APALACHEE CENTER, INC.

SERVICES

INPATIENT FINANCIAL ASSISTANCE

March, 2010
Revised: March, 2021

Policy: 120-7

1. Purpose: It is the purpose of this policy to describe Apalachee Center's process related to charity care for Eastside Psychiatric Hospital patients who are unable to pay for all or a portion of their bill.

2. Policy: It is the policy of Apalachee Center, Inc. (Apalachee) to provide all patients information regarding estimated or actual charges for Eastside Psychiatric Hospital (EPH) services and to assist them in applying for charity care based on financial need.

3. Reference: This program was developed in compliance with Florida Statutes 394.4787 and 395.301

4. Definitions: Charity Care – Free inpatient care provided to an uninsured or underinsured patient whose family income for the 12 months preceding the determination is equal to or below 200% of the current Federal Poverty Guidelines (FPG) established by the U.S. Department of Health and Human Services. Discounted inpatient care is available for uninsured or underinsured patients with family income greater than 200%, but less than or equal to 300% of the FPG.

   Family Income – Includes earnings, unemployment compensation, worker's compensation, Social Security, supplemental social security income, public assistance, veteran's payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (e.g., food stamps, housing subsidies, etc.) do not count. Family income is calculated before taxes.

5. Procedure:

   A. Social Service staff will assist patients to complete the Inpatient Financial Assistance Application (attachment 1) prior to discharge. Insurance Department staff will meet with the patient if requested to provide further information and assistance.

   B. Proof of income is required prior to processing of the application. The patient will be requested to provide, as appropriate, a current W2, last 4 paycheck stubs, disability benefit statement, letter from Social Security Administration, letter from employer, and letter from individuals providing support for the patient's basic living needs. External sources (e.g., Medicaid Enrollment) and / or Apalachee outpatient information may be used if indicated.

C. Patients who do not provide the requested information necessary to completely and accurately assess their financial status in a timely manner and /or who do not cooperate with efforts to secure governmental healthcare coverage information may not be eligible for charity care. Providing false information is also grounds for denial.

D. The completed Financial Assistance Application will be reviewed by the Insurance Department to determine eligibility for free or discounted service using the most recently published Federal Poverty Guidelines.

E. Inpatient discounts will be applied to the EPH per diem, or room and board rate and therapy charges, but do not apply to physician charges. Physician charges provided by Apalachee Center physicians are discounted per the Outpatient Sliding Fee Scale (see Policy 120-3). All physicians that work in the hospital are covered under the financial assistance policies.

F. Patients will be notified of the Insurance Department's determination in writing. A patient may be asked to sign a payment agreement based on the determination.

G. A patient has the right to appeal an eligibility determination if: 1) Incorrect information was provided; or 2) A change in the patient's financial status occurred; or 3) due to extenuating circumstances.

H. The Chief Financial Officer will be responsible for reconsideration of the appeal and determination.

I. If the patient has applied and obtained charity care within the past 12 months and the patient's financial circumstances have not changed, the patient will be deemed eligible for charity care without having to submit a new application.

J. If the patient defaults on a payment agreement, Apalachee will consider the account delinquent and reserves the right to refer the account to a collection agency.

K. The Insurance Department will maintain all applications on file.

APPROVED:

(Signed Original Copy on File)

______________________________ ____/____/____

Jay A. Reeve, Ph.D
Chief Executive Officer

Date

Attachment 1

APALACHEE CENTER, INC.

INPATIENT FINANCIAL ASSISTANCE APPLICATION

(Physician Fees are not covered under this Agreement)

Name of Patient: ______________________ Unit: __________

Name of Guarantor: ______________________ Date of Admission: __________

Address: __________ City/State/Zip: __________ Phone: __________

Applicant's Employer: ______________________ Work Phone: __________

Employer's Address: __________ City/State/Zip: __________

Proof of income verification is required for all members of household in order for application to be processed. Proof of income verification consists of most current W2, last 4 paystubs, disability benefits statement, letter from Social Security Administration, letter from employer, and letter from individuals providing support for patient's basic living needs.

List all members of the household including the patients birthdate, relationship to patient, and income from each source. State whether income is per week, month or year.

Name	Birthdate	Relationship	Income Wk / Mo / Yr

(Note to applicant) You do not have to report income for a person in the household who is not legally responsible for the patient's medical bills and is not counted in the family size. For example: (If you have a brother or sister who lives with you, that person is not responsible for paying your medical bills, and would not have to be counted or report income).

If income of any member is self-employment, you may give information on business costs so that we can determine actual income to be counted. Write details on the back of this sheet.

Income Certification:

I HEREBY ACKNOWLEDGE THAT, IN ACCORDANCE WITH FLORIDA STATUE 817.50, PROVIDING FALSE INFORMATION TO DEFRAUD A HOSPITAL FOR THE PURPOSE OF OBTAINING GOODS AND SERVICES IS A MISDEMEANOR IN THE SECOND DEGREE AND I ATTEST TO THE FACT THAT THE INFORMATION GIVEN ABOVE IS ACCURATE.

______________________ ______________________

Witness Signature Date Patient Signature Date

FOR STAFF USE ONLY

NUMBER IN HOUSEHOLD ______ TOTAL INCOME __________

VERIFICATION OF INCOME SUPPLIED YES ______ NO ______

ELIGIBLE FOR DISCOUNT YES ______ NO ______ APPROVED DISCOUNT PERCENTAGE __________

PREPARED BY ______________________ DATE __________

APPROVED BY ______________________ DATE __________

Attachment 2

APALACHEE CENTER, INC.
Sliding Fee Scale based on 150% of Federal Poverty Guidelines
2020
Effective 7/1/2020

	CO-PAYMENT AMOUNT							
	$ 2.00	$ 5.00	$ 10.00	$ 25.00	$ 35.00	$ 45.00	$ 55.00	Full Fee
Family Size	**Family Income**							
1	19,140	20,140	21,140	25,140	32,140	42,140	55,140	999,999
2	25,860	26,860	27,860	31,860	38,860	48,860	61,860	999,999
3	32,580	33,580	34,580	38,580	45,580	55,580	68,580	999,999
4	39,300	40,300	41,300	45,300	52,300	62,300	75,300	999,999
5	46,020	47,020	48,020	52,020	59,020	69,020	82,020	999,999
6	52,740	53,740	54,740	58,740	65,740	75,740	88,740	999,999
7	59,460	60,460	61,460	65,460	72,460	82,460	95,460	999,999
8	66,180	67,180	68,180	72,180	79,180	89,180	102,180	999,999
9	72,900	73,900	74,900	78,900	85,900	95,900	108,900	999,999
10	79,620	80,620	81,620	85,620	92,620	102,620	115,620	999,999

Instructions: To determine the minimum co-payment for a client, first select the correct row under family size. Next, read across the row to the right until you find the first column with an income figure greater than the client's family income. Now, read the dollar amount at the top of the column. This is the client's co-payment. They will be charged this co-pay or our standard fee, whichever is less, for each service.

Standard Fees

Service	Fee
Therapy 30 minutes	$ 50.00
Therapy 45 minutes	$ 75.00
Therapy 60 minutes	$ 100.00
Preliminary Assessment by non-licensed provider	$ 120.00
Preliminary Assess by licensed provider	$ 175.00
Psychiatric evaluation MD	$ 260.00
Psychiatric evaluation APRN	$ 210.00
Medication Management	$ 80.00
Medication Management Moderate	$ 100.00
Initial hospital low	$ 90.00
Initial hospital med	$ 130.00
Initial hospital high	$ 160.00
Subsequent hospital low	$ 50.00
Subsequent hospital med	$ 70.00
Subsequent hospital high	$ 100.00
Discharge Management	$ 75.00

APALACHEE CENTER, INC.

ADMINISTRATION

OUTPATIENT FEE POLICY

March, 1982
Revised: January, 2021 Policy: 120-3

1. Purpose: It is the purpose of this policy to establish guidelines for assessing fees for services provided by Apalachee Center, Inc. (Apalachee)

2. Policy:

   a. It is Apalachee's policy that services shall not be denied due to inability to pay.

   b. It is Apalachee's policy that all clients shall assume responsibility for payment for services rendered, based upon their ability to pay.

   c. It is Apalachee's policy to inform clients of the value of services, to identify all potential resources for third-party reimbursement and, in the absence of third-party reimbursement, to determine fees based upon the client's ability to pay.

   d. It is Apalachee's policy to make every reasonable effort to collect self-pay amounts; however, no delinquent accounts will be sent to collection agencies.

3. References: Chapter 394.674 Florida Statutes
   Chapter 65E-14 Florida Administrative Rule

4. Procedure:

   a. Upon determination that there is no third-party payer source, the client's ability to pay will be determined by gross income and family size.

   b. Gross income will be determined by an acceptable form of proof of income as outlined in Apalachee's Standard Operating Procedures Manual.

   c. Based upon gross income (as determined above) and family size, the fee discount will be determined using Apalachee's Fee Discount Schedule (Fee Assessment Procedure SOP FM 1.25.

   d. Fees may be further discounted upon an administrative staffing conducted by the appropriate Program Supervisor.

appropriate Program Supervisor.

e. Uncollectable accounts will be written off to bad debt with CFO approval.

APPROVED:

(Signed Original Copy on File)

__________________________________ ____/____/____

Jay A. Reeve, Ph.D. Date
Chief Executive Officer

APALACHEE CENTER, INC.
Sliding Fee Scale based on 150% of Federal Poverty Guidelines
2020
Effective 7/1/2020

	CO-PAYMENT AMOUNT							
	$ 2.00	$ 5.00	$ 10.00	$ 25.00	$ 35.00	$ 45.00	$ 55.00	Full Fee
Family Size	**Family Income**							
1	19,140	20,140	21,140	25,140	32,140	42,140	55,140	999,999
2	25,860	26,860	27,860	31,860	38,860	48,860	61,860	999,999
3	32,580	33,580	34,580	38,580	45,580	55,580	68,580	999,999
4	39,300	40,300	41,300	45,300	52,300	62,300	75,300	999,999
5	46,020	47,020	48,020	52,020	59,020	69,020	82,020	999,999
6	52,740	53,740	54,740	58,740	65,740	75,740	88,740	999,999
7	59,460	60,460	61,460	65,460	72,460	82,460	95,460	999,999
8	66,180	67,180	68,180	72,180	79,180	89,180	102,180	999,999
9	72,900	73,900	74,900	78,900	85,900	95,900	108,900	999,999
10	79,620	80,620	81,620	85,620	92,620	102,620	115,620	999,999

Instructions: To determine the minimum co-payment for a client, first select the correct row under family size. Next, read across the row to the right until you find the first column with an income figure greater than the client's family income. Now, read the dollar amount at the top of the column. This is the client's co-payment. They will be charged this co-pay or our standard fee, whichever is less, for each service.

Standard Fees

Service	Fee
Therapy 30 minutes	$ 50.00
Therapy 45 minutes	$ 75.00
Therapy 60 minutes	$ 100.00
Preliminary Assessment by non-licensed provider	$ 120.00
Preliminary Assess by licensed provider	$ 175.00
Psychiatric evaluation MD	$ 260.00
Psychiatric evaluation APRN	$ 210.00
Medication Management	$ 80.00
Medication Management Moderate	$ 100.00
Initial hospital low	$ 90.00
Initial hospital med	$ 130.00
Initial hospital high	$ 160.00
Subsequent hospital low	$ 50.00
Subsequent hospital med	$ 70.00
Subsequent hospital high	$ 100.00
Discharge Management	$ 75.00