St. Clair County Community Mental Health Authority

Financial Ability to Pay Agreement

Specialized Group/Foster Homes, Inpatient> 60 Days

Summary and Signature Page

As the responsible party for _____, ***Case #***_____,
I agree to the following statements: (Individual)

I certify that the information provided to St. Clair County Community Mental Health Authority (SCCCMHA) for the purpose of determining an ability to pay is correct, and I agree to notify St. Clair County Community Mental Health's Service Provider of any changes in this information during the course of treatment. I authorize payment directly to SCCCMHA for any insurance benefits to which I am entitled and authorize the release of information needed to process insurance claims. I agree to endorse over to SCCCMHA, within 10 business days, any reimbursement checks that may be sent to me. If I fail to do so, my account may be turned over to a collection agency.

I understand that I must pay the assessed Room and Board plus mental health service costs by the 5th working day of each month. At my discretion I may retain, on behalf of the individual, part or all of the Personal Allowance for the individual's needs, so long as there is not a licensing conflict.

☐ ***Monthly Payments (Non-HUD)***

I understand the Room and Board amount is $_____(current Personal Care Provider Rate) and should be paid directly to the Group Home Provider every month. I realize that the Personal Allowance is in addition to the Room and Board is $_____per month. A total of $_____is to be paid directly to the Group Home Provider every month effective _____.

In addition, the ability to pay for mental health services to be remitted to SCCCMHA has been determined to be $ _____per month effective _____.

~ OR ~

☐ ***Monthly Payments (HUD Only)***

I understand the Room amount payable to the HUD Designee is $_____and the Board amount to be paid to the Group Home Provider is $_____ for a total of $_____per month, effective _____. I realize that the Personal Allowance is in addition to the Room and Board, which is $_____per month.

In addition, the ability to pay for mental health services to be remitted to SCCCMHA been determined to be $_____ per month effective _____.

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I understand that failure to remit timely payment may result in the account being turned over to a collection agency and in rare cases, some or all services may be terminated. I understand that services will not be denied because of an inability to pay by the individual or responsible party, but may be denied for refusal to pay.

If the above ATP does not reflect my total financial picture and is causing an undue financial hardship, I may request a new determination to be completed based on new documentation that I have supplied. I have 30 days to appeal this determination in writing. If I am not satisfied with the new determination fee, I can request a hearing before the Hearing Officer in writing before thirty (30) days.

_____	_____	_____
Individual/Responsible Party Signature	Print Name	Date

_____	_____
Preparer Signature / Title	Date

cc: Individual/Responsible Party, Home Provider