

**PM FORM 3.4.1  
Non-Title XIX/XXI Co-payment Assessment**

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Instructions: Complete this form for all Non-Title XIX/XXI persons. Provide a copy to the person, parent or legal guardian.

**Name:**

**I. Person's Family Household Size and Income**

A. Size of person's family household (Family consists of: Applicant; parent(s) of a minor child; spouse; natural child, adoptive child and stepchild under 18 years of age or 19 if full time student):

B. Gross monthly family income (includes the gross family income; as family is defined in A.):

C. Third party liability coverage:  Yes  No

**II. Sliding Co-payment Schedule**

Circle: 1) family household size, 2) gross monthly family income, 3) the co-payment.

Size of Family Household by Gross Monthly Family Income									Co-payment based on type of service provided*		
1	2	3	4	5	6	7	8	9	S/R	T/M/D	R/I
<\$1040	<\$1400	<\$1760	<\$2120	<\$2480	<\$2840	<\$3200	<\$3560	<\$3920	\$0.	\$0.	\$0.
\$1040- \$1214	\$1400- \$1634	\$1760- \$2054	\$2120- \$2474	\$2480- \$2894	\$2840- \$3314	\$3200- \$3734	\$3560- \$4154	\$3920- \$4574	\$1.	\$2.	\$15.
\$1215- \$1387	\$1635- \$1867	\$2055- \$2347	\$2475- \$2827	\$2895- \$3307	\$3315- \$3787	\$3735- \$4267	\$4155- \$4747	\$4575- \$5227	\$3.	\$6.	\$30
\$1388- \$1561	\$1868- \$2101	\$2348- \$2641	\$2828- \$3181	\$3308- \$3721	\$3788- \$4261	\$4268- \$4801	\$4748- \$5341	\$5228- \$5881	\$4.	\$8	\$45.
\$1562- \$1734	\$2102- \$2334	\$2642- \$2934	\$3182- \$3534	\$3722- \$4134	\$4262- \$4734	\$4802- \$5334	\$5342- \$5934	\$5882- \$6534	\$6.	\$10.	\$60.
\$1735- \$1907	\$2335- \$2567	\$2935- \$3227	\$3535- \$3887	\$4135- \$4547	\$4735- \$5207	\$5335- \$5867	\$5935- \$6527	\$6535- \$7187	\$8.	\$12.	\$75.
\$1908- \$2081	\$2568- \$2801	\$3228- \$3521	\$3888- \$4241	\$4548- \$4961	\$5208- \$5681	\$5868- \$6401	\$6528- \$7121	\$7188- \$7841	\$10.	\$20.	\$90.
>\$2,082	>\$2802	>\$3522	>\$4242	>\$4962	>\$5682	>\$6402	>\$7122	>\$7842	Full	Full	Full

\* S/R is Support and Rehabilitation Services, T/M/D is Treatment, Medical and Day Program Services, R/I is Residential and Inpatient Services. Co-payments for Mental Health Services Not Otherwise Specified (NOS) (Room and Board) may be established independent of the Sliding Co-payment Schedule consistent with [Provider Manual Section 3.4, Co-payments](#).

**III. Co-payment Assessment for Non-Title XIX/XXI Persons**

Based on the person's family household size, gross monthly family income and third party coverage in Part I, use the Sliding Co-payment Schedule in Part II to determine if the person is required to pay a co-payment for behavioral health services that are provided. Indicate below:

Person is not required to pay a co-payment.

Person is obligated to pay a co-payment of \$ \_\_\_\_\_ for S/R services, \$ \_\_\_\_\_ for T/M/D services and \$ \_\_\_\_\_ for R/I services.

Person has third party coverage and is obligated to pay up to \$ \_\_\_\_\_ for S/R services, \$ \_\_\_\_\_ for T/M/D services and \$ \_\_\_\_\_ for R/I services, not to exceed the un-reimbursed portion of the service cost.

The co-payment will create an undue hardship for the person or his/her family, and thus the following is being recommended (e.g., reduce or waive):

\_\_\_\_\_ Title:

Date: / /

Staff Signature

**IV. Agreement to pay co-payment**

I am certifying that the information provided in this document is true and correct to the best of my knowledge. If it has been determined that I will need to pay a co-payment for the provision of behavioral health services, my signature below also indicates that 1) the co-payment and the method for calculating my co-payment has been explained to me and 2) I am agreeing to pay the co-payment each time services are provided unless other arrangements have been made with the provider.

\_\_\_\_\_ Person/Parent/Legal Guardian Signature

\_\_\_\_\_ Date