Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

Name: _____

FINANCIAL RESPONSIBILITY

FINANCIAL ASSISTANCE / BUDGET PAYMENT PLANS:

If you qualify, Financial Assistance may be available which could result in a reduction in the amount you may owe. Payment Plans are available. This is based on your household gross income.

Financial assistance may be used if you are to fall off of your insurance or if your insurance does not cover the services you need provided by MHA.

Updating Information:

- I am responsible for informing MHA of changes in insurance, place of employment, number of dependents, and income on a yearly basis.
- I understand if I qualify for a discount it will remain in effect for ***one year*** from the date signed or changed as needed when changes in income are reported.
- If a new financial responsibility form is not completed before it expires, the discount will stop and I will be billed at full rate until an updated form has been completed and signed.
- I have read the MHA Financial Responsibility and agree with its terms. ***I understand that I am responsible for confirming my insurance benefits and understand any copay and cost shares are my responsibility.*** Additionally I understand I will be paying more of a co-pay if I decline to provide allowable liabilities information the co-payment and deductible for my insurance plan are my responsibility.

Sliding Fee Agreement

_____ I **HAVE NO INSURANCE COVERAGE:**

Date:_____

For MHA clients who are Nebraska residents and **not covered by either insurance or Medical Assistance**, sliding fees may be available. MHA will need proof of income, i.e., tax forms, etc. If you have qualified for a sliding fee, the set amount will be due at the time of each visit.

I agree that I have no insurance and my discount is _____%. I understand that this rate will be reviewed periodically and could change depending on my financial situation. I agree to provide MHA with the most correct and updated information about by income and will be responsible for any charges incurred if the information provided is not correct or updated. MHA has the right to increase the overall fee scale on a yearly basis.

SUBSTANCE ABUSE URINALYSIS AND DRUG SCREENS ARE NOT DISCOUNTED. _____Initial

I have read this MHA Financial Responsibility document and agree with its terms. I understand that reduced fee amount is my full responsibility.

Patient (or guardian) Signature Date

Staff Member Signature Date

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United States Citizenship Attestation

Nebraska Law requires completion of this form effective 10-1-09 in order to receive services at a reduced rate. For the purpose of complying with Neb. Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

- ☐ I am a citizen of the United States.
- ☐ I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows:_____, and I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Patient (or guardian) Signature Date

Staff Member Signature Date

PROOF OF NEBRASKA RESIDENCY

- ☐ Utility bill or credit card bill issued within the last 90 days
- ☐ Account statement from a bank or other financial institution issued within the last 90 days
- ☐ Valid Nebraska vehicle registration
- ☐ Nebraska voter registration card
- ☐ A letter from the social security department with consumer's address.
  (The above documents must be accompanied with a picture ID)

- ☐ Valid Nebraska driver's license
- ☐ Nebraska State ID

PROOF OF INCOME

- ☐ Most current year's tax return
- ☐ SSI/Disability Statement
- ☐ Most current pay check stubs
- ☐ Self-written, signed letter by consumer stating no income is available
- ☐ Self-written, signed letter by individual responsible for the payment of consumer's housing, foot, etc.

CERTIFICATION OF ZERO INCOME

(To be completed by adult household members who are claiming zero income from any source, if appropriate.)

1. I hereby certify that I do not individually receive income from any of the following sources:

a. Wages from employment (including commissions, tips, bonuses, fees, etc.);

b. Income from operation of a business;

c. Rental income from real or personal property;

d. Interest or dividends from assets;

e. Social Security payments, annuities, insurance policies, retirement funds, pensions, or death benefits;

f. Unemployment or disability payments;

g. Public assistance payments;

h. Periodic allowances such as alimony, child support, or gifts received from persons not living in my household;

i. Sales from self-employed resources (Avon, Mary Kay, Shaklee, etc.);

j. Any other source not named above.

2. Choose one:

□ Currently, I have no income of any kind and while I am seeking employment, there is no definite job offer at this time.

□ Currently, I have no income of any kind and I will not be seeking employment at this time.

□ Currently, I have no income of any kind and I will be seeking social security disability.

3. I will be using the following sources of funds to pay for rent and other necessities: _____

_____

Under penalty of perjury, I certify that the information presented in this certification is true and accurate to the best of my knowledge. The undersigned further understand(s) that providing false representations herein constitutes an act of fraud. False, misleading or incomplete information may result in the termination of Region 1 benefits.

_____ _____ _____

Signature of Applicant Printed Name of Applicant Date

Name:

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No Yes	No Yes	No Yes
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No Yes	No Yes	No Yes
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill?	No Yes	No Yes	No Yes
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No Yes	No Yes	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No Yes	No Yes	No Yes
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No Yes	No Yes	No Yes
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No Yes	No Yes	No Yes
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No Yes	N/A	No Yes
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No Yes	N/A	No Yes
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9	No Yes	N/A	N/A

Nebraska Department of Health & Human Services
Division of Behavorial Health

Eligibility Worksheet for NBHS Funded Services

An initial Eligibility Worksheet must be completed at admission or as soon as possible after admission and must be completed annually thereafter. You may not bill the Region or DHHS for any services for this consumer until Financial Eligilty has been established. The worksheet does not need to be completed for services listed on the Emergency Access Services Fee Schedule.

Consumer Name: _____

Is the consumer covered by insurance? (must check one) Yes ☐ No ☐

Will filing the insurance pose a risk to the consumer? (Domestic Violence, child abuse or other danger occurring) Yes ☐ No ☐

Taxable Monthly Income _____

Annual Income _____ (Can be computed by dividing annual income by 12)

Less Monthly Total Allowable Liabilities:

Housing : Monthly rent/lease/ mortgage amount, not to exceed **$535** per month (Limited to the home or apartment the consumer currently occupies) _____

Utilities: For the house/apartment reflected above, if the utilities are not included in rent/lease amount:
Monthly utilities, not to exeed **$469** per month _____
OR
For the house/apartment reflected above, if only a portion of utilities are included in rent/lease amount:
Monthly utilities, not to exeed **$245** per month _____

(Utilities refers to heating & cooking fuel, air conditioning, septic tank, water, sewage, trash & basic telephone only)

Transportation: Car payment and average gasoline cost or cost of public transportation, not to exceed $250 per month _____

Daycare: (if paying a 3rd Party)
$200 for each child age one or younger (Number of children ____ x $200) _____
$175 for each child age two or older (Number of children ____ x $175) _____

Total Allowable Liabilities: $ -

Adjusted Monthly Income to be used to determine Eligibility for NBHS funded services: $ -
(Taxable Monthly Income less Monthly Total Allowable Liabilities)

Total Number of family members dependent on taxable income: _____
(consumer + spouse (if applicable) + # children (if applicable))

By signing this form, I am verifying the above amounts are correct to the best of my knowledge.

_____
Consumer signature Date

Note: You may be asked to supply documents for verification of income and liabilities claimed.

_____
Staff Person Date

For Agency Use Only:
Consumer is eligible for Hardship Fee Schedule due to:
_____ SPMI
_____ SED
_____ Medical Bills or Medical Debt in excess of 10% of the taxable annual income
(Taxable Monthly Income x 12 x 10%)

20% of Adjusted Monthly Income = $ -
(20% is reference for maximum monthly Hardship Copay Only)

As of January 26, 2018 for use in SFY19

As of February 1, 2016 for use in SFY17