

## INSTRUCTIONS

### Form 100

#### Section A.

"Client" 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 Client 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 Client.

#### Section B. Financial Party

"Financial Party" is the individual paying the bill for services.

It is possible for the Client 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.

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.

To calculate Section C, Row 1 (Wages, salaries, tips, etc.), use Form 100-1, Income Worksheet.

#### 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 100-1 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 auditor 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-Declaration

This document is required if the Client/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 Client's/Financial Party's circumstances change.

### Form 100-3A&B 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.



<b>FORM</b>	<b>100</b>
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# ADAMHS Board for Montgomery County

## Individual/Family Non-Medicaid Behavioral Health Care Subsidy Application

Section A.

Does Client have Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach copy of card	Client's county of residence	Client's Date of birth
Does Client have other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach copy of card		/ /
Client's first name and initial if client is a minor	Last name	Client's social security No.	

Section B. Financial Party

<b>Financial Party's (who is responsible to pay for the requested services? - Use responsible party's information to determine sliding fee)</b>				
Financial party's and/or client'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.	
City, town, or post office, state, and ZIP code.				
				<b>TAX FILING STATUS</b>
				<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
Calculation of Family Size	Yourselves, enter 1	Spouse, enter 1	Enter number of dependents	Total exemptions (your family)
	+	+	+	=

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

Enter gross monthly income from your family below. Family size is equal to your total exemptions.

Section C. Income of Financial Party

If financial party has zero income, check this box and complete Form 100-2 (Zero Income Self-Declaration Form) <input type="checkbox"/>		<b>Agency Office Use Only</b>  GOSH Reporting: Family size  # _____ Adjusted gross monthly income  \$ _____ Client's sliding fee co-pay percentage _____ % Subsidy schedule:
1 Wages, salaries, tips, etc. from Form 100-1 (Income Worksheet).	\$ _____	
2 Taxable interest, investment earnings, dividends .....	\$ _____	
3 Alimony Received .....	\$ _____	
4 Business income .....	\$ _____	
5 Pension / retirement / VA pension / Military pay .....	\$ _____	
6 Rental real estate income .....	\$ _____	
7 Farm income .....	\$ _____	
8 Trust fund income .....	\$ _____	
9 Unemployment compensation / TANF/DA .....	\$ _____	
10 Social Security benefits /SSDI/SSI/ VA disability/.....	\$ _____	
11 Child support income .....	\$ _____	
12 Worker's compensation benefits .....	\$ _____	
13 Other (List _____) .....	\$ _____	
14 Exclusions from Form 100-3 (Exclusions Worksheet).....	\$ (- _____ )	
<b>Adjusted Gross Monthly Income Total</b>		
\$ _____		

Staple documentation to Form 100 for all items entered above.

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

Section D. Signatures

_____	_____
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

**Individual/Family Non-Medicaid Behavioral Health Care Subsidy Application**
**Income Worksheet**

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, self-employment income, 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.

		<b>Date of</b>		
		<b>paystub:</b>		
<b>Monthly Income Calculation</b>	weekly pay box			
	Weekly Gross Pay	\$ <input style="width: 80px;" type="text"/>	multiplied by 52, divided by 12 =	\$ <input style="width: 80px;" type="text"/>
	<b>OR</b>			
	every 2 weeks			
	Every 2 Weeks Gross Pay	\$ <input style="width: 80px;" type="text"/>	multiplied by 26, divided by 12 =	\$ <input style="width: 80px;" type="text"/>
<b>OR</b>				
	twice a month			
	Twice a Month Gross Pay	\$ <input style="width: 80px;" type="text"/>	multiplied by 24, divided by 12 =	\$ <input style="width: 80px;" type="text"/>

		<b>Date of</b>		
		<b>paystub:</b>		
<b>Monthly Income Calculation</b>	weekly pay box			
	Weekly Pay	Gross \$ <input style="width: 80px;" type="text"/>	multiplied by 52, divided by 12 =	\$ <input style="width: 80px;" type="text"/>
	<b>OR</b>			
	every 2 weeks			
	Every 2 Weeks Gross Pay	\$ <input style="width: 80px;" type="text"/>	multiplied by 26, divided by 12 =	\$ <input style="width: 80px;" type="text"/>
<b>OR</b>				
	twice a month			
	Twice a Month Gross Pay	\$ <input style="width: 80px;" type="text"/>	multiplied by 24, divided by 12 =	\$ <input style="width: 80px;" type="text"/>

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.)

Total Monthly Income Box



**FORM**  
**100-2**

**ADAMHS Board for Montgomery County**

**Individual/Family Non-Medicaid Mental Health/AoD 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.

<b>Please Print</b>	First Name	M.I.	Last Name	UCI Number (when known)																				
				Your Social Security Number																				
				<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>																				

List your monthly bills and how you have been paying them over the past 90 days.

Bill	Monthly Amount	If paid by someone else, it is:			Explain if other is selected	
Rent/Mortgage	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Food	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Gas/heat fuel	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Electric	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Phone/Cell	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Car Payment/Insurance	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Cable/Internet	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Personal Expenses	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Other Expenses	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other
Other Expenses	\$	<input type="checkbox"/>	Gift	<input type="checkbox"/>	Loan	<input type="checkbox"/> Other

Additional comment(s) if needed about how you have been paying your monthly bills.

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<b>* Enter the date that you have applied for Medicaid:</b>	Date
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<b>* I have not applied for Medicaid, but I intend to apply on this date:</b>	Date
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<b>* I have applied for Medicaid and I have been rejected on this date:</b> (Rejection letter is attached)	Date
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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 ADAMHS Board Montgomery County or its designated representatives to have access to public assistance, social security, employment or other records needed to verify any statements I have made.

<b>X</b> Signature _____	Date _____
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**This form is required to be updated six months after signature or when circumstances change.**



FORM  
100-3A

ADAMHS Board for Montgomery County

**Individual/Family Non-Medicaid Behavioral Health 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 documents that can be used to validate qualifying expenses.

**Healthcare 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 current bills of expenses. Bills must be attached to this form.

Enter Annual Amount \$

**Child and dependent care expenses**

This allowance may be taken at 100% of actual expenses. In order to qualify the applicant must produce receipts of expenses paid.

These receipts would exclude any payments made on your behalf by another agency or government entitlement program.

Enter Annual Amount \$

**Court ordered obligations such as garnishment, restitution, child support, alimony, etc.**

This allowance may be taken at 50% of actual expenses. In order to qualify, the applicant must produce 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 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 \$

**Catastrophic Life Events**

In a catastrophic family situation resulting from fire, flood, or storm, damage to the family residence or other circumstances which create an unusual demand on the family's income during the period of treatment.

Enter Annual Amount \$

**Clinical Needs**

In situations where a member who has, based on clinical assessment, been diagnosed with more serious disorders, and/or been determined to be dangerous to self or others. **Please contact the Treatment Division.**

Comments:

**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 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.

FORM  
100-3B

ADAMHS Board for Montgomery County

Name

Sliding Fee Allowance Form Worksheet

Social Security Number

**Jail**

Clients who do not meet sliding fee income requirements and are in jail will be approved and entered into GOSH for a 7 day eligibility period. If services are going to be provided beyond the seven days for a client who will remain incarcerated, additional days may be requested as needed. Agency staff should request no more time than expected on the allowance from (i.e. 7 days, 10 days). Additional days will be approved for up to 30 days per request. A new Sliding Fee Allowance form should be submitted each time the eligibility needs to be extended.

Initial Request  
7 days

Addt'l Span  
Number of Days Max 30

**Non-Covered Medicare Services**

Clients who have Medicare will be required to apply for Medicaid to determine eligibility. The non-covered Medicare service(s) should be billed to Medicaid. Agencies have to verify eligibilty via MITS and upload documentation into GOSH.

**One-Time/Drops Out of Treatment**

For clients who only attend one session(one and done) and drop out of treatment before Medicaid can be obtained, the agency can apply for coverage for the session. Clients who are in ongoing treatment and have not received Medicaid coverage should be able to document Medicaid application.

**Non-Retroactive Medicaid Approval**

For clients who do follow through with the Medicaid application but who do not receive retroactive approval, the Board will consider coverage for the period of time that services were provided during the application period. Agencies should take necessary steps to assure that clients understand the application process to assure that services are covered by Medicaid whenever possible.

**Crisis**

Clients who are seen in crisis will be entered for a three day eligibility period. If the client follows up with the agency after the initial crisis contact, regular sliding fee documentation/Medicaid application should be completed retroactive to the crisis date.

**Comments:**

## **Introduction/FAQ'S**

The Montgomery County community supports a human services levy which may assist a person who would not otherwise be able to afford behavioral health services. Assistance may cover the full charge or a percentage of the charge based on your household size and income. We do this through a network of mental health providers commonly referred to as Providers. Someone from the office of the Provider is available to assist you in completing your application for Subsidy Assistance funding. To qualify for assistance you will need to fully complete an application for Subsidy Assistance, here on named Assistance. For the application to be complete, you must provide supporting proof of income documentation or complete a statement that you receive no income at all. Make copies of your proof of income and either attach to or have them accompany the Subsidy Assistance Application.

### **Subsidy Assistance \_ Commonly Asked Questions**

#### **What is meant by household size?**

All persons listed on your most recent IRS tax return. In the case of a minor, it would be the tax return where they would be listed as a dependent. A household to us will match what you describe as your household to the Internal Revenue Service. In cases where the tax return is Married Filing Separate where you have lived apart from your spouse for the last 6 months, we would include only those names listed on the patient's or responsible party's tax return.

#### **How often do I need to apply for the Subsidy Assistance?**

It depends on whether they have or do not have income. If they do not have income(see below) or are not employed they must reapply every six months. If they have SSI income or Medicaid they must reapply every 12 months and in either case they must reapply if there is a change in the number of people or income status in the total household.

#### **What is to be included in income?**

**Wages, salaries, tips, income from odd jobs, taxable interest, pension, annuity or IRA distributions and Social Security, business income, farm income, capital gains, other gains or losses, unemployment compensation, ordinary dividends, alimony received, rental real estate, royalties, partnerships, S corporations, trusts, etc., Taxable refunds, credits and other income.**

#### **If I do not want to divulge financial information, am I still eligible for Subsidy Assistance?**

Patients are not obligated or required to participate in the Subsidy Assistance program and will subsequently be selected as "Self Pay" status and responsible for all charges in total incurred during any office visit for any purpose.

#### **What is considered acceptable forms of receipts?**

Under an allowable exclusion, health care expenses, supportive documentation in the form of is acceptable: 1. bills with previous months payment reflected. 2. receipt(s). 3. copy of checks or money orders. 4. bank statement reflecting an EFT payment for healthcare expenses. For Child & Dependent Care Expenses, documentation in the form of a receipt(s) or statement from caregiver of expenses paid.

#### **I have no income...Am I eligible for Subsidy Assistance?**

If a household is claiming no income for the past six months, then the client or responsible party must provide documentation to show or provide a signed statement attesting to the lack of funds for how the household has been supported for the last six months. In most situations in order to receive subsidized services from the Board the client has to prove they are not eligible for Medicaid.



**I am eligible for Medicaid, am I eligible for Subsidy Assistance?**

The answer is both Yes and No. It depends on the service description. Subsidy will not pay or partially pay for those services covered by Medicaid because ADAMHS Board for Montgomery County is a payer of last resort. Yes, a client is eligible for subsidy for those services not covered by Medicaid or Medicare.

**I am eligible for Medicare, but unable to afford the cost of Medicare, am I eligible for Subsidy Assistance?**

No. Patients eligible for Medicare are not eligible for ADAMHS Board Subsidy Assistance because ADAMHS Board is a payer of last resort. The exception to this is that many services the Board offers are not eligible for Medicare or Medicaid reimbursement. In those cases, for those services the client would be eligible for Subsidy Assistance. If you are having difficulty affording the cost of Medicare, we can refer you to an agency that may be able to help with your individual situation. You may be eligible for a specific Medicaid that picks up the Medicare premiums.

**I have applied for Medicaid or Medicare, but am I eligible for Subsidy Assistance until I am accepted/denied by Medicaid or Medicare?**

Yes. As long as you have application on file and a copy is maintained within your record at the provider's office, you are eligible to receive services under the Subsidy Assistance.

**If I have high deductible Health Insurance, may I apply for Subsidy Assistance?**

Yes, if you have insurance, you are considered uninsured until the deductible is met, which is subject to the sliding fee scale.

**If I have an office visit co-pay Health Insurance, may I apply for Subsidy Assistance?**

Yes, if your insurance requires office visit co-pay, you are considered eligible for the Subsidy Assistance. You'll be instructed to pay your visit co-pay to the ADAMHS Board's Community Mental Health Center. The mental health provider will submit a claim to the insurance company for payment.

The provider will submit a claim to the ADAMHS Board for the agreed upon unit rate less your office visit co-pay, less the portion received from the insurance company. This information is subject to an review by the Board staff.

## Introduction/FAQ'S - continued

### **What if I do not file taxes?**

You will need to provide acceptable documentation that clearly demonstrates that someone is a dependent.

### **What if I am separated from my spouse?**

The Board will adhere to the IRS Guidelines regarding legal separation which states that a separation agreement must be in place or you must have lived apart from your spouse during the last 6 months. If you are legally separated, the sliding fee determination will be based solely on the clients income. If there is no legal separation and you have not lived apart for the last six months, income from both spouses will be used to determine financial liability.

### **Do we have to attach a copy of the Medicaid card or can we simply write in the numbers?**

The more documentation that we have, the better. This will be subject to chart review when ADAMHS does their audit. We may need to consider some type of secure phone/computer application that allows for a picture to be taken and attached to the file.

### **Our SSI clients do not file taxes, how do we complete Tax Filing Status?**

Mark whichever box would be applicable if they were to file.

### **On the Zero Income Declaration Form, what if the client doesn't pay for one or more of these bills?**

Place a zero in all boxes that the client does not pay so ADAMHS is ensured that we asked the question. If this form is not applicable, zeros are not necessary.

### **On the Zero Income Self-Declaration Form, do all household members have to sign off on this?**

No. Although all income has to be included, the client can sign off and validate the income amounts.

### **Do we have to have written receipts/documentation for Catastrophic Life Events and Clinical Needs?**

If the clinician has clear and convincing reason to believe that one of these two scenarios exist, they are to document it in the chart and request an ADAMHS review. ADAMHS staff will promptly review the scenario to ensure that the determination is appropriate. While we are awaiting the review process, the client income will stand as accurate for billing purposes. If it is possible to provide written evidence (ie receipts), then copies attached to the form will be helpful for the review process. For Clinical Needs, please call the Treatment Division and a review of the case will occur. Discretion is permitted to approve less or more than 90 days depending upon the case situation. For Catastrophic Life Events, please call the Claims Department.

### **What do we do if the client does not have a copy of their paystub with them?**

Clients should be required to show a copy of their paystub(s) before the Income Worksheet is completed. If they do not, they will be required to pay 100% of the billable service. Once they show proof, this can be corrected.

### **Regarding "Recertification period?" Isn't this just a way of saying that all clients receiving a subsidy need to have one, since it's the beginning of a new year?**

If you've already recertified the client for the year, then don't do it again. However, once this is put into action, all re-certs should include the new financial and residential forms so that we can document such in an audit.

### **How often are the Financial Forms updated?**

Financials will need to be updated every six (6) months (from date of Financial exception approval ) for Financial Exceptions and Zero Income Declarations.

### **If the responsible party has income above 230%, can payment for behavioral health treatment be allowed to place clients within the sliding fee schedule?**

Yes. Financial exceptions are permitted to determine Adjusted Gross Monthly Income total. Keep in mind, the responsible party must begin payments before the exclusion is considered.

**Introduction/FAQ'S**  
**Supplemental to Eastway**

The Montgomery County community supports a human services levy which may assist a person who would not otherwise be able to afford behavioral health services. Assistance may cover the full charge or a percentage of the charge based on your household size and income. We do this through a network of mental health providers commonly referred to as Providers. Someone from the office of the Provider is available to assist you in completing your application for Subsidy Assistance funding. To qualify for assistance you will need to fully complete an application for Subsidy Assistance, here on named Assistance. For the application to be complete, you must provide supporting proof of income documentation or complete a statement that you receive no income at all. Make copies of your proof of income and either attach to or have them accompany the Subsidy Assistance Application.

Why does Housing need to acquire the Medicaid card when we are not providing billable services? Obviously the case management referral source would already need to be pursuing this facet of documentation, but it has no bearing on the services we provide. Are we now required to obtain a copy of a Medicaid card/insurance card/Medicaid rejection letter prior to reviewing a referral?

No. This is an item that we agree to waive for the HOUSING-only programs.

Based on the previous clarification, we are obligated to terminate non-signers from subsidy assistance. Is that correct?

Yes. If a client refuses to complete the residency and income documentation, they are not eligible for Board subsidy.

So if someone ignores requests for income verification, how long before we withhold paying their rent subsidy, in essence initiating eviction?

If a person seeking housing refused to sign papers upon intake, they are not eligible for a subsidy from the Board. We expect documentation of reasonable efforts by SLS to obtain the income verification annually or at any time there is a suspected or known change of income.

As a practice, SLS staff may begin attempting to obtain updated financial verification as early as needed (to avoid a lapse in the annual documentation) if there is a concern that a client may refuse. A client should be informed immediately upon refusal that failure to sign may result in an eviction. Upon a client's refusal to sign the financial update documents, and after reasonable efforts to convince the client to sign, SLS should contact the Treatment Division to begin the UR process. ADAMHS would need to know if there may be a clinical need that is causing the client to refuse. If there is no clinical determination that could support an extension, SLS staff will be directed by the Treatment Division to begin an eviction.