

**Delaware Health and Social Services
Division of Mental Retardation
Dover, Delaware**

Title: Individual Ability to Pay

Approved By: *Marianne Smith*
Division Director

Written/Revised By: DMR Policy Committee

Date of Origin: January 1988

Date of Current Review/Revision: February 2000

I. Purpose

To ensure adherence to DHSS Policy Memorandum Number 37, pursuant to 29 Del. C §7940.

II. Policy

The Division of Mental Retardation (DMR) shall make a concerted effort to assure that individuals receiving services/legally liable individual(s) are informed of and understand their fiscal liability.

III. Application

Stockley Center/Accounting Department
Director's Office/Special Services Unit

IV. Exclusions

This policy is not applicable to persons support by Medicaid, Medicare, Champus, or private insurance with the exception of deductible, co-insurance and charges for not-covered services of those payors who have contracts with DMR. (DHSS Policy Memorandum #37)

V. Definitions

See DHSS Policy Memorandum #37 (Exhibit A)

VI. Standards

A. Parent or legal guardian shall be responsible for Cost of Care and Treatment for a child under the age of 18 years. (29 Del. C. §7940)

OR

No person other than the individual receiving services shall be responsible for the full cost of care and treatment, if the individual receiving services has attained the age of 18 years and resided in an ICF/MR Facility or approved community based program under the supervision of the Division for a period of five years (29 Del. D. §7940)

B. The ability of each individual receiving service/legally liable individual(s) ability to pay the cost of care and treatment shall be assessed by the appropriate Department Representative, prior to or on the date of admission for residential services as governed by 29 Del. C. §7940 and DHSS Policy #37 (revised 3-19-96).

- C. The individual receiving services and/or legally liable person/agency shall be informed in writing of his/her financial obligation for care and treatment and the right to appeal.
- D. All appeals shall be in writing from the legally liable person to the Director of Special Services; or for Stockley Center individuals receiving services, to the Director of Social Services; who shall forward the appeal to the Division Director.
- E. The Division Director shall implement the DMR policies, Individual Rights and/or appeal of DMR Decisions.
- F. If the rate for care and treatment is aggrieved, under extraordinary circumstances, the Division Director shall have the authority to make administrative adjustments to the established care and treatment fee in lieu of submission to the DMR Appeal Committee or to the DHSS Review Panel.
- G. The individual receiving services/legally liable individual/agency after exhausting the DMR appeal process may initiate the DHSS Appeal process per Policy Memorandum #37.

VII. Procedures

<u>Responsibility</u>	<u>Action</u>
Community Services Case Manager Stockley Center Case Manager	1. Notifies Special Service/Social Services in writing, of the individual's date of admission and program placement.
Director Special Services Director Social Services	2. Contacts individuals receiving services/legally liable person/ agency to assess financial resources and ability to pay, either prior to or on the day of admission. 3. Individual receiving services is determined eligible for Medicaid or other third party benefits no further activity is required to establish financial liability. Or Informs individual receiving services/legally liable person/agency of care and treatment rate, established rules/regulations governing method of payment, and appeal rights.
If Care and Treatment decision is appealed: Director Special Services Director Social Services	4. Forwards written request of reconsideration /appeal with pertinent information related to the case to the Division Director.
Division Director	5. Reviews information and may make an administrative adjustment decision if appeal is related to extraordinary expenses (i.e. medical), follows DMR Policy regarding appeals.

VIII. References

29 Del. C. §7940 – Financial Liability of Persons Served by the Department.

Department of Health and Social Services Policy Memorandum #37 (revised 3/19/96). Standard Ability to Pay Fee Schedule.

VIII. Exhibits

A. Financial Responsibility Agreement

B. Department of Health and Social Services Memorandum #37 (revised 3/19/96) 29 Del. C. §7940

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF MENTAL RETARDATION

Financial Responsibility Agreement

The signature below confirms that I/we have been fully advised of my/our financial responsibility for the cost of services provided by the State of Delaware, Department of Health and Social Services, Division of Mental Retardation, as established by 29 Del. C. §7940.

- 1) Before admission: I will fully disclose all information with regard to my financial status and will turn over said assets to the State of Delaware, Division of Mental Retardation, as payment for services provided. I further agree that any insurance benefits for which I am eligible or will accrue because of my admission will be applied toward the cost of my care.
- 2) After admission: Any income or assets which I now have or may acquire in the future, including Social Security, Supplemental Security Income (SSI), other pensions, proceeds from property settlements, inheritances, any health insurance benefits; or other related income will be turned over to the Division of Mental Retardation to be applied toward the cost of care.
- 3) Should I become certified for Medicaid my financial resources will be used in accordance with Medicaid Regulations.
- 4) I understand that the Division will oversee my financial affairs for me and that I will be given the balance in my account upon request:

and

At the time of my discharge or death, if my assets held by the Division are greater than my accumulated bill/obligation, the balance will be refunded to me or my estate.

_____	_____	_____
Signature of Individual	SS #	Date

_____	_____
Signature of Parent (if individual is a minor) or Substitute Decision-maker/Legal Guardian	Date

_____	_____
Witness	Date

STATE OF DELAWARE
DELAWARE HEALTH AND SOCIAL SERVICES

POLICY MEMORANDUM NUMBER 37

February 1, 2008

SUBJECT: STANDARD ABILITY TO PAY FEE SCHEDULE (replaces February 1, 2007)

I. PURPOSE

To establish a uniform ability to pay schedule and to supplement existing collection policy or agreements to standardize Departmental collection efforts for recovery of accounts receivable that amount to less than the full cost of care due, in accordance with Delaware Code, Title 29, Section 7940.

II. DEFINITIONS

1. The "Cost of Services Rendered" in this policy shall mean the "Cost of Care" as used in Delaware Code, Title 29, Section 7940 and DHSS Policy Memorandum Number 12.
2. Disposable income for determination of ability to pay shall be gross income less a standard deduction and taxes paid.
3. Standard deduction shall be based on 100% of the poverty level.

III. EXCLUSIONS

This Policy Memorandum is not applicable to persons supported by Medicaid, Medicare, CHAMPUS, or private insurance with the exception of deductibles, coinsurance and charges for non-covered services of those payers who have contracts with DHSS facilities.

IV. FOREWORD

1. Respective Divisions shall continue to pursue recovery of the full cost of services rendered in accordance with the Department of Health and Social Services Policy Memorandum Number 12, as applicable.
2. Facilities should make every effort to assure that clients and legally liable persons are aware of and understand their fiscal liability, their right to request an adjustment to that liability, and the procedures to appeal the ability to pay determination.
3. Division Directors will develop procedures under the guidelines in Section VI for implementation of this policy within their respective Divisions.

V. PROCEDURES

A. INPATIENT SERVICES

The facility administration shall request, preferably before or, in case of emergency, after the patient is admitted or treated, a written agreement with those persons receiving or to receive care and/or treatment from the facility and, where appropriate, of the liable person(s) for the recovery of the full cost of care. (Appendix A) Liability of persons other than the patient shall be governed by the provisions of 29 Del. C. 7940 (a). The following procedures shall be implemented when a written agreement for the recovery of the full cost of services rendered cannot be obtained.

1. DHSS Ability to Pay Worksheet (Appendix B) should be completed for the person receiving care and for any other person liable under 29 Del. Code, 7940 (a), to determine disposable income and the minimum annual fee due based on the ability to pay. (Instructions on completion of the worksheet are printed on the reverse side of the form.)
2. The liability will automatically be waived for anyone with disposable income less than \$6,000.
3. The liable person shall be informed, in writing, of his/her liability, due dates of payment, and appeal procedures. (Appendix C).
4. All other payment agreements, in force prior to implementation of this Ability to Pay Fee Schedule, shall be gradually phased-out, for conformance, at the time of automatic review, which is at least every two (2) years. (Delaware Code, Title 29, Section 7940, Paragraph (d)).

B. COMMUNITY-BASED & OUTPATIENT SERVICES

The Divisions shall determine the ability to pay of their clients for community-based and outpatient services and shall maintain a record of this information, which will be available at all service locations. The ability to pay will be determined, utilizing a sliding scale. The scale will be set using a range from 200% to 275% of the poverty level, with anyone whose gross income is at 200% or less of the poverty level, receiving the services free of charge. The percentage of charges to be paid will increase 20% for each 15% of the poverty level, the gross income increases with anyone whose gross income is above 260% of the poverty level paying 100% of the charge. The ability to pay sliding scale will be applied to the fees which are developed and implemented by the individual divisions of DHSS for each of the services they provide. The attached Table A shows the actual income levels to be used for family levels from 1 to 10.

TABLE A

Family Size % Poverty	Poverty Level	Annual Income Up To 200%	Annual Income Up To 215%	Annual Income Up To 230%	Annual Income Up To 245%	Annual Income Up To 260%	Annual Income Over 260%
1	\$10,400	\$20,800	\$22,360	\$23,920	\$25,480	\$27,040	\$27,040
2	14,000	28,000	30,100	32,200	34,300	36,400	36,400
3	17,600	35,200	37,840	40,480	43,120	45,760	45,760
4	21,200	42,400	45,580	48,760	51,940	55,120	55,120
5	24,800	49,600	53,320	57,040	60,760	64,480	64,480
6	28,400	56,800	61,060	65,320	69,580	73,840	73,840
7	32,000	64,000	68,800	73,600	78,400	83,200	83,200
8	35,600	71,200	76,540	81,880	87,220	92,560	92,560
9	39,200	78,400	84,280	90,160	96,040	101,920	101,920
10	42,800	85,600	92,020	98,440	104,860	111,280	111,280
% of Charge To Be Paid		-0-	20%	40%	60%	80%	100%

Note: Federal guidelines related to specific programs take precedent over this policy.

I. ADMINISTRATIVE DETERMINATION

Division Directors are authorized to make administrative adjustments to the monthly fee calculated by the facility in lieu of submission to the Appeals Committee, if circumstances justify such adjustments. Administrative adjustment should be made only where the individual(s) have extraordinary expenses over which they have no control (i.e., medical bills, etc.). The procedures for administrative determination shall be as follows:

1. Division Directors should establish a Review Panel, consisting of three members: the Division Director or Deputy Director, an Institutional Representative and a Community-Based Representative.
2. Upon receipt of a written request appealing the ability to pay determination, the facility administration shall notify the individual that the appeal has been received and will forward the appeal request to the Division Director's office within five (5) working days for administrative review.
3. The Review Panel will meet no less than once a month to review the appeals received and make their determination.
4. The Review Panel shall notify the facility and the individual who is making the appeal concerning their determination within five (5) working days of the review.
5. If the Review Panel concurs with the original determination, the appeal will be forwarded to the Appeals Committee for final review.

VII. APPEALS

After implementation of Ability to Pay Fee Schedule, any person aggrieved by any decision with respect to the payment of fees, refusal of admission or discharge for other than medical reasons, may appeal by petition to the Appeals Committee in writing, stating the substance of the decision appealed, the facts in support of the appeal and the relief sought.

The Appeals Committee consist of the Chairpersons of the:

- o Advisory Council on Developmental Disabilities Services;
- o Advisory Council on Substance Abuse and Mental Health;
- o Advisory Council for Delaware Hospital f/t Chronically Ill;
- o Public (Physical) Health Advisory Council.

1. The Appeals Committee shall hold a hearing within sixty (60) days and shall render its decision promptly. The Committee's decision shall be final and binding.
2. The Secretary's Office will receive the appeal information, schedule the hearing and notify the Appeals Committee and the individual appealing of the date and location of the hearing.
3. The appeals hearings will be chaired on a rotating basis with each member of the committee serving as chairperson for a period of three (3) months.

Note: Appeals Committee - Delaware Code, Title 29, Section 7940, Paragraph (m).

VIII. COLLECTION

Collection efforts and write-off procedures shall be in conformance with DHSS Policy Memorandum Number 19.

IX. ADMINISTRATION

An Ability to Pay Committee shall be available to help resolve implementation/interpretation problems. It will set up such rules and regulations as are deemed necessary, pursuant to the authority granted by 29 Del. C. 7940 (j).

1. A permanent committee shall be assigned to monitor and administer the Ability to Pay Fee Schedule.
2. The Ability to Pay Committee shall consist of:
 - (a) Two representatives each from the Divisions of Substance Abuse and Mental Health; Developmental Disabilities Services; and Public Health;
 - (b) One representative from the Division of Management Services, who shall serve as Chairman.

X. EFFECT

1. This policy shall become effective on February 1, 2008.
2. Any part thereof which is inconsistent with any Federal, State or local law shall be null and void.

Vincent P. Meconi

Vincent P. Meconi

Secretary

Department of Health & Social Services

APPENDIX A
LETTERHEAD

Patient Name _____

Date: _____

Dear _____,

This is to advise you that the charge for services rendered at (facility) is \$_____ per day. The patient and/or any persons legally liable under Title 29, Section 7940 of the Delaware Code will be billed for these services.

Please complete and return this form
to _____ by _____
Financial Services Rep. (Date)

Check if Applicable:

___ 1. I have the following insurance coverage, which should be billed:

- Blue Cross
- Medicare
- Other Insurance
- Medicaid

Group # _____ Policy # _____
Name of Person Insured _____

___ 2. I will make full payment as billed.

___ 3. I am unable to pay the full amount.

Date _____ Signature _____

If #3 is checked, please submit the following information for our review to determine an appropriate payment based on your ability to pay.

1. A copy of your most recent Federal and State Income Tax returns.
2. A copy of all W-2 Forms submitted with your tax returns.
3. Other documents which show your current income.

You will be notified in writing of our determination. We will be unable to make any adjustments to the amount, which you are required to pay if the information is not submitted.

Thank you for your cooperation.

Sincerely,

APPENDIX B

PATIENT NAME:

DATE:

ADDRESS:

GUARANTOR NAME:

ADMISSION DATE:

ADDRESS:

INSURANCE COVERAGE:

PREPARED BY: _____

APPROVED BY: _____

1. GROSS INCOME

\$ _____

LESS:

2. STANDARD DEDUCTION _____

3. TAXES WITHHELD

FICA _____

FEDERAL INCOME _____

STATE INCOME _____

CITY WAGE _____

4. TAX (REFUNDS)/PAYMENTS _____

5. TOTAL DEDUCTIONS (SUM OF LINES 2-4)

\$ _____

6. DISPOSABLE INCOME (LINE 1 LESS LINE 5)

\$ _____

7. MINIMUM ANNUAL FEE DUE BASED ON ABILITY
TO PAY. (10% OF LINE 6)

\$ _____

8. MONTHLY PAYMENT. (LINE 7 DIVIDED BY 12)

\$ _____

DHSS
ABILITY TO PAY WORKSHEET
INSTRUCTIONS

LINE 1. Gross income is obtained from a copy of the Tax Return, if one was filed, or from a copy of other payment sources (if non-taxable, such as Welfare payments, Pension payments, or other income).

LINE 2. Standard Deduction is shown below, (for families with more than 8 persons, add \$3,600 for each additional person).

Household Size	Amount	Household Size	Amount
1	\$10,400	6	28,400
2	14,000	7	32,000
3	17,600	8	35,600
4	21,200	9	39,200
5	24,800	10	42,800

LINE 3: Taxes withheld are obtained from a copy of W-2 forms.

LINE 4: Amount of tax refunds or payments are from Federal and State tax returns.

LINE 5: Total deductions equal the sum of Lines 2 through 4.

LINE 6: Disposable income is Gross income (Line 1) less total deductions (Line 5).

LINE 7: Minimum annual fee is 10% of disposable income (Line 6 X .1). (The minimum annual fee will be automatically waived if disposable income is less than \$6,000.)

LINE 8: Monthly payment = Annual payment (Line 7) divided by 12.

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APPENDIX C
LETTERHEAD

NAME:

DATE:

ADDRESS:

PATIENT NAME:

DEAR _____:

We have reviewed the information which you supplied and have calculated your minimum monthly payment according to Delaware Law 29 Del. C. 7940 and Department of Health and Social Services Policy Memorandum Number 37. You are responsible for a monthly payment of \$_____ for the services rendered to the above named patient. A copy of our calculation has been enclosed for your benefit. Payments are due by the 20th of the month for the previous month's care.

You have the right to appeal the determination, in writing, to the Appeals Committee stating the substance of the decision being appealed, the facts in support of the appeal, and the relief sought.

Appeals should be submitted to:

Appeals Committee Administrator

_____(Facility Name)

_____(Facility Address)

Thank you for your cooperation in this matter.

Sincerely,