NET INCOME OF 185% OF FEDERAL POVERTY LEVEL (FPL)

Household Size	Annual Income
1	$22,311
2	$30,044
3	$37,777
4	$45,510
5	$53,243
6	$60,976
7	$68,709
8	$76,442
9	$84,175
10	$91,908

FINANCIAL ELIGIBILITY (Calendar Year 2017)

Instructions
Please read and complete all questions on this form. This information will be used to determine your eligibility for services funded by the Division of Behavioral Health.

Behavioral Health Provider Use Only	
☐ **Eligible** – Annual Review Date:	
☐ **Ineligible**	Provider:
CID #:	Signature:

Personal Information *(Please Print)*

Consumer Name: _____
(First) *(MI)* *(Last)*

Parent/Guardian or Representative (if applicable): _____

☐ Yes ☐ No I (CYF and/or SUD Consumer) have applied for and been denied Medicaid and CHIP-NM.
☐ Yes ☐ No I (SMI Consumer) have applied for and been denied SSI.

Description of Household

Total Number of Persons Living in Household (dependent on household income): _____

Financial Information

Total Household Annual Gross Income: Include all sources of income (wages, TANF, child support) for the household members included above, except for any income from a child under the age of 18.

1) Earned Income *(i.e. wages)* $_____

2) Unearned Income *(i.e. child support, TANF, SSDI)* $_____

Minus Annual Deductions/Expenses:

3) $_____ Earned Income Deduction *(Deduct 20% of Earned Income. Do not deduct 20% from unearned income.)*

4) $_____ Childcare Expenses *(up to $6,000/year)*

5) $_____ Child Support Payments

Household Size	Annual Income
1	$22,311
2	$30,044
3	$37,777
4	$45,510
5	$53,243
6	$60,976
7	$68,709
8	$76,442
9	$84,175
10	$91,908

Annual Out of Pocket Disability Related Expenses:

6) $_____ Prescription Medications/Labs *(related to mental illness)* _____

7) $_____ Health Insurance Premiums _____

8) $_____ Assistive Devices *(related to mental illness)* _____

Equals Annual Net Income:

9) $_____ *(deduct lines 3 through 8 from line 1 and 2)*

I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report changes in circumstance which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services. I understand that if I am determined eligible and my situation should change before my annual review date, it is my responsibility to notify the Behavioral Health Provider so that eligibility can be reevaluated. Eligibility could be affected by increases in income, changes in the number of persons in the household, and/or any other significant change in financial circumstance.

_____
Signature (Consumer or Parent/Guardian) Date

HARDSHIP CONSIDERATION (Calendar Year 2017)

Instructions
To be completed by the Behavioral Health Provider. All "yes" answers must include a detailed explanation.

Personal Information *(Please Print)*

CID #: _____

Consumer Name: _____
(First) *(MI)* *(Last)*

Address: _____ Ph. #: _____
(Street) *(City)* *(State)* *(Zip)*

Parent/Guardian or Representative (if applicable): _____

Address (if different from above): _____

Check type of service: ☐Substance Use Services ☐Gambling ☐CARE ☐CYF ☐IMPACT ☐ MH Outpatient

☐ **YES** ☐ **NO** Will **CARE** services exceed two or more units per month? Please indicate the number of units per month and the duration for which services will continue.

_____

☐ **YES** ☐ **NO** Will **CYF** services exceed eight or more units per month? Please indicate the number of units per month and the duration for which services will continue.

_____

☐ **YES** ☐ **NO** Is there an imminent risk of hospitalization, residential placement, or out of home placement? Is there potential for involvement/increased involvement with other systems (e.g., law enforcement, CPS, UJS, DOC)? Please explain.

_____

_____

_____

☐ **YES** ☐ **NO** Is there an emergency situation (e.g., suicidal, acutely psychotic, demonstrates potential relapse, or co-occurring disorder) that can be treated in a community setting? Please explain.

_____

_____

_____

I hereby attest that this information is true and correct.

_____

Signature (Behavioral Health Representative) Date

Refusal of Hardship Consideration (Calendar Year 2017)

I understand that I have been found ineligible to receive mental health/substance use/gambling services funded by the Division of Behavioral Health. I also understand that the Division of Behavioral Health have policies in which all cases of ineligibility are reviewed for a possible hardship consideration and through this process, hardships that would make paying for services an undue financial burden are taken into account. The Hardship Consideration process has been explained to me, but I am declining to participate at this time. By signing this document, I hereby waive my right to the Hardship Consideration process and the entire appeals process.

Signature (Consumer or Parent/Guardian) Date

Non-Discrimination Statement

The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501, 605-773-3305.

Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).

Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).

Eligible Consumers

- Individuals found eligible for services funded by the Division of Behavioral Health are required to immediately report any significant changes in income, household composition, and/or other circumstance that affect their eligibility status.
- Eligible consumers/families are required to complete an annual review of eligibility. The Behavioral Health Provider will inform consumers of the date of the review.

Ineligible Consumers

- All individuals initially found ineligible for services funded by the Division of Behavioral Health will have the option of completing the Hardship Consideration process. This form must be completed and turned in (with necessary verifications) to the Division of Behavioral Heath within 60 days of the initial ineligibility determination. Failure to do so will result in the consumer/parent or guardian waiving his/her right to apply for the Hardship Consideration.
- Consumers or parents/guardians who do not wish to proceed with the Hardship Consideration process must sign a Refusal of Hardship Consideration Process form, which will be provided by the Behavioral Health Provider. This refusal waives the right for all appeals.
- A consumer or parent/guardian who is interested in the Hardship Consideration process should contact the Behavioral Health Provider for a Hardship Consideration form and assistance in completing the process. Once completed this form should be returned to the Behavioral Health Provider. The Behavioral Health Provider will submit all appropriate documentation and forms to the Division of Behavioral Health.
- Within 30 days of receiving the Hardship Consideration forms, the Division of Behavioral Health shall provide a determination regarding eligibility.
- A consumer or parent/guardian who is dissatisfied with the Division of Behavioral Health's decision regarding eligibility may request an Administrative Review (see process outlined below).

Administrative Review/Fair Hearing Process

- All individuals found ineligible for services funded by the Division of Behavioral Health, after the Hardship Consideration process, will be informed of their right to an Administrative Review and, if still dissatisfied, a Fair Hearing, including the manner to initiate the review.
- A consumer or parent/guardian may appeal the decision regarding ineligibility by submitting the request in writing to the Division of Behavioral Health within 30 days of receipt of the notice regarding ineligibility.
- Consumers may have mental health visits paid for by the Division of Behavioral Health within the first 30 days in which their eligibility is being determined. However, if eligibility has not been determined after the first 30 days, then the consumer or parent/guardian is responsible for payment of services.
- The Division of Behavioral Health shall provide a determination within 30 days of receipt of the request for review.
- A consumer or parent/guardian who is dissatisfied with the Division's determination regarding eligibility may request a Fair Hearing by notifying the Department of Social Services in writing within 30 days of receipt of the Division's decision.
- An impartial hearing officer will be sought to handle all arrangements and correspondence with the consumer and the Department of Social Services, including the date and location for the hearing. The hearing officer will send notice of the hearing to both parties.
- The consumer may be represented at his/her own expense by counsel or other appropriate advocate(s) and will be afforded the opportunity to examine all witnesses and other sources of information or evidence.
- The consumer or his/her representative may present additional evidence, information, and witnesses to the impartial hearing officer.
- Within 45 days of the hearing, the impartial hearing officer will provide a full written report of findings to the consumer (or designee if appropriate) and the Department of Social Services.
- The hearing officer's decision will be final.

For more information about this process you may contact: Department of Social Services, Division of Behavioral Health, Kneip Building, c/o 700 Governors Drive, Pierre, SD 57501, 605-855-878-6057.

Non-Discrimination Statement

The Department of Social Services does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of actual or perceived race, color, religion, national origin, sex, age, gender identity, sexual orientation or disability in admission or access to, or treatment or employment in its programs, activities, or services. For more information about this policy or to file a Discrimination Complaint you may contact: Discrimination Coordinator, Director of DSS Division of Legal Services, 700 Governor's Drive, Pierre, SD 57501, 605-773-3305.

Español (Spanish) - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-305-9673 (TTY: 711).

Deutsch (German) - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-305-9673 (TTY: 711).

Federal Poverty Guidelines

Below you will find the 2016 federal poverty guidelines; listed at the 100 percent level.

For families with more than 8 persons, add $4,160 for each additional person.

Persons in Family	Poverty Guideline
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890

SOUTHERN PLAINS BEHAVIORAL HEALTH SERVICES
2016 - 2017 FEE SCALE
FAMILY SIZE

Sliding Fee Schedule (SFS)

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
	Charge					
Family Size	Nominal Fee ($5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$11,880	$11,881-$14,850	$14,851-$17,820	$17,821-$20,790	$20,791-$23,760	$23,761+
2	0-$16,020	$16,021-$20,025	$20,026-$24,030	$24,031-$28,035	$28,036-$32,040	$32,041+
3	0-$20,160	$20,161-$25,200	$25,201-$30,240	$30,241-$35,280	$35,281-$40,320	$40,321+
4	0-$24,300	$24,301-$30,375	$30,376-$36,450	$36,451-$42,525	$42,526-$48,600	$48,601+
5	0-$28,440	$28,441-$35,500	$35,501-$42,660	$42,661-$49,770	$49,771-$56,880	$56,881+
6	0-$32,580	$32,581-$40,625	$40,626-$48,870	$48,871-$57,015	$57,016-$65,160	$65,161+
7	0-$36,730	$36,731-$45,913	$45,914-$55,095	$55,096-$64,278	$64,279-$73,460	$73,461+
8	0-$40,890	$40,891-$51,113	$51,114-$61,335	$61,336-$71,558	$71,559-$81,780	$81,781+
For each additional person, add	$4,160	$5,200	$6,240	$7,280	$8,320	$8,320

* Based on 2016 Federal Poverty Guidelines (http://aspe.hhs.gov/poverty)

Southern Plains
BEHAVIORAL HEALTH SERVICES

OUR PROMISE TO

- ✓ Serve all clients
- ✓ Offer discounted fees for clients who qualify
- ✓ Not deny services based on a person's:
    - Race
    - Color
    - Sex
    - National origin
    - Disability
    - Religion
    - Sexual orientation
    - Inability to Pay
- ✓ Accept insurance, including:
    - Medicaid
    - Medicare
    - Children's Health Insurance Program (CHIP)

500 EAST NINTH ST. WINNER, SD 57580 605-842-1465
605-842-2366 (FAX) WWW.SPBHS.NET

NATIONAL HEALTH SERVICE CORPS

AS A NATIONAL HEALTH SERVICE CORPS SITE,

WE PROMISE TO

✓ **Serve all patients**

✓ **Offer discounted fees for patients who qualify**

✓ **Not deny services based on a person's:**

- Race
- Color
- Sex
- National origin
- Disability
- Religion
- Sexual orientation
- Inability to Pay

✓ **Accept insurance, including:**

- Medicaid
- Medicare
- Children's Health Insurance Program (CHIP)

This facility is a member of the National Health Service Corps: **NHSC.hrsa.gov.**

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH RESOURCES AND SERVICES ADMINISTRATION

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration