

POLICIES AND PROCEDURE MANUAL

Chapter:	Finance		
Title:	Substance Use Disorder – Income Eligibility and Fee Determination		
Policy: <input type="checkbox"/> Procedure: <input checked="" type="checkbox"/> Page: 1 of 3	Review Cycle: Annually Author: SUD Workgroup	Adopted Date: 10.01.2015 Review Date: 05.13.2025 Revision Eff. Date: 02.01.2025	Related Policies: Financial Management SUD Income Eligibility and Fee Determination

DO NOT WRITE IN SHADED AREA ABOVE

Purpose

MSHN is required to maintain a clear and consistent process for income eligibility and fee determination. This procedure assures that regional substance use disorder treatment providers administer income eligibility and fee determination using a consistent format and criteria.

Procedure:

MID-STATE HEALTH NETWORK INCOME ELIGIBILITY FOR BLOCK GRANT for CALENDAR YEAR 2025

Income Eligibility based on 200% of the Federal Poverty Level Guidelines

Family Size	200% FPL
1	\$ 31,300
2	\$ 42,300
3	\$ 53,300
4	\$ 64,300
5	\$ 75,300
6	\$ 86,300
7	\$ 97,300
8	\$108,300
Each Add	\$ 11,000

Service Description and Code	Copay Amount
Individual Therapy (90832)	\$5.00 per session
Individual Therapy (90834)	\$7.50 per session
Individual Therapy (90837)	\$10.00 per session
Family Therapy (90846, 90847)	\$10.00 per session
Group Therapy (90853)	\$5.00 per session
Evaluation and Management (99202 - 99205, 99212 - 99215)	\$5.00 per session
Individual Counseling (H0004)	\$2.50 per 15-minutes
Group Counseling (H0005)	\$5.00 per session
Withdrawal Management (H0010, H0012)	\$10.00 per day
Residential Treatment (H0018, H0019)	\$5.00 per day
Individual Peer Recovery Support Services (H0038)	\$2.00 per 15-minutes
Individual Peer Recovery Support Services (T1012)	\$4.00 per session

INCOME VERIFICATION AND FEE AGREEMENT

Consumer Name: _____

Family Size:

Consumer _____ 1

Number of people living with and/or supported
by the consumer: _____

Total Family Size _____

Annual Income:

Gross Salaries, Wages \$ _____

Other Income:

Alimony \$ _____

Child Support \$ _____

Social Security \$ _____

Unemployment \$ _____

Workers Compensation \$ _____

Other (Describe):
_____ \$ _____

Total Income \$ _____

+++++

I hereby certify that the information shown above is a true and correct statement. Based upon this information it has been determined that I will be responsible for a fee of \$ _____ per session/day.

REASON FOR NO INCOME _____

Consumer Signature

Date

Witnessed by

Date

(Note: If the fee is reduced or waived, the Program Director, or designee, must be the witness signature.)

Applies to

- ☒ All Mid-State Health Network Staff
☐ Selected MSHN Staff, as follows:
☐ MSHN Affiliates: ☐ Policy Only ☐ Policy and Procedure
☒ Other: Sub-contract Providers

Definitions**Other Related Materials****References/Legal Authority**

Federal Poverty Guidelines - <https://aspe.hhs.gov/poverty-guidelines>

Change Log:

<u>Date of Change</u>	<u>Description of Change</u>	<u>Responsible Party</u>
10.01.2015	New Procedure	SUD Workgroup
11.13.2015	Changed co-pay for withdrawal management to \$10 per day regardless of number of times in treatment to coincide with policy approved 11.2015 board meeting	Finance Manager
11.13.2015	Detailed Individual Copay for 30 min., 45 min. and 60 min. increments	Finance Manager
11.01.2016	Updated Federal Poverty Levels	Finance Manager
03.20.2017	Annual Review	Chief Financial Officer
11.01.2017	Updated Federal Poverty Levels	Finance Manager
03.20.2018	Annual Review	Chief Financial Officer
11.01.2018	Updated Federal Poverty Levels	Finance Manager
11.01.2019	Updated Federal Poverty Levels	Finance Manager
10.01.2020	Updated Federal Poverty Levels	Finance Manager
01.01.2021	Updated Copay Amounts	Finance Manager
10.01.2021	Updated Federal Poverty Levels	Finance Manager
03.01.2022	Updated Federal Poverty Levels	Finance Manager
02.01.2023	Updated Federal Poverty Levels	Finance Manager
02.01.2024	Updated Federal Poverty Levels	Finance Manager
02.01.2025	Updated Federal Poverty Levels	Finance Manager