CLIENT FINANCIAL RESPONSIBILITY SUPPLEMENTAL INFORMATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION
SFN 1088 (4-2016)

Clear Fields

Client Name	Client ID

_____ 1. Our fees are assessed according to a sliding fee scale, which is determined by family size and proof of income. This information will be required on an annual basis. Failure to disclose this information will result in you being charged full fee for services.

_____ 2. It is your responsibility to inform the human service center of any changes in income, family size, marital status, mailing address, telephone number, responsible party, insurance coverage changes, etc.

_____ 3. If the human service center does not have your current mailing address and you have a balance due on your account, your address on the billing statement will be reflected as No Forwarding Address and will result in your account being sent directly to collection.

_____ 4. A statement for services received will be generated on a monthly basis. All inquiries regarding the statement , should be directed to the Regional Human Service Center Accounts Receivable Department at 1-866-275-2007 or 701-328-7050, and follow the prompts.

_____ 5. Routine monthly payment on your account is required. If you wish to make arrangements to set up monthly payments on an account that has not yet been turned over to the collection agency, please call 1-866-275-2007 or 701-328-7050, and follow the prompts.

_____ 6. Your insurance company information is required to enable us to submit claims for services you receive. If you fail to provide your insurance company information (a copy of the insurance card or the name/address/telephone number/policy number), you will not be eligible for the sliding fee scale. It is your responsibility to comply with requirements from your insurance company, as requested. This includes obtaining referrals as needed, as well as providing updated information your insurance may require.

_____ 7. You may restrict disclosure of protected health information to your insurance company (health plan) when you pay full fee for services, regardless of any sliding fee discount you may have qualified for, by filing SFN 1980, "Request to Restrict the Use and Disclosure of Protected Health Information (PHI)" with the Human Service Center.

_____ 8. There may be services you receive or services provided by a provider which may not be covered by your insurance. You will be billed for these non-covered services or services by a non-payable provider according to the sliding fee discount you may have qualified for.

_____ 9. If you receive payment directly from your insurance company for services received at the human service center, and the Regional Human Service Center Accounts Receivable Department is unable to secure a copy of the Explanation of Benefits from your insurance company, you will be billed full fee for those services regardless of any sliding fee discount you may have qualified for.

_____ 10. Medicaid/Medical Assistance requires the client be seen for a brief evaluation by one of our licensed independent practitioners in order for us to be able to request reimbursement from Medicaid/Medical Assistance for services you receive, in compliance with Federal requirements. Failure to comply with this requirement will result in you being charged full fee for services, regardless of any sliding fee discount you may have qualified for. **NOTE: You are responsible for the full amount of any assessed Recipient Liability and/or Copay amounts as sliding fee scale discounts do not apply.**

_____ 11. Medicaid/Medical Assistance is the payer of last resort. All other insurances you have must be billed first. Failure to provide us with this information will result in you being charged full fee for services.

_____ 12. If you have Medicare, the sliding fee discount does **not** apply to coinsurance and/or deductible. You are responsible for the full amount and will be billed accordingly.

_____ 13. If you have a Medicaid Expansion Policy, the sliding fee discount does **not** apply to copay amounts. You are responsible for the full amount and will be billed accordingly.

_____ 14. I have received the following: SFN 143 - Civil Rights Complaint (10/2013); DN 900 - Notice of Privacy Practices (09/2013); DN 721 - Client Grievance Policy (10/2010); DN112 Patient Rights/Responsibilities (3/2015).

Signature of Client/Parent/Guardian	Date
Human Service Center Representative	Date