

March 16, 2011



## Policy and Procedure Manual

2011

# STEP ME IN THE RIGHT DIRECTION: Understanding “Ability to Pay” in First Steps



First Steps Webinar  
April 2011

# Purpose of Webinar

- ◉ *To clarify “Ability to Pay” provisions and procedures*
- ◉ *To provide opportunity for POE staff to ask questions concerning “Ability to Pay”*



# CHAPTER 4

## Systems of Payment

# Systems of Payments

Federal law permits states to develop a system of payments that identifies:

- ❖ Services at no cost to all parents
- ❖ Services subject to a system of payments
- ❖ The schedule of payments (sliding fee scale)
- ❖ Basis and amount of fees

# Systems of Payments

Additionally, states must assure that:

- ⦿ Fees will not be charged for services the child is otherwise entitled to at no cost to the parent
- ⦿ Services are not denied to a child and family due to their inability to pay

# Systems of Payments

- ◉ Family Share Participation Fees;
- ◉ Private insurance with consent of the family;
- ◉ Medicaid;
- ◉ Kentucky Early Intervention System funds (general revenue);
- ◉ Tobacco Settlement funds; and
- ◉ Part C federal funds.



# Ability to Pay

- ◉ KY defines **ability to pay** to include Family Share Participation Fees and Private Insurance
- ◉ All families are asked about their financial resources
- ◉ No child is denied services due to the family's inability to pay

# Family Share

- ◉ Is a monthly participation fee, not a co-pay
- ◉ Based on household income and size
- ◉ Fee is for only one child per family
- ◉ Fee is triggered by early intervention services (ongoing IFSP services)



# Family Share

- ◉ No fee for services that must be provided at no cost to the family
- ◉ Minimum monthly fee is \$0; maximum is \$100
- ◉ Fee can be waived due to certain hardships

# Family Share Forms



**FIRST STEPS**  
KENTUCKY'S EARLY INTERVENTION SYSTEM

FINANCIAL ASSESSMENT VERIFICATION  
TOTS ID #: \_\_\_\_\_  
DOB: \_\_\_\_\_

POE Office Address, Phone  
and Fax

Child's Name: \_\_\_\_\_

**FIRST STEPS**  
KENTUCKY'S EARLY INTERVENTION SYSTEM

FAMILY SHARE TEMPORARY SUSPENSION OR WAIVER REQUEST

1040

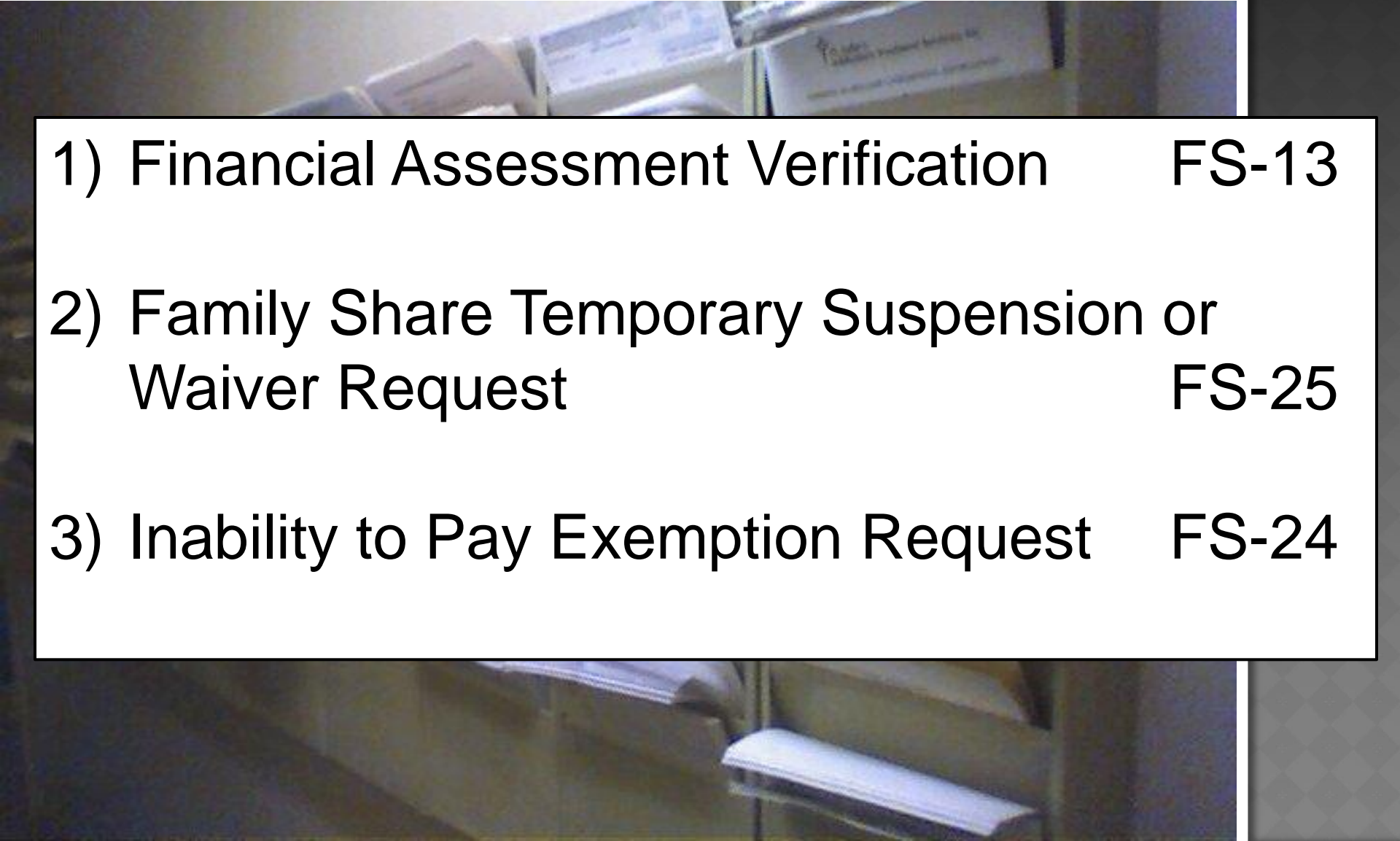
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Department of the Treasury  
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Rev. 3/2011

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# Family Share Forms

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- 1) Financial Assessment Verification      FS-13
  - 2) Family Share Temporary Suspension or  
Waiver Request      FS-25
  - 3) Inability to Pay Exemption Request      FS-24



275 East Main Street, HS2W-C  
Frankfort, KY 40621  
Phone: (502)564-3756  
Fax: (502)564-0329

FS-13  
Rev. 3/2011

### FINANCIAL ASSESSMENT VERIFICATION

Child's Name: Test Child      DOB: 3-22-10      TOTS ID#: 55555

PS 1. By viewing the most recent tax return or the last four consecutive pay stubs, my service coordinator has verified our current household annual adjusted gross income to be: \$ \_\_\_\_\_.

PS 2. I am reporting \_\_\_\_\_ number of people living in my home (please include all people living in the home even if they are not related).

PS 3. I have other children who are currently receiving First Steps services.  Yes     No

If yes, please list the children's names: \_\_\_\_\_

\_\_\_\_\_

PS 4. I am aware that I will be responsible for a Family Share participation fee of \$ \_\_\_\_\_/month. I will pay this monthly participation fee the month early intervention services start until my child is discharged.

PS 5. I understand that I am responsible for paying the Family Share participation fee even if I give consent for the early intervention providers to bill my private insurance.

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\_\_\_ 6. I want my/our income verified by the Family Share Administrator located at First Steps State Lead Agency and attach the following information:

\_\_\_ Copy of the first page of the most recent 1040, 1040A, 1040EZ tax return, or

\_\_\_ Copy of the most recent four (4) consecutive pay stubs that state my/our annual adjusted gross income.

\_\_\_ 7. I am refusing to have my/our income verified. I understand that by refusing to have my income verified, I am accepting the highest out-of-pocket maximum monthly participation fee (\$100/month).

\_\_\_ 8. I understand that this refusal can be revoked at any time.

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9. My child is covered by a KY Children's Health Insurance (K-CHIP)/Medicaid card:  Yes  No

The card number is: 000111222

10. My child does not currently have a KY Children's Health Insurance (K-CHIP)/Medicaid card however:

I have already applied for one

I plan to apply for one this month

Parent/Guardian Name (Printed): Parent Signature

Parent/Guardian Signature: Parent Signature

Service Coordinator Signature: Paula Coordinator

Date: 4-14-11

*The cost of printing was paid from state funds through the Department for Public Health, First Steps Program, pursuant to KRS 57.375*





## FAMILY SHARE TEMPORARY SUSPENSION OR WAIVER REQUEST

Child's Name: Test Child TOTS ID #: 55555

### Check One:

The above named child will not be able to access their First Steps services from

\_\_\_\_\_ through \_\_\_\_\_.\*  
Month/Year Month/Year

Reason(s): this means child is hospitalized for extended period or recovering from surgery and does not have medical clearance for FS services. Or, child may be out of country or state for extended period.

*\*Minimum one calendar month at a time.*

OR

The family requests a temporary waiver from their Family Share, from

\_\_\_\_\_ through \_\_\_\_\_, due to the following reason(s):  
Month/Year Month/Year

1. significant reduction income (job loss) 2. bankruptcy

3. periods when child is covered by Medicaid

*\*Maximum three calendar months at a time.*

OR

The family requests a reduction of their Family Share from \$\_\_\_\_\_ to \$\_\_\_\_\_ from

\_\_\_\_\_ through \_\_\_\_\_, due to the following reason(s):  
Month/Year Month/Year

time—parent may be between jobs for short period of time, has an unexpected one-time, large expense, etc

*\*Maximum three calendar months at a time.*

Service Coordinator's

Signature: Paula Coordinator Date: 4-14-11

Address: POE Office Address Some City, KY 40011

Phone: 1-800-000-0000 Fax: 502-111-2222

Send form to: **Family Share Administrator**  
**Department for Public Health, Division of Maternal and Child Health**  
**First Steps**  
**275 E. Main Street, HS2W-C**  
**Frankfort, KY 40621**  
  
or FAX to Family Share Administrator at: (502)564-0329

**For Office Use Only**

Date received: \_\_\_\_\_ Approved:  Yes  No Signature \_\_\_\_\_

The cost of printing was paid from state funds through the Department for Public Health, First Steps program pursuant KRS 57.375





275 East Main Street, HS2W-C  
Frankfort, KY 40621

Rev. 3/2011

Phone: (502)564-3756

Fax: (502)564-0329

**FAMILY SHARE INABILITY TO PAY EXEMPTION REQUEST**

Child's Name: Test Child TOTS ID #: 55555

**SECTION A: EXTRAORDINARY EXPENSES WORKSHEET**

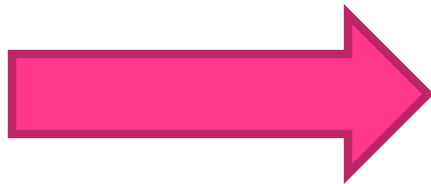
(Identify on average, "out of pocket" expenses, such as purchases, expenses, and modifications to accommodate extended/additional needs related to child's disability, and expenses related to other family members with disabilities or require extended care, such as elderly. These considerations do not extend to medical services for other family members. If more than one child is enrolled in First Steps please complete an individual Exempt Request for each child.)

EXPENSE	Eligible Child ANNUALIZED	Other Family Member ANNUALIZED
Current Hospital/Medical Payments		N/A
Child Care Special Cost (difference related to disability) <i>Include Written Documentation</i>		N/A
Materials, Supplies, Modifications related to disability		
Specialized Equipment		
Medical/Health Services – related to child's disability		N/A
Special Medications		N/A
Special Food Supplements		
Transportation/Parking Cost related to disability		N/A
Health Insurance Premiums (amount not paid by employer)		N/A
Co-payments or sliding fee payments for services related to the disability		
Other:		
<b>TOTAL ANNUAL EXTRAORDINARY EXPENSES</b>	<b>a. \$</b>	<b>b. \$</b>
<b>GRAND TOTAL ANNUAL EXPENSES (a. + b.)</b>	<b>\$</b>	

Parent/Guardian's Signature: \_\_\_\_\_



## SECTION B: ADJUSTED INCOME AMOUNT WORKSHEET



	\$ _____	Annual Income (TOTS Financial Screen)
- (minus)	\$(-) _____	Grand Total Annual Expenses (Section A)
=	\$ _____	Adjusted Income
	\$ _____	New Family Share Monthly Obligation
	_____	New Family Share Category

Apply adjusted income with household size to determine new Family Share monthly obligation.  
Approval may only be granted for three [3] calendar months at a time.

Service Coordinator's Signature: Paula Coordinator

**MAIL TO: Family Share Administrator, Department for Public Health, Maternal and Child Health Improvement - First Steps, 275 E. Main Street - HS 2WC, Frankfort, KY 40621 or FAX to the Family Share Administrator at 502-564-0329.**

For Office Use Only

Date Received: \_\_\_\_\_

Approved: Yes \_\_\_\_\_ No \_\_\_\_\_

Signature: \_\_\_\_\_

Approved for Months of \_\_\_\_\_

# Public Health Insurance: MEDICAID



# Public Health Insurance: MEDICAID

- Families potentially eligible for Medicaid are encouraged to apply for this benefit
- Medicaid coverage is monitored and families are urged to re-apply if coverage lapses
- Families who do not reapply for Medicaid are charged the maximum Family Share amount-\$100/month

# Private Health Insurance

- Families must give written consent for use of private insurance to pay for early intervention services



- The consent is voluntary and can be revoked by the parent at any time

# BENEFITS:

## Private Health Insurance

- ◉ No annual or lifetime cap limitations
- ◉ No co-pay or deductible paid by the family
- ◉ No partial payments due to the provider
- ◉ Claims for early intervention services may be applied towards the annual deductible

# Providers:

# PRIVATE HEALTH INSURANCE

- In cases where insurance pays less than the First Steps rate for the service, First Steps pays the provider the difference



- Providers can become in-network with an insurance company and negotiate a payment rate higher than the First Steps rate

# Private Health Insurance

- Parents who do not give consent for use of insurance will receive the services that must be provided at no cost:
  - Service coordination;
  - Screening;
  - Evaluation and assessment;
  - IFSP development; and,
  - The provision of procedural safeguards

# Private Health Insurance: Services Without First Steps

- ◉ Navigate insurance and identify service providers on your own
- ◉ No guarantee that service provider will have B-3 experience
- ◉ Clinic or hospital for services
- ◉ Little or no participation in therapy
- ◉ Incur out-of-pocket costs—
  - ◉ Co-pays
  - ◉ Deductibles
  - ◉ Costs not covered by insurance
  - ◉ 100% of costs when annual cap met

# DUAL COVERAGE-

Medicaid

and

Private Insurance



- Medicaid rules require that private insurance be billed first—parents agreed to this when enrolling in Medicaid

# QUESTIONS?

[chfs.firststeps@ky.gov](mailto:chfs.firststeps@ky.gov)

Or call:

1-877-417-8377

1-877-41 STEPS



# UPCOMING EVENTS

- Webcast #3: April 20, 2011
  - Policy and Procedure:
    - Chapters 5-8
  
- Webcast #4: May 4, 2011
  - Policy and Procedure:
    - Chapters 9, 10, Records, Provider Guidelines
  
- Webcast #5: May 18, 2011
  - Policy and Procedure:
    - Forms and Templates

