PM FORM 3.4.1
Non-Title XIX/XXI Co-payment Assessment DRAFT

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Instructions: Complete this form for all Non-Title XIX/XXI persons. Provide a copy to the person, parent or legal guardian.

Name:

I. Person's Family Household Size and Income

A. Size of person's family household (Family consists of: Applicant; parent(s) of a minor child; spouse; natural child, adoptive child and stepchild under 18 years of age or 19 if full time student):

B. Gross monthly family income (includes the gross family income; as family is defined in A.):

C. Third party liability coverage: ☐ Yes ☐ No

II. Sliding Co-payment Schedule

Circle: 1) family household size, 2) gross monthly family income, 3) the co-payment.

Size of Family Household by Gross Monthly Family Income										Co-payment based on type of service provided*			
FPL	1	2	3	4	5	6	7	8	9	**T/M/D**	**R/B**	**C**	**R/I**
<100%	<$903	<$1214	<$1526	<$1838	<$2149	<$2461	<$2772	<$3084	<$3396	$0	$0	$0	$0
100% - 120%	$903 $1110	$1214 $1457	$1526 $1831	$1838 $2206	$2149 $2579	$2461 $2953	$2772 $3328	$3084 $3701	$3396 $4075	$5	$10	$20	$20
120% - 140%	$1111 $1267	$1458 $1700	$1832 $2136	$2207 $2573	$2580 $3009	$2954 $3445	$3329 $3882	$3702 $4318	$4076 $4754	$10	$20	$35	$35
140% - 160%	$1268 $1444	$1701 $1942	$2137 $2442	$2574 $2941	$3010 $3438	$3446 $3938	$3883 $4437	$4319 $4934	$4755 $5434	$15	$30	$50	$50
160% - 180%	$1445 1625	$1943 $2185	$2443 $2747	$2942 $3308	$3439 $3868	$3939 $4430	$4438 $4991	$4935 $5551	$5435 $6113	$20	$40	$65	$65
180% - 200%	$1626 $1805	$2186 $2428	$2748 $3052	$3309 $3678	$3869 $4298	$4431 $4922	$4992 $5546	$5552 $6168	$6114 $6792	$25	$50	$80	$80
>200%	>$1805	>$2428	>$3052	>$3678	>$4298	>$4922	>$5546	>$6168	>$6792	Full**	Full**	Full**	Full**

*T/M/D is Treatment, Medical and Day Program Services, R/B is Room and Board, C is Crisis Intervention Services (stabilization), and R/I is Residential and Inpatient Services.
**Full cost is the fee-for-service rate (see Appendix B-2 of the ADHS/DBHS Covered Behavioral Health Services Guide)

III. Co-payment Assessment for Non-Title XIX/XXI Persons

Based on the person's family household size, gross monthly family income and third party coverage in Part I, use the Sliding Co-payment Schedule in Part II to determine if the person is required to pay a co-payment for behavioral health services that are provided. Indicate below:

☐ Person is not required to pay a co-payment.

☐ Person is obligated to pay a co-payment of $ for T/M/D services, $ for Room and Board, $ for Crisis Intervention Services (stabilization) $ for R/I services, and $ for medication.

☐ Person has third party coverage and is obligated to pay up to $ for T/M/D services $ for Room and Board, $ for Crisis Intervention Services (stabilization), $ for R/I services, and $ for medication, not to exceed the un-reimbursed portion of the service cost.

________________________________ Title: Date: / /
Staff Signature

IV. Agreement to pay co-payment

I am certifying that the information provided in this document is true and correct to the best of my knowledge. If it has been determined that I will need to pay a co-payment for the provision of behavioral health services, my signature below also indicates that 1) the co-payment and the method for calculating my co-payment has been explained to me and 2) I am agreeing to pay the co-payment each time services are provided unless other arrangements have been made with the provider. I understand that I may be refused services or my services may be terminated for nonpayment of co-payments.

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Person/Parent/Legal Guardian Signature Date