Pay	twice a month $	**multiplied by 24, divided by 12 =**	$

After you have entered the paystub information into the boxes above,
add the amounts in the above boxes into the Total Monthly Income Box below.



Enter this total on Form 100, Section C, Row 1 (Wages, salaries, tips, etc.) $ -

FORM 100-2

Butler County Mental Health & Addiction Recovery Services Board

Individual/Family Care Subsidy Application

ZERO INCOME SELF-DECLARATION FORM

Please complete and sign this form if you have claimed zero or no income on the attached application, Form 100.
Leaving this form blank or writing N/A or dashes (---) is not acceptable.

Please Print

First Name	M.I.	Last Name	UCI Number (when known)
Current Address			Your Social Security Number
City	State	Zip Code	Daytime Telephone Number including Area Code ( )

List your monthly bills.

Bill	Monthly Amount
Rent/Mortgage	$
Food	$
Gas/heat fuel	$
Electric	$
Phone/Cell	$
Car Payment/Insurance	$
Cable/Internet	$
Personal Expenses	$
Other Expenses	$
Other Expenses	$

BOARD IS PAYOR OF LAST RESORT

Before seeking Board assistance all other means must be exhausted.

If the income is below 138% of poverty then a Medicaid denial must be presented before the services can be billed to the Board

Tell us how you have been paying your monthly bills and any other comments you may want to share.

A.	*** Outcome of Medicaid Application.** **(Rejection letter is attached)**	**Date**

I agree to report any changes in my finances immediately to the Agency where I am receiving mental health / AOD services.
I understand that by signing this form, I authorize the BCMHARS Board or its designated representatives to have access to public assistance, social security, employment or other records needed to verify any statements I have made.

X Signature ________________ Date __________

This form is required to be updated six months after signature or when circumstances change.

FORM 100

Butler County Mental Health & Addiction Recovery Services Board

Individual/Family Care Subsidy Application

INSTRUCTIONS

Form 100

Section A.

"Consumer" is the individual who is to be enrolled in GOSH.
"Financial Party" is the individual responsible for paying the bill for services.
It is possible for the Consumer not to be the Financial Party. If this is the case, provide answers to the Medicaid/Insurance questions for the Financial Party if the insurance also covers the consumer.

NEW IN 2017

Proof of County of Residence must accompany Form 100. This could be any third party document that shows the consumer and financial party as being a Butler County Resident.
ALSO:
Subsidy is not to be billed until after insurance is billed. The Federal Law requires all citizens to have health insurance. The subsidy addresses uninsured services or balances after the insurance has paid.
Per Contract between Board and Provider the Board is payor of last resort

HEALTH INSURANCE:
Two types exist, co-pay per visit and deductibles.
If the insurance card states the co-pay amount, then the agency is to collect the co-pay, bill insurance and then bill the Board up to the agreed amount, showing the collection of co-pay & insurance deducted
If a service is not eligible for insurance, the the pay amount is determined by using the sliding fee process.
Deductible: Agency is to bill insurance and if the amount has been charged to client's deductible, the client qualifies to pay the amount determined on the sliding fee process.

Section B. Financial Party

"Financial Party" is the individual paying the bill for services.
It is possible for the Consumer not to be the Financial Party. In the case of services being provided to a client under the age of 18, typically their parent or guardian is responsible for payment.

"Family Size" is equal to the Financial Party's IRS 1040 tax exemptions.

Section C. Income of Financial Party

This section is completed by combining all applicable incomes of the members listed in the box titled "Total Exemptions" (your family). Your family should mirror your tax return.
There is a 90 day grace period allotted to obtain documentation to verify all income items listed in this section. All income listed in this section must be verified by acceptable documentation such as paycheck stub, employer payroll record, IRS 1040 form, bank statement, court record or bona fide documents that can be used to validate income.
ATTN: If you are relying on the 90 day grace period to obtain verification then there will need to be a note written on the bottom of FORM 100 stating that the agency is waiting on documentation.
For example: ***On mm/dd/yyyy, Income verification request submitted to the Social Security Admn.***
Another example: ***On mm/dd/yyyy, Agency requested for a second time from client a copy of current paystub.***
To calculate Secion C, Row 1 (Wages, salaries, tips, etc.), use Form 100-1, Income Worksheet.

Agency Office Use Only section

Form 100 is not complete until GOSH Member screens are complete. In this section, the provider shall write on this form the entires made to the GOSH billing system.

Section D

There is a space provided for the Financial Party and Agency Staff to sign and date the form.
Both signatures are required. Form 100 must be updated when changes occur or at least annually.

Form 100-1 Income Worksheet

This worksheet is required for converting paystub information into a monthly income to be entered in Form 100, Section C, Row 1 (Wages, salaries, tips, etc.).
An examiner from the Board must be able to verify the documentation and come up with the same result for monthly income as it appears on this application, Form 100.

Form 100-2 Zero Income Self-Delcaration

This document is required if the Consumer/Financial Party is claiming zero income.
This Zero Income Self-Declaration form must be completed in its entirety and updated six months after signature or when the Consumer's/Financial Party's circumstances change.

Form 100-3 Exclusions Worksheet

This worksheet is required when calculating expenses that may be excluded from the gross monthly income amount to arrive at an Adjusted Gross Monthly Income total on Form 100, Section C.
Annual amounts are collected for each eligible Exclusion and totaled in Box. A.
Divide the Annual Amount in Box. A by 12 to get a Total Monthly Exclusions Amount in Box B.

FORM 100-3

Butler County Mental Health & Addiction Recovery Services Board

Individual/Family Care Subsidy Application

Exclusions Worksheet

This worksheet is provided to calculate expenses that may be excluded from the gross monthly income amount to arrive at an Adjusted Gross Monthly Income total on Form 100, Section C.

All expenses listed in this section must be verified by acceptable documentation such as original receipts, checking or credit card statements, court records or other bona fide documents that can be used to validate qualifying expenses.

Medical / Dental expenses greater than 10% of gross monthly income

This allowance can be used in cases where the individual or family is incurring healthcare expenses that are not covered by insurance or government entitlements. In order to qualify, the applicant must produce bona fide receipts of expenses paid. Receipts must be attached to this form.

Enter Annual Amount $

Child and dependent care expenses

This allowance may be taken at 100% of acutal expenses. In order to qualify the applicant must produce bona fide receipts of expenses paid. These receipts would exclude any payments made on your behalf by another agency or government entitlement program.

Enter Annual Amount $

Alimony and child support payments

This allowance may be taken at 50% of actual expenses. In order to qualify, the applicant must produce bona fide receipts of expenses paid.

Enter Annual Amount $

College tuition, books, room & board expenses above $425 per month

This allowance may be taken for any expenses greater than $425 per month. In order to qualify, the applicant must produce evidence that they or a dependent that they claim as a deduction on their federal income tax return (Form 1040, etc.) is enrolled in an accredited institution of higher education in addition to producing bona fide receipts of such expenses paid minus any grants and scholarships. This allowance may be calculated by averaging expenses over twelve months to arrive at an annual expense after grants and scholarships.

Enter Annual Amount $

Long-term care expense above $425 per month

This allowance may be taken for any expenses greater than $425 per month. In order to qualify, the applicant must produce bona fide receipts of expenses paid.

Enter Annual Amount $

TOTAL ANNUAL EXCLUSIONS AMOUNT Box A. $

Divide amount in Box A. by 12 to get **TOTAL MONTHLY EXCLUSIONS AMOUNT** Box B. $

Enter the amount from Box B. as a negative amount on Form 100, row 14.

FISCAL YEAR 2019

SCHEDULE OF PARTIAL PAYMENTS FOR MENTAL HEALTH AND ADDICTION SERVICES

PERCENT OF COST TO BE PAID BY THE FAMILY

TABLE FOR FEE ASSESSMENT BASED ON 200% OF THE STATE MINIMUM STANDARD OF NEED

%	Family Size 1		Family Size 2		Family Size 3		Family Size 4		Family Size 5		Family Size 6		Family Size 7		Family Size 8	
5	2,023	2,143	2,743	2,895	3,463	3,652	4,183	4,402	4,903	5,155	5,623	5,915	6,343	6,619	7,063	7,323
10	2,144	2,264	2,896	3,048	3,653	3,842	4,403	4,622	5,156	5,408	5,916	6,208	6,620	6,896	7,324	7,584
15	2,265	2,385	3,049	3,201	3,843	4,032	4,623	4,842	5,409	5,661	6,209	6,501	6,897	7,173	7,585	7,845
20	2,386	2,506	3,202	3,354	4,033	4,222	4,843	5,062	5,662	5,914	6,502	6,794	7,174	7,450	7,846	8,106
25	2,507	2,627	3,355	3,507	4,223	4,412	5,063	5,282	5,915	6,167	6,795	7,087	7,451	7,727	8,107	8,367
30	2,628	2,748	3,508	3,660	4,413	4,602	5,283	5,502	6,168	6,420	7,088	7,380	7,728	8,004	8,368	8,628
35	2,749	2,869	3,661	3,813	4,603	4,792	5,503	5,722	6,421	6,673	7,381	7,673	8,005	8,281	8,629	8,889
40	2,870	2,990	3,814	3,966	4,793	4,982	5,723	5,942	6,674	6,926	7,674	7,966	8,282	8,558	8,890	9,150
45	2,991	3,111	3,967	4,119	4,983	5,172	5,943	6,162	6,927	7,179	7,967	8,259	8,559	8,835	9,151	9,411
50	3,112	3,232	4,120	4,272	5,173	5,362	6,163	6,382	7,180	7,432	8,260	8,552	8,836	9,112	9,412	9,672
55	3,233	3,353	4,273	4,425	5,363	5,552	6,383	6,602	7,433	7,685	8,553	8,845	9,113	9,389	9,673	9,933
60	3,354	3,474	4,426	4,578	5,553	5,742	6,603	6,822	7,686	7,938	8,846	9,138	9,390	9,666	9,934	10,194
65	3,475	3,595	4,579	4,731	5,743	5,932	6,823	7,042	7,939	8,191	9,139	9,431	9,667	9,943	10,195	10,455
70	3,596	3,716	4,732	4,884	5,933	6,122	7,043	7,262	8,192	8,444	9,432	9,724	9,944	10,220	10,456	10,716
75	3,717	3,837	4,885	5,037	6,123	6,312	7,263	7,482	8,445	8,697	9,725	10,017	10,221	10,497	10,717	10,977
80	3,838	3,958	5,038	5,190	6,313	6,502	7,483	7,702	8,698	8,950	10,018	10,310	10,498	10,774	10,978	11,238
85	3,959	4,079	5,191	5,343	6,503	6,692	7,703	7,922	8,951	9,203	10,311	10,603	10,775	11,051	11,239	11,499
90	4,080	4,200	5,344	5,496	6,693	6,882	7,923	8,142	9,204	9,456	10,604	10,896	11,052	11,328	11,500	11,760
95	4,201	4,321	5,497	5,649	6,883	7,072	8,143	8,362	9,457	9,709	10,897	11,189	11,329	11,605	11,761	12,021
100	4,322	25,000	5,650	25,000	7,073	25,000	8,363	25,000	9,710	25,000	11,190	25,000	11,606	25,000	12,022	25,000

Revision Date 1/13/2018