SISKIYOU COUNTY

Health and Human Services Agency

TERRY BARBER
Director of Health and Human Services Agency
CONNIE CESSNA SMITH, M.P.A.
Deputy Director of Administrative Services Division

DEPARTMENTAL PROCEDURES

SUBJECT	POLICY NO.	EFFECTIVE DATE
Uniform Method Determining Ability to Pay (UMDAP)	FISCAL 14-05F	11/05/2014
APPROVED BY Terry Barber Director of Health and Human Services Agency	SUPERCEDES N/A	PAGES 1

POLICY: It is the Policy of Siskiyou County Health and Human Services Agency, Behavioral Health Division (SCBHD) to provide specialty mental health services regardless of ability to pay. SCBHD will follow the Sliding Scale of liabilities as set forth in the California Department of Mental Health (DMH) Information Notice 98-13 and the liability scale published by DMH and effective October 1, 1989. Medicaid laws supersede UMDAP for Clients on Medi-Cal.

PROCEDURES:

- Clients beginning services at SCBHD will be seen for a fiscal intake interview at the onset of services. The fiscal intake will include collecting, verifying and inputting the client's financial information for the purpose of determining the client's ability to pay.
- Clients are provided with an intake packet by the Health Assistant, and asked to complete. The client will then be seen by the Fiscal Technician for fiscal intake.
- The Fiscal Technician will :
  - Ensure that client is completing intake packet while Fiscal Technician begins data input.
  - Collect the clients financial information, including: Private Insurance, Medi-Cal, Medicare, Other Resources and verify eligibility, if appropriate. The Fiscal Technician will key this information into the Third Party Coverage form in the Management Information System (MIS).
  - Verify the client's income with the client, and complete the annual UMDAP form in the MIS with the client present.
  - Print the UMDAP form, review and explain the results of the sliding scale calculation with the client.
  - Sign the UMDAP form and obtain the client's signature.
  - Verify that client has signed the forms in the Intake Packet, including the Financial Review Form. (The Financial Review Form explains how services will be billed the client's responsibilities regarding payment).
- UMDAP sliding scale fee calculations will be updated annually.

ATTACHMENT C

UNIFORM PATIENT FEE SCHEDULE
COMMUNITY MENTAL HEALTH SERVICES
Effective October 1, 1989

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
0- 569					
570- 599					
600- 649					
650- 699	50				
700- 749	56				
750- 799	63				
800- 849	71	64			
850- 899	79	71			
900- 949	89	80			
950- 999	99	90	80		
1000-1049	111	100	90		
1050-1099	125	112	101		
1100-1149	140	126	113		
1150-1199	156	140	126	113	
1200-1249	177	159	143	129	
1250-1299	200	180	162	146	
1300-1349	226	203	183	165	149
1350-1399	255	230	207	186	167
1400-1449	288	259	233	210	189
1450-1499	326	293	264	238	214
1500-1549	368	331	298	268	241
1550-1599	416	374	337	303	273
1600-1649	470	423	381	343	309
1650-1699	531	478	430	387	348
1700-1749	600	540	486	437	393
1750-1799	678	610	549	494	445
1800-1849	752	677	609	548	493
1850-1899	835	752	677	609	548
1900-1949	927	834	751	676	608

MONTHLY ADJUSTED GROSS INCOME*	PERSONS DEPENDENT ON INCOME ANNUAL DEDUCTIBLES				
	1	2	3	4	5 or more
1950-1999	1029	926	833	750	675
2000-2049	1142	1028	925	833	750
2050-2099	1268	1141	1027	924	832
2100-2149	1407	1266	1139	1025	923
2150-2199	1562	1406	1265	1139	1025
2200-2249	1734	1561	1405	1265	1139
2250-2299	1925	1733	1560	1404	1264
2300-2349	2136	1922	1730	1557	1401
2350-2399	2371	2134	1921	1729	1556
2400-2449	2632	2369	2132	1919	1727
2450-2499	2922	2630	2367	2130	1917
2500-2599	3275	2948	2653	2388	2149
2600-2699	3482	3134	2821	2359	2285
2700-2799	3695	3326	2993	2694	2425
2800-2899	3915	3524	3172	2855	2570
2900-2999	4139	3725	3353	3018	2716
3000-3099	4370	3933	3540	3186	2867
3100-3199	4607	4146	3731	3358	3022
3200-3299	4850	4365	3929	3536	3182
3300-3399	5099	4589	4130	3717	3345
3400-3499	5458	4912	4421	3979	3581
3500-3599	5830	5247	4722	4250	3825
3600-3699	6214	5593	5036	4532	4079
3700-3799	6610	5949	5354	4819	4337
3800-3899	7018	6316	5684	5116	4604
3900-3999	7438	6694	6025	5423	4881
4000-4099	7870	7083	6375	5738	5164
4100-4199	8314	7483	6735	6062	5456

Above $4200 Add $400 for each $100 additional income.

*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).

Prepared and published by the California Department of Mental Health in accordance with Sections 5717 and 5718 of the Welfare and Institutions Code.

SISKIYOU COUNTY HUMAN SERVICES AGENCY
Client Financial Review Form

Client Name:	Client Number:

Main (1) tab

*Review Date: Use Actual	*Reviewed By:
*Financial Type: ○ Individual ○ Family	*Program: ○ Mental Health ○ Substance Abuse ○ Both
Family Members in Treatment	
Name: (*for Family Financial Type)	Client#:
Name:	Client#:
Name:	Client#:
Name:	Client#:
Name:	Client#:
Name:	Client#:
Bill To: (Responsible Person defaulted from Registration Form)	
☐ **Assignment of Benefits Signed? (Check box if "Yes")**	
☐ **Financial Info Provided/Verified (Check box if "Yes")**	
Reason for Unverified Income: ○ N – N/A ○ U – Unemployed ○ P – Documentation Pending ○ R – Doc Not Provided/Refused	
☐ **Suppress printing statements**	
(27)Suppress Reason: (*If suppressing statements) ○ A – Administrative ○ N – No Permanent Mailing Address ○ H – Homeless ○ CR – Client Request ○ MR – Management Request ○ T – Therapeutic	

Financial (2) tab

*Number dependents on income:				
Gross Family Income			**Monthly**	**Annual**
		Responsible Party (Self)		
		Spouse		
Misc. Income:	Family			
	Disability			
	Social Security			
	Unemployment			
	Public Assistance			
	Additional Source			
SubTotal (enter in "Other" field below)				
		Other		
		Gross Income		

SISKIYOU COUNTY HUMAN SERVICES AGENCY
Client Financial Review Form

Liquid Assets (Container disabled if Program = Substance Abuse)

Checking Accounts		
Savings Accounts		
Other		
Gross Liquid Assets		
Asset Allowance		

Allowable Expenses (Container disabled if Program = Substance Abuse)

	Monthly	Annual
Court Ordered Obligations		
Child Care (necessary for employment)		
Dependent Support		
Medical Expenses		
Medical Expenses in excess of 3% Gross Income		
Mandated Deductions for Retirement Plans		
Total Allowable Expenses		

	Monthly	Annual
Adjusted Gross Income		

Substance Abuse Slide (Container disabled if Program = Mental Health)

Slide %	Additional Slide %	Total Slide %

Mental Health UMDAP (Container disabled if Program = Substance Abuse)

Max Annual Liability	
For Period:	Thru:

Payment Plan (3) tab	
☐ Payment Plan	
Agreed upon Payment Amount (*If Payment Plan) $	Per (*If Payment Plan) ○ Month ○ Visit

Comments (4) tab
Comments:

Signature of Patient or Responsible Person Date

SISKIYOU COUNTY HUMAN SERVICES AGENCY
Client Financial Review Form

BILLING OF SERVICES AND ASSIGNMENT OF BENEFITS

You have or will be receiving services provided by Siskiyou County Human Health Services Agency. We are a county agency and rely upon Federal, State, County, client and other funding sources to pay for the services we offer.

Depending on your financial resources and available benefits, you may be responsible to pay for some or all of the fees associated with the services provided to you. Because of this, every consumer who receives services is asked to complete a Financial Review Form. Based on the information you provide to us, we will determine an amount that would be your maximum annual liability for payment for services. This determination will consider your Family size, Monthly Income, Total Assets and Allowable Deductions and will follow the California Department of Mental Health's Uniform Method of Determining Ability To Pay (UMDAP). Verification of the information will be required, as needed. The Annual Liability can either be paid in full or on a monthly basis. The method of payment will be determined when the Annual Liability amount is set. The Annual Liability will be updated every twelve months. If more than one person in the family receives services, all will be covered by one Annual Liability amount. As long as your financial situation remains the same, you will never be obligated for more than your Annual Liability, even if the cost of your care may be higher.

If you are **Medi-Cal without a Share of Cost**, you will not be charged the Annual Liability. However, if you have **CMSP Medi-Cal**, Behavioral Health will bill you in accord with your Annual Liability. If you are on **Medi-Cal with a Share of Cost,** you will be responsible for paying the Share of Cost up to the Annual Liability amount.

If you have **Medicare and/or Private Insurance**, these third parties will be billed for the services provided. If the full amount is not paid by the third party and you do not also have Medi-Cal, you will be responsible for the remainder of the cost up to your Annual Liability amount. **Medicare covers only certain services provided by Medicare certified clinicians and private insurance often covers only a limited number of services.** If your Private insurance is a supplement to Medicare, it will follow the Medicare rules. Consequently, even if you have third party coverage, you could still be liable for payment up to the Annual Liability amount.

If you have **Medicare and Medi-Cal:**

a) without a Share of Cost, and your services are not fully covered by Medicare, the services will then be billed to Medi-Cal. You will not be responsible for the cost.

b) with a Share of Cost, and your services are not fully covered by Medicare, you are not considered to be on Medi-Cal until the Share of Cost is met and we must collect your Share of Cost up to the Annual Liability amount before billing Medi-Cal.

If you are covered by any insurance/benefit plan, you must give us the right to bill and receive payment for services provided to you by signing the authorization and acknowledgement below.

AUTHORIZATION AND ACKNOWLEDGEMENT

I understand and accept that I am financially responsible for all services provided by Siskiyou County Human Services Agency up to the Annual Liability amount. I authorize Siskiyou County Human Services Agency to release to my insurance company or other third party payor any personal or medical information necessary to determine benefits and/or for the processing of claims for payment. I also authorize payment of medical benefits by any third party insurer/payor to Siskiyou County Human Services Agency for services rendered. I permit a copy of this authorization to be used in place of the original.

I agree to provide all necessary insurance/benefit information to Siskiyou County Human Services Agency for the processing of claims for services rendered to me.

I acknowledge that I have read, understood and agree to the billing policies above.

Client Signature_____ **Date:**_____

Confidential Patient Information - See California Welfare and Institutions Code Section 5358

SISKIYOU COUNTY HUMAN SERVICES AGENCY	NAME_____
Client Cost/How Billed	CLIENT NO:_____

SISKIYOU COUNTY HUMAN SERVICES AGENCY
Client 3rd Party Coverage – Medi-Cal/Healthy Family

Shaded Areas are not to be completed – leave blank

Main – Tab 1			
Client Name:		**Client Number:**	
Reviewed By:		Review Date:	
***Pay Source:**	❑ Medi-Cal 100 ❑ Healthy Families 120	***Effective Date:**	
Benefit Plan:	❑ MH/HF 9010	Expiration Date:	
***Policy #(CIN)**		***Priority:**	7

Group			Policy Holder	
Number			(16)Relationship to Insured	
Name			*Name (Last,First,MI)	
Medi-Cal Rol ID			*Address	
Record Details			City/St/ZIP	
Date Entered		By	DOB	*(7)Sex

Main – Tab 2			
☐ SSI	Enrollment ID		
Alias - if different from Client legal name			
Name (Last,First,MI):			
DOB:			***(7)Sex:**
Change** ***(Required for changes only)			
Date:		Reason:	

California / New York / AZ – Tab 3

County of Responsibility _____
Primary Aid Code(s) _____ _____

Share of Cost/Spend Down

☐ Subject to Share of Cost/Spend Down
Monthly Share of Cost/ Spend Down Amount $ _____

Comments – Tab 4

*Key: *=Required Field*

SISKIYOU COUNTY HUMAN SERVICES AGENCY
Client 3rd Party Coverage – Other

Shaded Areas are not to be completed – leave blank

Main – Tab 1			
Client Name:		**Client Number:**	
Reviewed By:		Review Date:	
***Pay Source:**		***Effective Date:**	
Benefit Plan:		Expiration Date:	
***Policy #**		***Priority:**	

Group		**Policy Holder**	
Number:		**(17)Relationship to Insured:**	
Name:		Name (Last,First,MI):	
Medi-Cal Pol ID:		Address:	
Record Details		City/St/ZIP:	
Date Entered:	By:	DOB:	***(7)Sex:**

Main – Tab 2			
☐ SSI	Enrollment ID:		
Alias - if different from Client legal name			
Name (Last,First,MI):			
DOB:			***(7)Sex:**
Change** ***(Required for changes only)			
Date:		Reason:	

California / New York / AZ – Tab 3

Comments – Tab 4

*Key: *=Required Field*

Client Name: _____ Client #: _____