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**
<$957	<$1,283	<$1,609	<$1,935	<$2,261	<$2,587	<$2,913	<$3,239	<$3,565	$0.	$0.	$0.
$957-$1,339	$1,283-$1,795	$1,609-$2,252	$1,935-$2,708	$2,261-$3,164	$2,587-$3,621	$2,913-$4,077	$3,239-$4,534	$3,565-$4,990	$1.	$2.	$15.
$1,340-$1,530	$1,796-$2,052	$2,253-$2,573	$2,709-$3,095	$3,165-$3,617	$3,622-$4,138	$4,078-$4,660	$4,535-$5,181	$4,991-$5,703	$3.	$6.	$30
$1,531-$1,722	$2,053-$2,308	$2,574-$2,895	$3,096-$3,482	$3,618-$4,069	$4,139-$4,656	$4,661-$5,242	$5,182-$5,829	$5,704-$6,416	$4.	$8	$45.
$1,723-$1,913	$2,309-$2,565	$2,896-$3,217	$3,483-$3,869	$4,070-$4,521	$4,657-$5,173	$5,243-$5,825	$5,830-$6,477	$6,417-$7,129	$6.	$10.	$60.
$1,914-$2,104	$2,566-$2,822	$3,218-$3,539	$3,870-$4,256	$4,522-$4,973	$5,174-$5,690	$5,826-$6,408	$6,478-$7,125	$7,130-$7,842	$8.	$12.	$75.
$2,105-$2,296	$2,823-$3,078	$3,540-$3,861	$4,257-$4,643	$4,974-$5,425	$5,691-$6,208	$6,409-$6,990	$7,126-$7,773	$7,843-$8,555	$10.	$20.	$90.
>$2,297	>$3,079	>$3,862	>$4,644	>$5,426	>$6,209	>$6,991	>$7,774	>$8,556	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.

_____

Person/Parent/Legal Guardian Signature Date

Last Revised: 4/14/2005
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