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

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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*		
1	2	3	4	5	6	7	8	9	**S/R**	**T/M/D**	**R/I**
<$1040	<$1400	<$1760	<$2120	<$2480	<$2840	<$3200	<$3560	<$3920	$0.	$0.	$0.
$1040-$1214	$1400-$1634	$1760-$2054	$2120-$2474	$2480-$2894	$2840-$3314	$3200-$3734	$3560-$4154	$3920-$4574	$1.	$2.	$15.
$1215-$1387	$1635-$1867	$2055-$2347	$2475-$2827	$2895-$3307	$3315-$3787	$3735-$4267	$4155-$4747	$4575-$5227	$3.	$6.	$30
$1388-$1561	$1868-$2101	$2348-$2641	$2828-$3181	$3308-$3721	$3788-$4261	$4268-$4801	$4748-$5341	$5228-$5881	$4.	$8	$45.
$1562-$1734	$2102-$2334	$2642-$2934	$3182-$3534	$3722-$4134	$4262-$4734	$4802-$5334	$5342-$5934	$5882-$6534	$6.	$10.	$60.
$1735-$1907	$2335-$2567	$2935-$3227	$3535-$3887	$4135-$4547	$4735-$5207	$5335-$5867	$5935-$6527	$6535-$7187	$8.	$12.	$75.
$1908-$2081	$2568-$2801	$3228-$3521	$3888-$4241	$4548-$4961	$5208-$5681	$5868-$6401	$6528-$7121	$7188-$7841	$10.	$20.	$90.
>$2,082	>$2802	>$3522	>$4242	>$4962	>$5682	>$6402	>$7122	>$7842	Full	Full	Full

* S/R is Support and Rehabilitation Services, T/M/D is Treatment, Medical and Day Program Services, R/I is Residential and Inpatient Services. Co-payments for Mental Health Services Not Otherwise Specified (NOS) (Room and Board) may be established independent of the Sliding Co-payment Schedule consistent with Provider Manual Section 3.4, Co-payments.

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 S/R services, $ for T/M/D services and $ for R/I services.

☐ Person has third party coverage and is obligated to pay up to $ for S/R services, $ for T/M/D services and $ for R/I services, not to exceed the un-reimbursed portion of the service cost.

☐ The co-payment will create an undue hardship for the person or his/her family, and thus the following is being recommended (e.g., reduce or waive):

______________________________ 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.

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Person/Parent/Legal Guardian Signature Date

Last Revised: 03/20/2008
Effective: 04/01/2008