VERA FRENCH
Mental Health for Healthy Living

FINANCIAL ASSISTANCE INFORMATION

Vera French Community Mental Health Center is dedicated to ensuring that financial barriers do not hinder your access to the mental health services you need. For Iowa residents who are uninsured or have significant out-of-pocket costs (deductibles, copays), a variety of funding assistance options are available.

Funding Options Available:

- Iowa Medicaid
  - Apply online at https://hhsservices.iowa.gov/apspssp/ssp.portal
  - Apply via paper: https://hhs.iowa.gov/media/5825/download?inline
- IA Behavioral Health Service System (SNMIS)
- Financial Accountability Form (Sliding Fee Scale)

Documentation Needed:

- Proof of Residence in Iowa (example: recent utility bill)
- Valid Photo ID
- Proof of income for yourself and others in your household
  - Most recent pay stubs-1 month
  - Unemployment statement
  - Social Security statement
  - Disability statement
  - Child Support statement
  - Food stamp statement

To apply for assistance:

Please complete the attached funding applications and include the required supporting documentation listed above. The IA Medicaid application can be submitted electronically or via paper. If you need assistance printing the application, let us know and we can print it for you.

> **Note:** IA Medicaid application must be submitted with IA Behavioral Health Service System (SNMIS) or Financial Accountability Form (Sliding Fee Scale) unless IA Medicaid application was already submitted within past 30 days.

If you prefer to schedule an appointment to meet with a member of our Intake team to complete the applications, please call 563-383-1900.

Completed paperwork can be returned to any Vera French location, or mailed to:

Vera French Community Mental Health Center
Attn: Billing Department
852 Middle Road Ste 101
Bettendorf, IA 52722

IOWA Health and Human Services

Behavioral Health Services Eligibility Form

Behavioral Health Services funding is intended to support at-risk populations, including but not limited to children, youth, young adults, individuals with disabilities, pregnant and parenting women, older adults, and people with limited access to financial resources.

Iowa residents who meet the requirements below are eligible to receive behavioral health services from the enrolled provider(s) of their choice.

Reimbursement for behavioral health services is subject to the financial eligibility and resource requirements for Iowa residents in Iowa Administrative Code (IAC) 441-301.1.

Part 1. Income at or below 200% of the Federal poverty guidelines as published by the U.S. Department of Health and Human Services

To determine financial eligibility individuals must provide documentation of income as listed below. *Income requirements apply only to the individual for adults, or to the household for children. Please indicate which form of financial documentation is being provided*:

- ☐ Pay stub, wages verification, or SSI benefits statement
- ☐ Federal income tax filing
- ☐ Iowa Workforce Development "white sheet"
- ☐ Other form of documentation
- ☐ No Income

Any documentation used to demonstrate income must be provided prior to initiating behavioral health services. This form and a copy of the documentation must be maintained in the individual's service file. A copy of the completed form, including the determination of eligibility and appeal rights, must be provided to the individual receiving services or their guardian.

Part 2. Resource limits are equal to or less than $2,000 in countable value for a single-person household or $3,000 in countable value for a multi person household. *Household is defined as a group of individuals who impact the applicant or recipient's family size or household income. This typically consists of the applicant plus their spouse and any dependents who are required to file tax returns. The marketplace generally considers your household to be you, your spouse if you're married, and your tax dependents.*

Resource	**Value**
Houses (do not include the primary residence; include second homes or investment property)	
Automobiles (one vehicle is exempt; only include additional autos but deduct the amount of loans on the vehicles)	
Cash on hand	
Checking accounts	
Savings accounts	
Certificates of deposit	
Trust funds	
Stocks and bonds	
Life insurance cash surrender value (only include if value greater than $1500 per insured)	

Based on the income and resource information provided, the individual meets financial eligibility for services (Yes or No).	☐ Yes	☐ No

Identifying Information: You may have someone help you complete this section.

Client Name (First & Last):

Client Address (Place of Residence):

Client County of Residence (Must be a Resident in the State of Iowa):

Provider Information: Provider receiving the application.

Provider Name:

Provider Address:

Attestation:
By signing this document, I attest that the financial information provided is accurate and demonstrates my eligibility.

Client Signature	Date
Witness Signature	Date

You Have the Right to Appeal

What is an appeal? An appeal is asking for a reconsideration because you do not like a decision that was made relating to an eligibility determination or denial of behavioral health or disability services. You have the right to file an appeal if you disagree with a decision. You do not have to pay to file an appeal. [441 Iowa Administrative Code Chapter 223 for Disability Services or Chapter 303 for Behavioral Health].

How do I appeal? Appeals must be done in writing. The appeals form for the behavioral health and disability services system can be found at https://hhs.iowa.gov/appeals. There are multiple ways to file an appeal. Choose the one that works for you:

- **Email:** appeals@hhs.iowa.gov
- **FAX:** (515) 564-4044
- **Mail:** Iowa Department of Health and Human Services, Appeals Bureau,
  321 E 12th Street, Des Moines, Iowa 50319

We will let you know in writing that we received your appeal.

How long do I have to appeal? You have 120 calendar days to file an appeal from the date of the eligibility determination or denial of services.

How will I know if my appeal was accepted? If the appeal request is granted, you will be given a chance to submit a written statement and documentation to support your case. You will have 14 calendar days from the date of the acknowledgment letter to provide this information. Then, you should receive a written Proposed Decision from HHS within 30 calendar days that explains the decision and next steps that may be available to you. You will get a letter telling you if your appeal is denied.

Can I have someone else help me? You or someone else, such as a friend or relative, can tell why you disagree with the HHS's decision. You may also have a lawyer help you, but HHS will not pay for one. Your county HHS office can give you information about legal services. The cost of legal services will be based on your income. You may also call Iowa Legal Aid at 1-800-532-1275.

Policy Regarding Discrimination, Harassment, Affirmative Action and Equal Employment Opportunity

It is the policy of the Iowa HHS to provide equal treatment in employment and provision of services to applicants, employees and clients without regard to race, color, national origin, sex, sexual orientation, gender identity, religion, age, disability, political belief or veteran status.

If you feel HHS has discriminated against or harassed you, please send a letter detailing your complaint to: Iowa HHS, Hoover Building, 5th Floor – Policy Bureau, 1305 E Walnut, Des Moines, IA 50319-0114 or via email FDHS@hhs.iowa.gov.

Persons with disabilities who require alternative means of communication for program information (e.g., Braille, large print, audiotape, American Sign Language, etc.), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

This institution is an equal opportunity provider.

VERA FRENCH
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Internal Use Only: Approved For:
☐ Sliding Fee Scale
☐ Payment Plan
☐ Balance Reduction

Internal Use Only: MRN:
☐ Approved
☐ Denied
☐ Declined Form Completion

Financial Accountability Form (FAF)

Vera French empowers clients to be independent and self-reliant and provides needed services regardless of a client's ability to pay. **If you would like to be considered for a payment plan and/or discounted services, please complete this form and return to:**

Vera French Business Office
852 Middle Road Ste 101
Bettendorf, IA 52722

Income & Demographics Verification

Patient Information

Last Name:	First:	Middle:
Address:		
City:	State:	Zip Code:
Phone Number:		

Insurance Information:

☐ No Insurance

Insurance name & Policy #

Insurance deductible amount: $ Insurance copay amount $

☐ Individual ☐ Family

Income Verification (Proof of income is required to be considered for a discount/payment plan)

Monthly household income from all sources: $

Family size*:_____# Adults; _____# Dependents

# of family members in household_____

Significant expense information you would like us to consider:

Status of Medicaid application:	Status of Scott County application:
☐ Applied, waiting notice of decision Application Date: _____ ☐ Denied coverage due to: _____	☐ Applied, waiting notice of decision Application Date: _____ ☐ Denied coverage due to: _____
☐ Eligibility gap, will be covered in a month	☐ Eligibility gap, will be covered in a month
☐ Other: _____	☐ Other: _____

How can we help?
☐ Sliding Fee Scale
☐ Payment Plan (Complete "Payment Plan" section below)
☐ Balance Reduction (Complete "Balance Reduction section below)
☐ Other_____

I understand that Vera French may verify information provided on this form prior to determining eligibility for sliding fee scale, payment plans, or a balance reduction. I certify that the information I have provided on this form is true and accurate to the best of my knowledge. I understand that additional information may be requested to qualify for assistance.

Patient or Guardian Signature:_____

Date: _____

Payment Plan Request (If applicable)

Patients who are unable to pay the full amount due at each visit may request a payment plan. Proof of income is required, and payment terms are subject to approval by the Business Office. Please include proof of income with this application.

I am unable to pay the full amount owed at the time of service.

I will pay $ _____ today and I am requesting a payment plan in the amount of:

$_____/month

(or)

$_____/every 2 weeks

Payment Method:

☐ Credit Card (**please complete credit card authorization form**)	☐ Check (Please mail check to): Vera French Community Mental Health Center Attn: Business Office 852 Middle Rd Ste 100 Bettendorf, IA 52722

Phone number I can be reached at regarding this payment plan request: _____

If I am unable to make a scheduled payment or need to update my payment information, I will contact the Vera French billing department at 563-383-1900 to make alternate arrangements. I understand that failure to make scheduled payments without notifying the billing department may result in a suspension of services at Vera French.

Patient or Guardian Signature: _____

Date: _____

Balance Reduction Request (If Applicable)

Patients who are unable to pay a balance at Vera French may request a one-time balance reduction based on need. Please indicate how much you are able to pay and how you intend to make this payment (one time payment or payment plan).

Current Account Balance: $_____

Proposed Balance Reduction Amount $_____

Proposed Payment Amount: $_____

Payment Method:

☐ One Time Payment ☐ Payment Plan

I attest that I am unable to pay my account balance and understand that a balance reduction is subject to approval from the Vera French Business Office. If approved, I agree to pay the proposed payment amount listed.

Patient or Guardian Signature: _____

Date: _____

FOR VF USE ONLY

Form Prepared by:	Date:

Checklist:

☐ Completed FAF

☐ Proof of income Type of Proof Provided: _____

☐ Denial from Medicaid and/or Scott County

Approved by:	Date:

Approved length of time: ☐ One time approval ☐ Review in 3 months ☐ Review in 6 months

Approved For:

☐ Sliding Fee Scale ____% Copay ☐ Payment Plan: Amount/Frequency_____

☐ Balance Reduction: Amount $_____ ☐ Other_____