MENTAL HEALTH SERVICES FOR CLARK AND MADISON COUNTIES

POLICY AND PROCEDURE

POLICY: Inpatient Reimbursement POLICY NO. MHS-F-06

POLICY MANUAL: Finance REVIEWED: 2018 (YR)

CHAMPION: _____ COMMITTEE APPROVED: SMG

POLICY:

All clinical programs and facilities of Mental Health Services for Clark and Madison Counties, Inc. will be made available without discrimination on account of race, religion, color, sex, national origin, age, ancestry, handicap, or inability to pay.

The following procedures shall be followed to ensure provision of services that can both meet the patient's needs and avoid unnecessary financial burden to the patient.

PROCEDURE:

1. The Inpatient Biller will discuss payment arrangements with patients and families with limited coverage or self-pay accounts for the charity programs available. Clark and Madison County patients without insurance coverage will be considered a Board patient in which MHRB funds will pay for Inpatient Care.

2. The Health Care Assistance Program is available for open balances for patients with up to 250% of federal poverty guidelines for free care and 400% for discounted care. An HCAP application needs completed and if the patient qualifies, the balance will be adjusted accordingly.

3. Patients who provide information that they have medical expenses over $5,000 will be eligible for a 30% discount on their account.

4. Patients who are out of county and have no insurance are eligible for a 30% discount on their account.

5. Patient financial file shall be maintained for all inpatient admissions.

MHS/AC _____
MHS/YC _____

Mental Health Services For Clark County

Healthcare Financial Assistance Application

Account Number _____

Date of Service _____ Date of Application _____

Patient Name _____ Date of Birth _____

Spouse or Guarantor _____ Date of Birth _____

Address _____ City, State _____

Zip Code _____ Phone (Home) _____ (Work) _____

Expenses

Mortgage/Rent $ _____

Utilities:

- Gas $ _____
- Electric $ _____
- Water $ _____
- Telephone $ _____
- Cable $ _____

Insurance:

- Health $ _____
- Life $ _____
- Auto $ _____

Automobile Loan (s) $ _____

Groceries/Food $ _____

Other (list below)

_____ $ _____

_____ $ _____

Total $ _____

Income (**Please attach income verification**)

Gross Wages (Patient)$ _____

Gross Wages for Spouse or Guarantor $ _____

Other $ _____

Number In Household _____

Unemployment $ _____

Workman's Comp. $ _____

Child Support $ _____

Disability $ _____

Social Security $ _____

Other (list below)

_____ $ _____

_____ $ _____

_____ $ _____

Total $ _____

I attest that the above information is complete and accurate as shown.

X _____ _____

Patient / Guarantor Date

Total Hospital Bill $ _____

Approved / HCAP _____