



**Subsidy Assistance Frequently Asked Questions Regarding Form 100**

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Q1. <6.25.14 **What is meant by household size?**

All persons listed on your most recent or next IRS tax return. In the case of a minor, it would be the tax return where they would be listed as a dependent. A household to us will match what you describe as your household to the Internal Revenue Services. In the cases where the tax return is Married filing separate, we would include only those names listed on the patient or responsible party's tax return.

Q2. <6.25.14 **How often do I need to apply for the Subsidy Assistance?**

It depends on whether you have or do not have income. If you do not have income you must reapply every six months. If you have income you must apply every 12 months and in either case you must reapply if there is a change in the number of people or income status in the total household.

Q3. <6.25.14 **If I do not want to divulge financial information, am I still eligible for Subsidy Assistance?**

Clients are not obligated or required to participate in the Subsidy Assistance program and will subsequently be selected as "Self Pay" status and responsible for all charges in total incurred during any visit to this office for any purpose.

Q4. **What is to be included in income?**

Wages, salaries, tips, income from odd jobs, taxable interest, pension, annuity or IRA distributions and Social Security, Business income, farm income, capital gain, other gain or loss, Unemployment compensation, Ordinary dividends, Alimony received, Rental real estate, royalties, partnerships, S Corporations, trusts, etc., Taxable refunds, credits and Other income.

Q5. <6.25.14 **I have no income...Am I eligible for Subsidy Assistance?**

Yes. If a household is claiming no income, no financial resources for the past three months, then the client or responsible party must complete Form 100-2.

Q6. <6.25.14 **I am eligible for Medicaid, am I also eligible for Subsidy Assistance?**

The answer is both Yes and No. It depends on the service description. Subsidy will not pay or partially pay for those services covered by Medicaid because Butler County Mental Health Board is a payer of last resort. Yes, a client is eligible for subsidy for those services not covered by Medicaid.

Q7. <6.25.14 **I have applied for Medicaid, but am I eligible for Subsidy Assistance until I am accepted/denied by Medicaid?**

Yes. As long as you have application on file and a copy is maintained within your record at the provider's office, you are eligible to receive services under the Subsidy Assistance.

Q8. <6.25.14 **I have Medicaid with a spend down; may I apply for Subsidy Assistance?**

Yes, if you have a spend down with Medicaid, we consider you to be uninsured until the spend down is met. Once the spend down is met, the Subsidy Assistance will become mostly inactive and most services for the client will be billed to Medicaid with the exception of Non Reimbursable Services. This agency will not send any part of the claims under the Subsidy Assistance to Medicaid to be applied toward their spend-down. You may obtain a receipt for the amount paid to this agency and submit that to Medicaid.

Q9. <6.25.14 **I have health insurance, may I apply for Subsidy Assistance?**

Yes.

Q10. <6.25.14 **If I have high deductible Health Insurance, may I apply for Subsidy Assistance?**

Yes, the professional will submit an insurance claim to your insurance company. See Q11, 12

Q11. <6.25.14 **In the case where a client presents to a professional where the insurance company considers the professional an in-network provider, may I apply for Subsidy Assistance?**

Or, If I have an office visit co-pay health insurance, may I apply for Subsidy Assistance?

Yes, if the professional is considered in-network with the insurance company you are considered eligible for the Subsidy Assistance. You'll be instructed to pay your visit co-pay as stated on your insurance card to the staff of the contract provider. The mental health provider will submit a claim to your insurance company for payment.

The unpaid balance can be submitted to the Mental Health Board for the balance up to the Mental Health Board's approved rate. The client or financial party will be required to complete Form 100.

Q12. <6.25.14 **In the case where a client presents to professional where the insurance company does not consider the professional an in-network provider, may I apply for Subsidy Assistance? Commonly known as "Out of Network" professional. The professional is not in my insurance network, will I be eligible for Subsidy Assistance?**

Yes. If the (Mental Health Board's) contract provider mental health professional is not in the insurance network associated with your health insurance then you will be instructed by the professional/provider to assign payments over to them. They will then do two things: submit your insurance claim to your insurance company for you and help you complete Form 100. When your explanation of benefits arrives back to the provider it will reveal one of three things: 1.) whether or not the service was covered, 2.) a payment for the service 3.)

record of an amount counted toward your insurance company deductible. In either case you would pay your sliding fee portion toward any balance up to the Mental Health Board's approved charges. Completion of Form 100 is necessary to determine your (the client) sliding fee portion. The remaining balance would then be submitted by the professional to the Mental Health Board for payment up to the Board's approved rate. Disregard the amount stated on the client's card as an office visit charge.

Q13. <6.25.14 **What if I do not file taxes?**

In the additional comments section, note that the client does not file a tax return and then also explain how the household size was determined.

Q14. <6.25.14 **Is there an exception to the Social Security Number requirement?**

Yes. For all services the SS# is requested but we realize it might not be possible in all Crisis Intervention situations.

Yes. For all other services we allow 30 days in which to obtain a valid Social Security number. If more time is needed after 30 days, the agency MUST contact the Board before the end of the 30 days to obtain an extension. Typically, evidence must be provided that you (client) are seeking a SS# through appropriate agencies in the form of a letter, etc. from them.

Q15. <6.25.14 **If the client has in-network insurance coverage, why does the Board still require a completed Form 100?**

The mental health board tracks household incomes of those it serves for reporting annual data (BCMHB Annual Reports) to constituents.

Q16. <7.23.14 **If the child is in custody of Children's Services is a form 100 required?**

No. The child would have Medicaid. Form 100 is only required when the provider intends to bill the BCMHB for services.

Upon the change in custody of the child, for example the custody is returning to the parents, a form 100 would be completed at that time.

Q.17 <7.24.14> **If a client who pays for their spend down out of pocket at the beginning of every month directly to JFS and it is over 10% of monthly income, would this count as a medical/dental expense?**  
Yes. Refer to Form 100-3 Exclusions Worksheet.

Q. 18 <2.3.15> **A client failed to bring necessary FORM 100 verification papers - will the Board accept the GOSH claim for that days services?**  
Yes. The Board will extend the time required to obtain the necessary verification such as paystub, Social Security etc verifications of income for 90 days from the first date of service for a newly opened case - or for a returning client where it has been more than a year since the client was served by the specific agency.  
The agency is to complete FORM 100 and make a notation near where the staff member signs which explains the plan put in place to obtain the verifications. This has not been extended for anniversary date renewals of FORM 100.

Q. 19 <7/22/2016> Q. Client presents with insurance and it seems that there is a contradiction between the contract (section 10.2) and the Form 100 process – could you please clarify?  
Answer:  
1. All clients seeking Board subsidy are to complete Form 100  
The understanding is within the following: In Network –vs - Out of Network  
IN NETWORK  
**In short:** Collect co-pay based on the signed agreement with the network. Bill and collect insurance. Deduct the two amounts and submit a GOSH claim for the balance.  
In network indicates that the provider of the service or the provider's company has signed a contract with the insurance company to abide by specific rules as spelled out in a contract.  
Typically, the client has a deductible and a patient co-pay. The professional has agreed to accept the client or patient's co-pay as payment in full.  
In these cases, the intent is to get the professional paid up to the Board's contract rate. With the Board as payor of last resort, this would mean the professional:  
1. collected the patient co-pay  
2. and billed insurance.  
The provider will submit a GOSH claim showing the co-pay, insurance amount and the net amount payable from the Board.  
Form 100 is completed to provide the means to which the Board will subsidize the provider for the uncollected amount up to the Board's contract rate. Basically the sliding fee does not apply to a claim that was billed to insurance.  
OUT OF NETWORK  
**In short:** Collect the client's sliding fee portion using the Board's sliding fee schedule. Bill and collect insurance. Deduct the two amounts and submit a GOSH claim for the balance.  
Out of network indicates that the provider of the service or the provider's company has not signed a contract with the insurance company.  
A client could be referred to an In Network provider etc., or be served out of the network where In Network rules will apply.  
1. Client or patient co-pay will not apply  
2. Reimbursement rates will be lower  
The provider will submit a GOSH claim showing the client's sliding fee, insurance amount and the net amount payable from the Board.  
This information is not to include Medicare.

Q. 20 <9/13/16> **What is the approved method intended by the new requirement of receiving a Medicaid denial before billing subsidy?**  
The contract and the Zero income form indicate that if the client's household income is below 138% of poverty that there must be a Medicaid rejection on file prior to billing the subsidy. This models the current practice of requiring a provider to bill insurance when there is insurance.  
In cases where there is insurance, **the provider is to submit the claim with the COB (Coordination of Benefits Code) and dollar amount received.**  
Once the provider has the Medicaid rejection letter on file **the provider can begin to file the claims to the board.**

Waivers and Scenarios: In the following scenarios, Yes or No, would a waiver be required?

- 9/16/2019 1. Client has insurance which the provider is on their panel. The provider serves the client, bills third party insurance, receives payment, then bills board for difference listing the third party insurance as well as their payment. Provider has available for the audit third party EOB  
No waiver is required
- 9/16/2019 2. Client has insurance which the provider is not on their panel. The provider serves client, bills third party insurance, receives payment/denial, bills board listing third party insurance as well as third party payment. Provider has available for the audit third party EOB.  
Yes Waiver is required
- 9/16/2019 3. Client has insurance which they agency has a therapist with credentials the insurance company will pay for but that therapist is not available.  
Yes Waiver is required
- 9/16/2019 4. Client has no third party and doesn't qualify for MCD.  
No waiver is required

Please direct all additional questions to Marion Rhodus, Director of Finance, by email RhodusM@bcmhars.org

All references to "Mental Health Board" now should be understood to mean: Butler County Mental Health and Addiction Recovery Services Board.