TITLE: COMMUNICATION TO PATIENT REGARDING FINANCIAL ASSISTANCE DETERMINATION

PURPOSE: To define the documents and information to be shared with the client regarding the assigned financial assistance classification.

GUIDELINES/PROCEDURES STATEMENT:

Each client applying for financial assistance will receive written communication regarding the assigned level of financial assistance, payment requirements, and notice of right to appeal the assigned classification.

ELABORATIONS:

I. CLIENTS APPROVED FOR FINANCIAL ASSISTANCE:

Each client approved for financial assistance shall receive these forms:

A. Harris Health System (Harris Health) Form 283183, Notification of Financial Assistance Classification, and Right to Request Appeal describes the client’s assigned financial assistance classification, the client’s responsibilities for reporting changes in information, and appeal rights. This form shall include the following information:

1. Patient’s Name;
2. Patient Identifier Number and Application Number;
3. Eligibility Plan;
4. Eligibility Expiration Date;
5. Notice of the availability of eligibility determination policies for review;
6. Notice of the right to appeal the assigned classification within sixty-five (65) calendar days of the date of determination;
7. Notice of the appropriate address for filing appeals;
8. Policy for reporting changes in information; and
9. Names, locations, and phone numbers of Harris Health System facilities.

B. Harris Health Form 282744, Financial Assistance Approval Notice describes payment amounts for assigned financial assistance classification. This form will include the following information:
1. Patient’s name and address;
2. Patient Identifier Number;
3. Eligibility Center and Eligibility Counselor Name;
4. Eligibility Plan;
5. Minimum deposit or copayment requirements for clinic visit, dental, prescription, central supply, emergency room visit, day surgery, inpatient.
6. Name of Family Member, Patient Identifier Number (#), Date of Birth, Sex, Effective date, Expiration date, Third Party Coverage; and
7. Information about Medicare Part D Prescription costs.

C. Harris Health Form 283791, Healthy Texas Women Program (HTWP) Referral Notice shall be provided to the clients who are potentially eligible and are referred to apply for HTWP.

II. CLIENTS INELIGIBLE FOR FINANCIAL ASSISTANCE:

Clients ineligible for financial assistance shall receive these forms:

A. Harris Health Form 283183, Notification of Financial Assistance Classification and Right to Request Appeal. This document shall provide the following information:

1. Patient’s Name;
2. Patient Identifier Number and Application Number;
3. Eligibility Plan;
4. Eligibility Expiration Date;
5. Notice of the availability of eligibility determination policies for review;
6. Notice of the right to appeal the assigned classification within sixty-five (65) calendar days of the date of determination;
7. Notice of the appropriate address for filing appeals;
8. Policy for reporting changes in information; and
9. Names, locations, and phone numbers of Harris Health facilities.

B. Harris Health Form 282744, Self-Pay Financial Obligation Notice. This document shall provide the following information:

1. Patient’s name and address;
2. Patient Identifier Number;
3. Eligibility Center and Eligibility Counselor Name;
4. Eligibility Plan;
5. Minimum deposit requirements for clinic visit, dental, prescription, central supply, emergency room visit, day surgery, inpatient.
6. Name of Family Member, Patient Identifier Number, Date of Birth, Sex, Effective date, Expiration date, Third Party Coverage; and
7. Information about Medicare Part D Prescription costs;
8. Notice of making a payment arrangement.

III. CLIENTS WITH APPLICATIONS PENDED FOR FURTHER INFORMATION:

Clients whose applications are pended for additional information shall be provided with Harris Health Form 283116, Notification of Pending Eligibility Status. This form shall contain:

A. Patient’s name;
B. Patient Identifier Number and Application Number;
C. List of missing verifications;
D. Methods for returning the missing items;
E. The timeframe within which items must be returned;
F. Management assistance availability; and
G. Notification regarding denial action if the requested information is not provided within the allowed timeframe.

IV. CLIENTS DENIED FOR FINANCIAL ASSISTANCE:

Clients denied for financial assistance due to not a resident of Harris County shall receive Harris Health Form 283177, Notification of Denial for Financial Assistance
Due to out of Harris County Residence. This document shall provide the following information:

A. Client’s name;
B. Patient Identifier number and Application number;
C. Date denied;
D. Reason for the denial of financial assistance;
E. Notice of the right to appeal the financial assistance denial with sixty-five (65) calendar days of the date of determination.
F. Notice of the appropriate address for filing appeals.

V. CLIENTS HAVE BEEN REFERED TO APPLY FOR MEDICAID/CHIP/CHIP PERINATAL/ OR REFUGEE MEDICAID:

Client or client’s household members who are potentially eligible and are referred to apply for the appropriate third (3rd) party assistance program such as Medicaid, Children’s Health Insurance Program (CHIP), CHIP Perinatal, or Refugee Medicaid shall receive these Harris Health forms described below:

A. Harris Health Form 283787, State or Federal Assistance Program Referral Notice, this form shall contain:

1. Patient’s name;
2. Patient Identifier Number;
3. The third party assistance program that client is referred to apply;
4. The method for obtaining and submitting the third party assistance program application;
5. The method for returning the third party certification or denial notice; and
6. Names, locations, and phone numbers of Harris Health Eligibility centers.

B. Harris Health Form 282744, Self-Pay Financial Obligation Notice:
VI. CLIENTS WITH TITLE V OR FAMILY PLANNING ENROLLMENT:

Client or client’s household members who are potentially eligible for Title V or Family Planning program (FP) shall be enrolled into the program and shall receive these forms:

The Harris Health Form 283117, Application for Financial Assistance:

A. The “Statement of Applicant’s Right and Responsibilities” must be read and checked off block “Yes” to acknowledge the reading; and

B. The “Race” and “Ethnicity” should be selected and marked appropriately.

VII. CLIENTS WITH HEALTHY TEXAS WOMEN PROGRAM REFERRAL:

Client or client’s household members who are potentially eligible and are referred to apply for the Healthy Texas Women Program (HTWP) shall receive the Harris Health Form 283791, Healthy Texas Women Program (HTWP) Referral Notice, this form shall contain:

A. Patient’s name;

B. Patient Identifier Number

C. Methods for applying HTWP;

D. Methods for returning the HTWP certification or denial notice; and

E. Names, locations, and phone numbers of Harris Health Eligibility centers.

VIII. CLIENTS WITH MY HARRIS HEALTH (MHH):

A. My Harris Health Approval:

Client or client’s household members approved for My Harris Health Program shall receive these forms:
1. Harris Health Form 283907, Notification of My Harris Health and Right to Request Appeal, this form shall contain:
   a. Patient’s Name;
   b. Patient Identifier Number and Application Number;
   c. Notice of the availability of eligibility determination policies for review;
   d. Notice of the right to appeal MHH within sixty-five (65) calendar days of the date of determination;
   e. Notice of the appropriate address for filing appeals;
   f. Policy for reporting changes in information; and
   g. Names, locations, and phone numbers of Harris Health facilities.

2. Harris Health Form 284632, My Harris Health Contract, this form shall contain:
   a. Household monthly income and family size;
   b. My Monthly MHH Payment;
   c. Co-payments for emergency room and prescriptions;
   d. Contract effective date;
   e. Applicant’s authorization and responsibility; and
   f. Signatures of applicant and Harris Health Representative.

3. My Harris Health ID Card, this card shall contain:
   a. Participant ID number;
   b. Patient’s Name;
   c. Patient’s Date of Birth;
   d. Patient Gender; and
   e. Effective Date.

B. My Harris Health Referral:

Client or client’s household members who are potentially eligible and are referred to apply for My Harris Health shall receive the form:
Harris Health Form 283920, My Harris Health Program Referral Notice, this form shall contain:

A. Patient’s name;
B. Patient Identifier Number;
C. Eligibility Center and Eligibility Counselor Name;
D. The method for applying the MHH;
E. Notification regarding the financial status “self-pay”;
F. Minimum deposit requirements for clinic visit, dental, prescription, emergency room visit, day surgery, inpatient admission, general radiology or lab, MRI, PET scan, Upper Endoscopy/Colonoscopy, CT scan; and
G. Notice to establish the payment arrangement.

B. My Harris Health Decline

The Harris Health Form 283976, My Harris Health Declined Form will be provided to the My Harris Health enrolled client who chooses to disenroll to the My Harris Health program, to complete and be scanned into the eligibility software system. This form shall contain:

a. Patient’s Name;
b. Patient Identifier Number;
c. Reason;
d. Signatures of patient or legal representative;
e. Legal representative’s relationship to patient; and
f. Harris Health Eligibility Counselor’s name.

IX. EXPLANATION OF FORMS:

The eligibility counselor shall complete the forms described above. The forms shall be given or mailed to the clients.
REFERENCES/BIBLIOGRAPHY:

Harris Health System Form 282744 Financial Assistance Approval Notice

Harris Health System Form 283183 Notification of Financial Assistance Classification and Right to Request Appeal

Harris Health System Form 283116 Notification of Pending Eligibility Status

Harris Health System Form 283791 Healthy Texas Women Program (HTWP) Referral Notice

Harris Health System Form 283787 State or Federal Assistance Program Referral Notice

Harris Health System 2015 Eligibility Redesign Training Package

Harris Health System Form 284632 My Harris Health Contract

Harris Health System Form 283907 Notification of My Harris Health and Right to Request Appeal

Harris Health System Form 283920 My Harris Health Program Referral Notice

Harris Health System Form 283976 My Harris Health Declined Form

Harris Health System Form 283177 Notification of Denial for Financial Assistance Due to out of Harris County Residence

Harris Health Form 282744 Self-Pay Financial Obligation Notice

OFFICE OF PRIMARY RESPONSIBILITY:

Harris Health System Eligibility Services Department
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