

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.

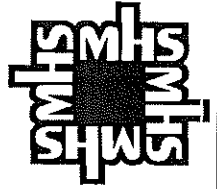
The following procedures shall be followed to ensure provision of services that can both meet the patient's needs and avoid unnecessary financial burden to the patient.

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

Income (\*\*Please attach income verification\*\*)

Mortgage/Rent \$ \_\_\_\_\_  
Utilities:  
    Gas \$ \_\_\_\_\_  
    Electric \$ \_\_\_\_\_  
    Water \$ \_\_\_\_\_  
    Telephone \$ \_\_\_\_\_  
    Cable \$ \_\_\_\_\_  
Insurance:  
    Health \$ \_\_\_\_\_  
    Life \$ \_\_\_\_\_  
    Auto \$ \_\_\_\_\_  
Automobile Loan (s) \$ \_\_\_\_\_  
Groceries/Food \$ \_\_\_\_\_  
Other (list below)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Total \$ \_\_\_\_\_

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 \_\_\_\_\_