

CF OPERATING PROCEDURE
NO. 55-7

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, December 5, 2011

Financial Management

FEE ASSESSMENT AND COLLECTION

This operating procedure describes the policy and procedures for the assessment and collection of fees for services provided by the Department of Children and Families, primarily in residential facilities operated or funded by the department.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

SCOTT STEWART
Assistant Secretary for
Administration

SUMMARY OF REVISED, DELETED, OR ADDED MATERIAL

Added new paragraph 6-4c(1) entitled "Referral for Collection."

This operating procedure supersedes CFOP 55-7 dated October 6, 2009.

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DISTRIBUTION: X: OSES; OSGC; ASGO; ASFM; PDFS; SMS; SMF; Regional Directors; Region Fiscal Offices; Institution Administrators and Business Managers.

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Chapter 1

INTRODUCTION

1-1. Purpose. This operating procedure describes the policy and procedures for the assessment and collection of fees for services provided by the Department of Children and Families (DCF), primarily in residential facilities operated or funded by the Department.

1-2. Authority.

- a. Section 402.33, Florida Statutes (F.S.), "Department authority to charge fees for services provided."
- b. Section 402.17, F.S., "Claims for care and maintenance; trust property."
- c. Chapter 65-6, Florida Administrative Code (F.A.C.), "State Residential Treatment Facilities – Fee Collection System."
- d. Chapter 39, F.S., "Dependency Proceedings."
 - (1) Subsection 39.402, F.S., "Placement in a shelter."
 - (2) Subsection 39.521, F.S., "Disposition hearings; powers of disposition."

1-3. Background.

- a. Section 402.33, F.S., gives the Department the authority to charge fees for services with certain exceptions. It also provides that fees should be reasonably related to the cost of providing services and to the client's or responsible party's ability to pay. An additional stipulation is that the Department assists clients in securing third party benefits. Third party benefits shall be applied to the established cost of maintenance, supervision and care. If payments from third parties do not cover the total cost, the client or responsible party may be assessed a fee for the remaining cost.
- b. The legislature intended that, whenever practical, the Department would require the client, responsible party, and third party payers to participate in the cost of services provided by the Department. The legislature considered it essential that a plan be developed to offset the rapidly rising costs incurred by the state in providing social and rehabilitative services. The legislature also felt that many families wished to participate in the cost of care of family members.
- c. Prior to the implementation of Section 402.33, F.S., the mental health treatment facilities had their own fee programs.
- d. Chapter 39, F.S., provides for the circuit court to order parents of a child in emergency shelter or foster care to pay fees for the care, support, and maintenance of the child.

1-4. Principles.

- a. Based on their ability to pay, the client or responsible party shall participate in the cost of maintenance, supervision, and care.
- b. The fee assessment process considers the following:
 - (1) Certain family expenses remain constant regardless of the absence of one or more members of the family;

(2) The client is entitled to a share of the family income, as expenses would be incurred on the client's behalf if the client was living at home; and,

(3) The family members remaining at home require a level of income which is sufficient to take care of basic needs.

c. No person or estate should be unjustly enriched or make a profit at the expense of the Department. A client or responsible party who collects third party benefits and retains these funds for personal use, or diverts these funds to savings or investments, has wrongfully profited at the expense of the Department.

1-5. Definitions. For the purposes of this operating procedure, the following definitions shall apply:

a. ASFM. The Office of Financial Management.

b. Benefit Payments. Cash payments from retirement, survivors or disability insurance, or from supplemental security income programs. This includes but is not limited to payments from Social Security, Veterans Administration, and Railroad Retirement. A personal allowance, not to exceed \$100 per month, should be provided to the client from client benefit payments before using the balance to offset cost of care. Benefits received by the Department in excess of cost of care shall be deposited into the individual client's trust account.

c. Child Support Collections. Court ordered child support payments made for the benefit of a client in residential care. These payments should be treated similar to benefit payments received on behalf of a client, except that a personal allowance is not required to be deducted from such income before applying amounts to cost of care. Child support payments received in excess of cost of client care shall be deposited into the individual client's trust account.

d. Client. Any person receiving services provided or purchased by the Department including supervision, care, and maintenance, but not as a licensee subject to regulation by the Department for purposes of licensure. Clients include, but are not limited to, forensic, incompetent, voluntarily or involuntarily committed persons.

e. Client Trust Fund. An account established for the purpose of accepting and administering in trust any money received for personal use or benefit of a client, such as parent contributions, interest, child support payments, or benefit payments received in excess of cost of care. Any income received by the Department in excess of cost of care should be deposited into the individual client trust account. Departmental client trust funds shall be administered in accordance with DCF Accounting Procedures Manual, 7 APM 3 and 7 APM 6.

f. Cost of Care. The actual cost of residential care, including any supplemental payments made. This amount should be verified using information systems that would provide the actual cost of care. For state facilities, the established per diem rate is the daily cost of care and must be multiplied by the number of days in care for a month to use in making fee assessments.

g. Cost of Service. The average cost of providing a service to a client. This includes direct and indirect costs.

h. Dependent. The definition used by the Internal Revenue Service (IRS) that should be used as a guide when determining the appropriateness of dependents listed on form CF 280, Maintenance Fee Information (available in DCF Forms). There may be instances when it is justifiable to go beyond the limits of the IRS definition.

i. Direct Costs. Those costs which are traceable to the unit providing service.

j. Direct Service Worker. The counselor, case manager, or social worker who has primary responsibility for providing social or case management services to the client, or other direct service staff as assigned.

k. Distinct Part (DP). The Medicaid certified psychiatric section of mental health treatment facilities.

l. Fee Collection Unit. The unit at the region, circuit, lead agency or institution responsible for collection of fees. Wherever used in this operating procedure, the term fee collection unit applies to region, circuit, community based care (CBC) and institution fee collection units.

m. Fee(s). A fee charged to the client or responsible party as partial or total reimbursement to the state for maintenance of the client in a residential facility or for the cost of services, except where prohibited or limited by state or federal law or regulation. Also called maintenance fee, cost of care or service fee.

n. Fee Formula. The methodology used to determine the client's ability to pay fees for services or care. It is based on the client's income and expenses. This formula is used only for unmarried adult clients with no dependents.

o. Fixed Rate. An amount established by the Department based on a daily rate for services or required deliverables. The rate method is applied in the following programs: emergency shelter.

p. Gross Income. Income before any deductions. This includes: income from salaries; wages; commissions; tips; net rental and royalty income; net income from self-employment; alimony; pensions; annuities; gain from the sale of assets, in the years recognized for income tax purposes; capital gain distributions; public assistance or welfare payments; retirement or disability insurance payments; unemployment or workers' compensation; Social Security or Veterans Administration payments; interest; and dividends from stocks, bonds and other securities, or estates or trusts, including interest on client trust funds. The benefit payments (e.g., SSA, SSI, VA, Railroad Retirement) mentioned here are those received for member(s) of the family other than the client. Benefit payments received for the client are not considered part of gross income.

q. Indirect Costs. Those costs which benefit a unit providing a service, but are not traceable to that unit.

r. Net Income. Gross income less federal, state or local payroll taxes (income and Social Security). Deductions for payroll savings plans, bond purchases, or contributions to retirement systems may not be used to determine net income.

s. Office of Financial Management (ASFM). The Headquarters office responsible for the program and system for maintenance fee collection.

t. Office of Software Maintenance and Development (ITSSM). The Headquarters office responsible for maintaining the automated Maintenance Fee Collection Accounts Receivable System (FMS).

u. Payer. The party responsible for payment of fees.

(1) First Party. The client.

(2) Second Party. The client's responsible party.

(3) Third Party. An individual or entity other than first or second party payers who are or may be liable to pay all or part of the cost of service. This may be an individual, institution, corporation

or public or private agency, but does not include any program sponsored or supervised by the Department.

v. Per Diem Rates. The daily rate for cost of residential care at the various Departmental facilities. The Legislature generally sets the ranges of rates for community based programs. Facilities must, at least annually, establish per diem rates in accordance with Volume 4, DCF Accounting Procedures Manual, Chapter 4 (4 APM 4), for non-Medicare/Medicaid certified units or facilities.

w. Personal Allowance. Funds set aside from benefit payments, not to exceed \$100 per month, to provide for the client's personal expenses. Each program area and facilities has procedures for establishing the standard amount and for utilizing personal and incidental allowances.

x. Representative Payee. An individual or entity acting on behalf of the client as a receiver of any or all benefits owing to the client.

y. Residential Facilities. Includes hospitals, institutions, foster homes, group homes, child care facilities, and other establishments which provide 24 hour care and are either operated or funded by the Department for the provision of residential services to clients of the Department.

z. Residential Services. Those services for maintenance, supervision and care provided, contracted or purchased by the Department for clients in residential facilities; also called residential care.

aa. Responsible Party. Any person legally responsible for the financial support of the client, and may include a minor client's natural or adoptive parent(s), a client's spouse, an estate or trust established for the financial support of the client, but not a payer of third party benefits.

bb. Service. Aid, assistance or goods provided or purchased by the Department, either directly or through its agencies or contractors, including, but not limited to treatment, counseling, therapy, training or residential care.

cc. State and Federal Aid. Cash assistance or cash equivalent benefits based on an individual's proof of financial need, including Temporary Cash Assistance (TCA) and Food Stamps.

dd. Third Party Benefits. Any payments received or owing to the client, responsible party, or the Department as reimbursement for the cost of services provided by the Department. Such benefits include, but are not limited to, commercial insurance, Civilian Health and Medical Program of the Uniformed Services or of the Veterans Administration (CHAMPUS/ CHAMPVA), Medicare, and Medicaid. A personal allowance may not be provided a client from third party benefits. Cash benefits, such as SSA, SSI, and VA, are referred to in this operating procedure as benefit payments, to distinguish them from third party benefits as defined in s. 402.33(1)(h), F.S.

1-6. Scope.

a. Programs Subject to Fee Collection. Fees are assessed clients receiving residential care in the following facilities and receiving non-residential services from the following programs:

(1) Mental Health Treatment Facilities (MHTF).

(a) Florida State Hospital (FSH), Chattahoochee;

(b) GEOCare/South Florida State Hospital (SFSH), Pembroke Pines;

(c) Northeast Florida State Hospital (NEFSH), MacClenny;

- (d) North Florida Evaluation and Treatment Center (NFETC), Gainesville;
- (e) South Florida Evaluation and Treatment Center (SFETC), Miami.
- (f) West Florida Community Care Center;
- (g) Treasure Coast Forensic Treatment Center; and,
- (h) Florida Civil Commitment Center.

(2) Community Based Programs (CBC).

(3) Family Safety Programs (FSP).

- (a) Emergency shelter;
- (b) Non Title IV-E foster home care for children;
- (c) Non-psychiatric residential group care;
- (d) Non-Title IV-E adoption subsidy program;
- (e) Psychiatric residential group care (FSP and ADM dual eligibility);

(f) Agency for Persons with Disabilities (APD) residential care for FSP client (FSP and APD dual eligibility).

b. Persons Subject to Fee Collections. Liability for the payment of fees extends to clients, their responsible parties and third party payers as described in chapter 3 of this operating procedure.

1-7. Region/Facility Internal Procedures.

a. In accordance with CFOP 5-2, regions/circuits/lead agencies or facilities may write specific procedures which expand on this operating procedure. Regions/circuits/lead agencies or facility specific procedures may not impose additional requirements or forms on the public (clients, responsible parties) beyond those specified in Chapter 65-6, F.A.C. These procedures also cannot supersede relevant Florida Statutes, Florida Administrative Code, and Medicaid and Medicare regulations.

b. The regional director or circuit administrator may re-assign responsibility for any of the procedures described in this operating procedure.

Chapter 2

RESPONSIBILITIES

2-1. Introduction. For the fee collection program to succeed, there must be cooperation and coordination of efforts between regions/circuits/lead agencies and institution legal counsel, and ASFM. Coordinated efforts are required in order to identify third party benefits and benefit payments and other income to assist in fee collection activities, to expedite delinquent fee collection activities, and to provide assistance to the fee review committee.

2-2. Direct Service Staff. The direct service worker makes the initial contact with the client and, therefore, is to advise the client and/or responsible party of the responsibility of sharing in the cost of care for residential placements. As a corollary, direct service staff should also gather financial information regarding the client and/or responsible party to forward to the regions/circuits/lead agencies for determination of fee assessment and collection.

NOTE: In instances where the client does not have a direct service worker assigned for case management purposes, staff responsible for coordinating residential placement for the department are responsible for the direct service worker functions.

a. For new clients, the direct service worker must:

(1) Identify responsibility for payment in accordance with chapter 4 of this operating procedure.

(2) Inform the client and/or responsible party of the state law and departmental policy which requires the assessment and collection of fees.

(3) Assist the client and/or responsible party in identifying possible third party benefits and benefit payments (SSI, SSA, VA, commercial insurance, Medicare, etc.).

(a) Referring the client and/or responsible party to SSA office, or requesting that a representative of the SSA office visit the client and/or responsible party; or,

(b) Informing the client of the documentation needed to apply for benefits, such as Social Security cards, birth, marriage and death certificates, etc; or,

(c) Applying for benefits or applying to be representative payee of benefits when the department has legal custody of the client in residential care or where another appropriate representative payee is not available.

(4) Assist the client and/or responsible party in completing form(s) required by the department.

(5) Assist the client and/or responsible party in documenting severe, unusual and/or unavoidable circumstances that could result in a lower fee assessment.

(6) Inform the client/responsible party of the right to have the assessed fee reviewed.

b. Notice of Admission and Admission Package. It is the responsibility of the direct service worker to notify the fee collection unit within seven (7) working days of the admission of a client into care. The admission package for clients entering residential care should include the following:

(1) Form CF 281, Admission and Movement Record (available in DCF Forms), or form CF-ES 2626A, Child in Care Title IV-E and Medicaid Application (available in DCF Forms), or another

approved program or institution specific form. The form is used to notify the fee collection unit of the admission of the client, of demographic data on the client, and of the specific location of the client in care.

(2) Form CF 280, Maintenance Fee Information (available in DCF Forms) or other approved program or institution specific form (such as form CF-ES 2626A, which is used as a substitute for forms CF 280 and 281 for initial placements of children in foster care). This form provides detailed financial information on the client and any other person or entity responsible for the client's care and is used as a basis for determining liability for paying fees.

NOTE: Since the completion of the financial information form is the first and most important step in the fee collection process, every effort will be made to include a completed form CF 280 (or approved substitute form) in the admission package for programs where fees are assessed. In out-of-circuit placements in community programs only, this form will be completed by the sending circuit at the time that the placement decision is made. In cases where the client has no responsible party and is incapable of completing the form CF 280, the direct service worker should assist the client in completing the form as needed.

(3) Documentation of having identified potential benefit payments or third party benefits, either by using a checklist or by utilizing information obtained from the financial information form. Copies of any application for benefits should be attached. In children and family services foster care programs, a copy of checklist shall be attached.

(4) For emergency shelter and other children and family services programs, relevant court orders setting the amount to be paid, court orders placing the child in the custody of the department, or court orders setting an amount of child support to be paid (divorce, paternity, etc.) should be attached.

c. For clients in community residential placements, it is the responsibility of the direct service worker to perform the following activities:

(1) Notify the regions/circuits/lead agencies, within seven working days of transfers, deaths, discharges, or permanent commitments of clients in programs where fees are assessed using form CF 281, Admission and Movement Record, or form CF-ES 2694, Child in Care Eligibility Review and Change Report (available in DCF Forms), or another approved form.

(2) Assist in the completion of the annual review of form CF 280 or form CF 280A, Maintenance Fee Information – Short Form (available in DCF Forms), as appropriate. In the case of an adult unmarried client or a client in foster care, if there is knowledge that the client's financial condition has not changed or the department is representative payee for all eligible benefits, the fee collection unit will continue collection of the client's or responsible party's current fee or will adjust the fee for any changes in benefits if necessary. The direct service worker may sign a Maintenance Fee Information – Short Form (form CF 280A) certifying that the information on file has not changed except as noted on the form.

d. For clients in institutional residential placements, institutional fee collection staff generally assumes responsibility for obtaining and updating financial information and for filing to be representative payee of benefit payments when appropriate.

e. For clients with individual trust fund balances, direct service staff should be managing the funds and ensuring that a client does not accumulate excess resources that would make that client ineligible for benefits such as SSI and/or Medicaid coverage.

2-3. Fee Collection Unit. Fee collection units were established to implement Section 402.33, F.S. The units are located in each DCF region/circuit/lead agency and in most facilities. These units are under the direction of the regional director, hospital administrator or institutional superintendent. Specific duties are as follows:

- a. Follow-up with client or responsible party to obtain form CF 280, Maintenance Fee Information, if necessary (see attachment 1 to this chapter for a suggested letter format, or make personal contact);
- b. Those units that utilize the Fee Maintenance System will assess, bill, and collect fees in accordance with CFOP 55-10 (Web-Based Fee Maintenance Accounts Receivable System), and with the DCF Accounting Procedures Manual;
- c. Ensure that only the cost of care (or service) is recouped and that any amounts collected in excess of cost of care are deposited into the individual client's trust account;
- d. Assist the direct service worker or client or responsible party with the identification of and application for third party benefits and/or benefit payments;
- e. Assist in the management and accounting for benefits when the department is representative payee of those benefits, including ensuring that a personal allowance is provided to the client before applying amounts to cost of care;
- f. Refer child welfare/community based care foster care cases to the Department of Revenue's (DOR) local child support enforcement unit for collection of child support and for the recoupment of unreimbursed cost of care amounts;
- g. For appropriate cases, initiate collection efforts on past due and delinquent accounts prior to referral to legal counsel in accordance with chapter 6 of this operating procedure;
- h. Refer delinquent accounts to region/circuit/lead agency or institutional legal counsel for legal action as appropriate (children and family services cases are referred to the DOR child support enforcement unit);
- i. Perform a monthly review of delinquent account records to determine if new information, such as a finding of financial resources or location of the responsible party, indicates that collection is feasible;
- j. Coordinate with legal counsel to file a lien against the client or responsible party (legal counsel must approve the legality and appropriateness of the Notice of Lien);
- k. Prepare the necessary documentation to write off uncollectible accounts as stated in paragraph 6-6 of this operating procedure;
- l. Provide training in fee collections to all regional staff as needed; and,
- m. Ensure that copies of the client's Maintenance Fee Information (form CF 280 or other approved substitute form) and other relevant fee collection file information are sent to the fee collection unit in the region or institution of financial responsibility when a transfer occurs.

2-4. Legal Counsel. Legal counsel and the region/circuit/lead agency must work closely together to collect fees successfully. Legal counsel should assist and coordinate collection efforts with other legal counsel to more effectively collect delinquent accounts as necessary. At a minimum, legal counsel should perform the following activities.

a. Review delinquent accounts referred by the region/circuit/lead agency to determine the appropriate legal action for enforcement. Legal action may include but is not limited to:

(1) Following procedures in 402.17(1), F.S., to obtain amounts for care and maintenance as appropriate for clients with assets;

(2) Seeking a judgment;

(3) Reviewing and approving a lien against the client or responsible party, and then filing the lien, if approved;

(4) Filing a caveat; and,

(5) Entering suit to enforce financial information requirement as required by Section 402.33 (6)(b), F.S.

b. Review appropriate documents and sign required documents to notify the client or responsible party of the type of action intended, no later than fifteen days after receipt of client's file from the fee collection unit.

c. Initiate legal action if payment or agreement for settlement is not received within thirty days of such notification.

d. Notify the region/circuit/lead agency of the status of referred accounts and provide copies of any correspondence affecting the case.

e. Provide technical assistance to the fee collection unit on legal issues.

2-5. Office of Financial Management (ASFM). The Office of Financial Management has been established as the Headquarters office responsible for the maintenance fee collection program. Specific duties are as follows:

a. Provide administrative direction, support, and technical assistance to the regions/circuits/lead agencies and Headquarters entities concerning the department's fee collection program.

b. Monitor the fee collection program.

c. Develop mechanisms and procedures to collect, record and report fee collections.

d. Determine and recommend desired changes in state law and Florida Administrative Code required to facilitate departmental fee collection efforts.

e. Promulgate rules and regulations regarding the maintenance fee collection program.

f. Determine annual interest rate from the State Treasurer and notify the Office of Information Technology Services to program the new interest rate into the accounts receivable system for delinquent accounts.

2-6. Inter-Region Placements. A region/circuit/lead agency transferring a client to a facility which is in the jurisdiction of another region/circuit/lead agency may not assess or collect fees as the sending region/circuit/lead agency. Financial responsibility rests with the region/circuit/lead agency that has jurisdiction over the facility or institution in which the client is placed, unless special arrangements are made that are approved by both regions/circuits/lead agency or institutions.

SAMPLE LETTER FORMAT
(use letterhead paper)

Date: _____

Client Name _____

Facility/Program: _____

Cost of Care _____

Date Admitted: _____

Dear

The Department of Children and Families is authorized by law to charge fees to help cover the cost of services provided to its clients. If a client is unable to pay the cost of care, others who are legally liable for the support of that client are responsible for paying the fees. Individuals with legal responsibility are: husband or wife; parents of a minor child; and legal guardians.

The department is also authorized to accept payment in an amount less than the actual cost of care, if it is determined that payment of actual cost would create a hardship for the responsible party. In order to determine your ability to pay and assess an appropriate fee, we must have some basic financial information.

Please complete the attached Maintenance Fee Information form and return it to us within thirty (30) days of receipt of this letter. If we do not receive this information, you may be charged the full cost of care until the completed form is received.

If you have any questions or need assistance in completing the form, please call me at _____.

Sincerely,

Fee Collection Manager

Chapter 3

ADMISSION PROCEDURES, REFERRAL TO FEE COLLECTION AND LOCATION ACTIVITIES

3-1. Admission Procedures – General. When a client is admitted to residential care, the direct service worker has the responsibility for notifying the fee collection unit of the admission on a timely basis. This notification is necessary in order for the department to promptly bill the parties liable for payment of fees and to be aware of any benefit payments that should be received by the department. Delays in notifying the fee collection unit of a placement could cause loss of revenue to the department.

3-2. Admission Forms. The following are the forms to complete for admission, referral to fee collection, and updating of information.

a. Admission and Movement Record (form CF 281, available in DCF Forms).

(1) The direct service worker shall notify the fee collection unit within seven (7) working days of a client's admission, transfer, death or discharge. (An exception exists in institutional programs.) Notification shall be on the Admission and Movement Record (form CF 281) or on a substitute form approved by ASFM. The Admission and Movement Record must not be delayed pending additional information for completing the Maintenance Fee Information form (form CF 280 [available in DCF Forms] or approved substitute) but should include information on the status of the Maintenance Fee Information form.

(2) In community programs, it is important that the direct service worker notify the fee collection unit on a timely basis of any change in admission status, such as transfer, death or discharge, using the same form CF 281 (or substitute form).

(3) For FSP programs, form CF-ES 2694, Child in Care Eligibility Review and Change Report (available in DCF Forms), can be used in place of form CF 281.

(4) For FSP Foster Care programs, FLORIDA referral forms used to determine client eligibility for Title IV-E and Medicaid benefits can substitute for form CF 281 and form CF 280, Maintenance Fee Information.

b. Maintenance Fee Information (form CF 280, available in DCF Forms). The direct service worker is the person responsible for providing the Maintenance Fee Information form (or approved substitute form) to the client or responsible party and assisting in its completion.

(1) In appropriate cases, the direct service worker shall provide a Maintenance Fee Information form (or approved substitute) and instructions for its completion to the client or responsible party at the time a person applies for services and becomes a client or is admitted to a residential facility, preferably in a personal conference.

(2) The direct service worker or a person designated by the regional director, hospital administrator or institution superintendent shall assist the client or responsible party in completing the form and shall inform him that:

(a) The form must be completed and returned to the department within 30 days of its receipt.

(b) The form will be used to determine ability to pay fees for cost of service. (The cost of service is the institution's rate or the rate paid the contract provider by the department for cost of care.)

(c) If the client or responsible party do not complete the form, he or she may be billed for the total cost of service. (If verifiable information is later received, an adjustment in billing may be done retroactive to admission.) However, the form does not have to be completed if the client or responsible party agrees to pay the cost of service (less benefits applied) as stated in Part II of the form, and documents this agreement by signing in the space provided in Part II.

(3) If the responsible party is not present at the time the client is admitted for services or the client is unable to complete the form, the direct service worker or the fee collection unit may deliver or mail a blank form to the client or responsible party within 10 days of the client's admission for services. This includes an explanation that a completed and signed form must be returned to the region fee collection unit within 30 days of receipt in order to avoid being billed for the total cost of service. The direct service worker may contact the fee collection unit for assistance, if necessary.

(4) Follow-up for completion of the form should be by the most effective means determined jointly by the direct service worker and the fee collection unit, and may include:

(a) The direct service worker visiting the client or responsible party and assisting in the completion of the form;

(b) A representative of the business office or fee collection unit assisting in the completion of the form; or,

(c) If appropriate, the direct service worker or representative of the business or fee collection unit contacting the responsible party by mail or telephone (contact must be documented in client file).

(5) In children and family services programs, a form equivalent to the form CF 280 that is used by the DOR child support enforcement program will be completed by the direct service worker for parents of children placed in the custody of the department under Chapter 39. Currently, form CF-ES 2626A, Child in Care Title IV-E and Medicaid Application (available in DCF Forms), is being used.

(6) For the annual update required for an adult unmarried client, if there is knowledge or verification of the client's current financial condition available to the direct services worker or to the fee collection unit, the direct service worker (or fee collection staff member for institutional programs or region programs where the department is representative payee for all client benefits) can complete a form CF 280A (Maintenance Fee Information – Short Form, available in DCF Forms). The fee collection unit will assess fees based upon the information available.

c. Checklist for Third Party Benefits and Benefit Payments. The direct service worker should complete a checklist for third party benefits and benefit payments for every client that is admitted to the care of the department.

3-3. Admission Procedures – Benefit Payments. In community programs (in most circuits), the direct service worker is responsible for identifying all benefit payments for which a client is eligible and, in many cases, is responsible for applying for benefits on behalf of the department. In institutional programs, the fee collection unit applies for benefits where appropriate.

a. Family Safety (FSP) Programs.

(1) Non-Title IV-E Eligible Children.

(a) For a child placed in the custody of the department under Chapter 39, F.S., a checklist for third party benefits and benefit payments should be completed by the direct service

worker. The purpose of the checklist is to determine if the child is eligible for benefit payments such as SSA, SSI or VA, or to determine if a family member is already receiving benefits for the child.

(b) The direct service worker, on behalf of the department, must submit an application to the local Social Security Administration or Veteran's Administration office to apply for benefits for the child or to apply to be representative payee of any existing benefits for which the child is eligible. The direct service worker should contact the appropriate local federal agency on the procedures to follow in making application.

(c) All applications for benefits must reflect the local DCF Regional Office as the payee and reflect the local regional office address as the proper address for the direction of notices and payments.

(2) SSI Eligible Children.

(a) Direct service workers should monitor client trust fund balances to ensure that balances do not exceed the limit allowed for SSI eligibility.

(b) Medicaid cards will also be directed to the local regional office. Therefore, it is imperative that the direct service worker notify the regional fee collection unit on a timely basis of the placement of the child in order for fee collection staff to forward the Medicaid card to the child's residence upon receipt.

(3) Title IV-E Eligible Children. The Title IV-D Child Support Enforcement Program in the Department of Revenue (DOR) is charged with collecting child support for all Title IV-E children. The IV-D program transfers these collections by Journal Transfer to DCF Headquarters to use to offset or recoup the Title IV-E payments made for cost of care. The Title IV-D program has elected to be solely responsible for all collection activity related to Title IV-E children. Therefore, direct service workers do not generally apply for benefits in these cases.

(4) Emergency Shelter Care. In cases where the child is placed in emergency shelter care, generally the direct service worker does not apply for benefits until an adjudicatory or dispositional hearing is held which places the child in the custody of the department. However, in some cases, the department or someone else is receiving benefits for the child in question. Those benefits, less a personal allowance, can be used to offset the cost of care. If a parent or other relative is representative payee of benefits for the child, the direct service worker should request that the court order the payee to pay for cost of care from those benefits.

b. Mental Health Treatment Facilities.

(1) In most cases, fee collection staff applies for benefits or apply to be representative payee of benefits as appropriate. The institution fee collection unit in the fiscal office receives such benefits and applies them, less a personal allowance, to cost of care.

(2) There will be situations where the client or responsible party, who is already the recipient of client benefits, wishes to continue to receive client benefits. The direct service worker will notify institutional fee collection unit staff that will bill the client or responsible party for the amount of benefit, less the personal allowance, in accordance with chapter 5 of this operating procedure. The direct service worker has a responsibility for ensuring that the representative payee, who generally is retaining the personal allowance for the client, is participating in the client's day to day activities and providing for the client's personal needs.

3-4. Admission Procedures – Court Orders.

a. FSP Emergency Shelter Care.

(1) When a child is placed in emergency shelter care under Chapter 39, F.S., the court can order one or both parents to pay for the cost of care.

(2) The department cannot bill parents for cost of emergency shelter care unless the court has ordered the one or both parents to pay part or all the cost of emergency shelter.

(3) Because these are generally short term placements, the direct service worker usually requests the court to assess fees at the adjudicatory or dispositional hearing when either the child is being returned to the family or being placed in the custody of the department or being located in an alternative (e.g., relative) placement.

(4) If the court orders child support, it is important that the direct service worker forward a copy of the court order to the fee collection unit along with the other required forms so that proper billing can be done. The court may order a daily rate per child to be paid for the time the child is in emergency shelter care. It is also imperative that the direct service worker advise the fee collection unit of when the client was discharged from emergency shelter care.

b. Court Ordered Child Support.

(1) Court Ordered Child Support under Chapter 39, Florida Statutes.

(a) When a child is placed in the custody of the department under s. 39.41(2), F.S., the court is empowered to order one or both parents to pay child support for the child. If the direct service worker is not prepared to submit a recommendation for child support at the dispositional hearing, the attorney representing the department should reserve jurisdiction for the purpose of ordering support at another time.

(b) The direct service worker must forward to the fee collection unit a copy of the dispositional court order placing the child in the custody of the department.

(2) Other Court Ordered Child Support.

(a) The court may have already ordered a parent to pay support in, for example, a paternity or divorce proceeding. That court order has precedence in establishing the parent's liability to support a child. The department, as legal custodian of the child, has a right to receive such payments on behalf of the child while the child is in the care of the department.

(b) The direct service worker should inform the fee collection unit of any orders for support and, if possible, provide a copy of said order to the fee collection unit.

c. Other Court Ordered Commitments. In the case of a client placed in a residential facility by court order (other than as provided above in FSP programs), the direct service worker must ensure that the department's recommendation to the court includes a provision for the payment of fees.

(1) The recommendation shall be specific as to the person liable for fees and the amount. It should also address the use of benefit payments to offset the cost of services.

(2) A copy of the court commitment shall be transmitted to the fee collection unit.

(3) If the fee cannot be determined promptly, the recommendation to the court must include a statement such as:

“Fees shall be paid by _____ in accordance with the procedures established pursuant to section 402.33, F.S.”

(4) Refer to chapter 6 of this operating procedure for procedures regarding court ordered fees.

d. Court Ordered Alimony.

(1) If the court has ordered a spouse or former spouse to pay alimony for a client who is in one of the department’s residential facilities, the department is entitled to receive the alimony and apply amounts to cost of care.

(2) The direct service worker should inform the fee collection unit of any orders for alimony and, if possible, provide a copy of said order to the fee collection unit.

3-5. Referral to Fee Collection Unit.

a. The referral to the region or institution fee collection unit should be comprised of the following information packet:

- (1) Admission and Movement Record;
- (2) Maintenance Fee Information form on the client and responsible parties;
- (3) Checklist for potential third party benefits and benefit payments;
- (4) Copies of any applications for benefits made on behalf of the client; and,
- (5) Copies of any relevant court orders, especially in FSP programs.

b. After the initial referral is made to the fee collection unit, the direct service worker has the following responsibilities in community programs (for institutional programs, fee collection staff generally handles these responsibilities):

(1) The fee collection unit must be notified of any change in client status, such as a transfer, discharge or death.

(a) An Admission And Movement Record (or approved substitute form) must be submitted to the fee collection within seven (7) working days of a transfer, discharge or death of a client.

(b) Delays in notifying the fee collection unit of such changes could cause the misdirection of income received by the department in support of the client.

(2) Annually, an updated Maintenance Fee Information form should be completed and sent to the fee collection unit in most cases. For clients whose only source of income is benefit payments, form CF 280A can be used. In institutional programs, fee collection staff generally assume this responsibility. For regional programs where the department is representative payee of all client benefits, fee collection staff may assume this responsibility.

(3) For the annual update in financial information required for an adult unmarried client, if there is knowledge or verification of the client’s current financial condition available to the direct

services worker or to the fee collection unit, the direct service worker or fee collection staff member, as appropriate, can complete form CF 280A (Maintenance Fee Information – Short Form).

3-6. Receipt of Referral by Fee Collection Unit. Upon notification of admission, the fee collection unit should perform the following initial activities:

- a. Date stamp the referral.
- b. Determine if the referral is complete and set up the fee collection file.
- c. Place the file in suspense if insufficient information is available to collect fees. For example;

(1) If the Maintenance Fee Information form is not included with the referral, follow up should be done within 15 working days with the direct service worker or responsible party as appropriate to obtain the necessary information to make fee assessment.

(2) If the Maintenance Fee Information form is received but is incomplete or contains questionable data, follow-up should be made within 15 days by the most effective means as determined jointly by the direct service worker and the fee collection staff, if necessary.

(a) In instances where the direct service worker or fee collection staff member has located a responsible party whose address was previously unknown, the fee collection unit may mail a blank form CF 280 to the responsible party, if appropriate.

(b) When the completed form CF 280 is received, fee collection staff should assess the correct fee and bill retroactively to the date of the client's admission to the facility.

(3) Failure to Complete or Sign Form CF 280. If the client or responsible party fails to complete or sign the initial form within the required time frame, the fee collection unit may confer with region legal counsel. Legal action should be considered only after all other alternatives to obtain the needed information have failed. Legal counsel or the fee collection unit shall decide on one of the following alternatives:

(a) Bill the client or responsible party for the cost of services less reimbursements from third party payers; or,

(b) Enter suit to enforce the financial information requirement.

3-7. Income Verification. The fee collection unit shall verify any of the information reported on the Maintenance Fee Information form in accordance with the following procedures.

a. The income verification system of the Office of the Auditor General provides information regarding employers and wage earnings of clients or responsible parties by social security numbers. The FLORIDA system provides access to the income verification information available from the Auditor General's Office. Each fee collection unit has been provided information on obtaining clearance from region management systems staff to access the FLORIDA system. Each fee collection unit has been approved access to the system for inquiry purposes only. The information is confidential and should be guarded accordingly. The Region ACCESS/Economic Self-Sufficiency Services (ESS) Program Office can provide technical instructions on accessing the information in the system.

b. The Third Party Query System (TPQY) may be used to inquire regarding Social Security benefits. Fee collection units should contact their local SSA office for appropriate user codes and detailed instructions for TPQY system usage.

c. To verify income information, the fee collection manager may call the client or responsible party's employer and say "I work for DCF and would like to verify information that has been submitted to the department by _____." If there are any problems, or if the employer refuses to cooperate, say "Thank you" and end the conversation. Do not reveal that the subject of the inquiry is a client or responsible party.

3-8. Location Procedures. If the social security numbers of responsible parties are known, the income verification system described in paragraph 3-7 may be used to locate parties through employers. In addition, the following suggestions are useful for locating responsible parties or discharged clients. The fee collection unit shall also contact the direct service worker in an effort to update information on payer location.

a. Send a registered letter to the responsible party, return receipt requested, and deliver to addressee only, at all known previous addresses. If there is reason to believe that a responsible party may be residing in another city, but an exact address is unknown, send a letter addressed to the responsible party, "general delivery" for that city.

b. Write to the public utilities companies in the city where the responsible party was last known to reside.

c. Write to the Bureau of Registration Service, Division of Motor Vehicles, Department of Highway Safety and Motor Vehicles, Neal Kirkman Building, Tallahassee, Florida for information on file for a responsible party. Name, date of birth, social security number and last known address information should be supplied, if known.

d. Write to the state unemployment office if the social security number is known.

e. If the responsible party is in the military, the following are locator sources for the various branches of the military:

Army:.....	Personnel Service Support Center Fort Benjamin Harrison Indianapolis, Indiana 46249
Navy:.....	Commander Naval Military Personnel Command Washington, D. C. 20307
Marines:	Commandant of the Marine Corps - DGH Headquarters, U.S. Marine Corps Washington, D. C. 20380
Air Force:	USAF Military Personnel Center (ADPMDRA-ID) Randolph Air Force Base, Texas 78150
Coast Guard:..... and Merchant Marines:	Commandant U.S. Coast Guard Headquarters 2100 Second Street, S. W. G-PE Room 4412 Washington, D. C. 20593

NOTE: When requesting assistance from any of these sources, provide as much information as possible, such as: social security number, last duty station, rank, where individual enlisted, etc.

- f. If a responsible party has been, or is, in prison, write to the prison.
- g. If the responsible party has a history of mental illness, contact the state mental health hospitals.
- h. If the responsible party has gone to a community college or university, write a letter to the school requesting a current address.
- i. If the responsible party has ever been a member of a particular labor union, write the union giving them the name of the last known employer.
- j. If the responsible party has been on public assistance, contact the local assistance payments section.
- k. Request, in writing, a records check from the Florida Highway Patrol and appropriate county and city law enforcement agencies.
- l. The notation "Address Correction Requested" should appear (under the return address) on departmental envelopes mailed first class. If the mail is undeliverable, it will be returned to the sender at no charge, with the new address information and reason for non-delivery annotated on or attached to the envelope.

3-9. Annual Update of Maintenance Fee Information. The client or responsible party is required to submit a new Maintenance Fee Information form at least annually and submit any changes in gross income in excess of \$50 per month, any changes in benefit payments received, or any changes in dependents, if applicable, within 15 days of the change. If a change in income or benefits or dependents has been sent to the fee collection unit on a timely basis and no other changes have occurred during the year, a new Maintenance Fee Information form will not be necessary.

- a. The fee collection unit may notify the direct service worker at least 30 days prior to the end of the 12 month period that the client has been in a residential facility and that updated Maintenance Fee Information form (form CF 280) is needed.
- b. The form should be submitted within 15 days after the proper blank form is provided by the department. If the form is not returned within that time frame, the fee collection unit may effect delivery of another blank form by hand or certified mail and request a return within 15 days.
- c. If an updated form is not received by the fee collection unit, the fee may remain at the current level, unless updated or new information is available from other sources such as income verification inquiries, and Social Security inquiries. The fee collection unit should contact the direct service worker to determine if the client and/or responsible party's financial status has changed and if a revised fee assessment is warranted. This should be documented for the file as in paragraph e below.
- d. In the case of an adult, unmarried client or a client in foster care, if there is knowledge that the client's financial condition has not changed, the fee collection unit will continue collections of the client's current fee. The direct service worker may sign form CF 280A certifying that the client's form 280 is on file and that there has been no change in the client's financial status other than those changes noted on the form 280A. The statement should indicate the source, amount and payee of any benefit payments being received on behalf of the client.

e. The fee collection unit shall recompute the fee (if necessary) and notify the client/responsible party of any new fee assessment on form CF 285, Notice of Maintenance Fee To Be Charged (available in DCF Forms).

3-10. Confidentiality. The department is authorized by s. 402.33(6) (b), F.S., to verify financial information. This does not, however, permit the department to reveal the fact that a person is a client or responsible party. All care must be taken to ensure that confidentiality is preserved.

Chapter 4

FEE ASSESSMENT

4-1. Introduction. This chapter provides details on who is or may be liable to pay fees for client services. The types of income subject to fee assessment are also discussed.

4-2. Parties Liable for Fees. Liability for fees begins on the first day that services are provided and terminates on the next to the last day that services are provided to the client. [An exception exists in the handling of benefit payments for a deceased client. See paragraph 4-3a(6) of this operating procedure.] The direct service worker should clearly explain fee responsibility to the client or responsible party and specify who will be liable for fee payment as described below. The following shall be liable for the payment of fees for services or reimbursement for the cost of services:

a. First Party Payer – Client.

(1) Adult Clients. All client income is subject to fee assessment, with exceptions noted, in accordance with this operating procedure.

(2) Minor Clients. For minors, income available for the support of that minor, such as direct payments from parents, court ordered child support, and benefit payments and trusts, is subject to fee assessment. However, the minor cannot be directly held liable for fees owed. Client wages earned by a minor are not subject to fee assessment. Liens should not be filed in a minor's name.

b. Second Party or Responsible Party. This term means any person legally responsible for the financial support of the client and includes the following:

(1) Parents of a minor client;

(2) Spouse, regardless of the age of either party; and,

(3) Guardians, representative payees and trustees, not as individuals, but in their fiduciary capacity in handling benefit payments, trusts and estates established or received for the financial support of the client.

c. Third Party Payer. Third party payers include commercial insurers, workers' compensation, CHAMPUS/VA, Medicare and Medicaid.

(1) Third party payers are liable to the extent that they may be required by contract or law to provide or to participate in the cost of providing services to the client. For example, insurance companies are billed for the cost of service, but are liable for the amounts as described in the insurance policy.

(2) Third party benefits are not considered income to the client or responsible party, but when applied toward the cost of care they reduce the client's or responsible party's liability for the cost of services.

(3) Third party payers usually assist in funding residential treatment programs at institutional hospital settings, such as at state mental hospitals.

4-3. Client Income Subject to Fee Assessment.

a. Benefit Payments. These cash payments from the federal government (SSA, SSI, VA, etc.) made on behalf of the client are considered client income but require special procedures for fee assessment and billing because the payments are specifically designated to meet the current needs of

the client. The client may be entitled to these payments due to the client's own disability, blindness or age or entitled to payment as a dependent from a parent's disability, retirement, or death benefit.

(1) Benefit payments paid for the client, less a personal allowance, shall be applied to the cost of residential care. Any amounts collected in excess of the cost of care shall be placed in the individual client's trust account.

(2) Parties such as a parent or other relative may have been designated as representative payee by a federal agency and be receiving the client's benefit payments for the client. Fee assessment is the same as if the client was receiving the benefit directly.

(3) When a child is committed to the care and custody of the Department under subsection 39.41(2), F.S. (FSP foster care), the Department shall apply to be representative payee of any benefits for which the child may be eligible.

(4) If a client resides in a Medicaid certified Institutional Care Program (ICP) facility, Medicaid regulations generally should be used in making fee assessments.

(5) Any benefits a client receives for a spouse or dependent child shall not be considered as available to the client under this chapter. Benefits received by or for a spouse of a client shall be considered as part of the spouse's gross income that is used to determine that spouse's ability to pay for the client's cost of care.

(6) Death of a Client. If a client dies while in care, any benefit payment received for the month in which the death occurred must be returned to the granting agency.

b. Client Earnings.

(1) Under certain circumstances, client earnings are subject to fee assessment. Clients who are employed while in residential care and who earn minimum wage or above may keep monthly earnings of up to \$100. Of the remaining amount of earnings, the client may keep one third (1/3). Two thirds (2/3) of the balance of earnings (after social security and income tax deductions) shall be subject to fee assessment. Ability to pay is based on the client's disposable income after the following fixed and allowable expenses are deducted:

- (a) Rent on domicile;
- (b) Homestead payment;
- (c) Real estate taxes on homestead;
- (d) Utility payments;
- (e) Life insurance;
- (f) Automobile payments;
- (g) Automobile insurance;
- (h) Home insurance;
- (i) Health insurance;
- (j) Repayment of SSA/VA or other governmental overpayments;

(k) Transportation costs (mileage is allowed at the rate approved under state travel regulations);

(l) Uninsured medical expenses and uninsured casualty losses of such assets as housing or tools of a trade incurred by the client;

(m) Legal fees and court costs which are incurred for the benefit of the client for such purposes as restoration of competency; filing of reports by relatives, parents or guardians of estate or property; adoption; and other legal fees for which a client could normally be responsible; and,

(n) Maintenance on a home and major repairs on a home or major appliances or automobile which is a primary vehicle.

(2) Fees shall not be assessed on wages which are below the minimum hourly wage under the Federal Fair Labor Standards Act, nor against the wages of a minor client.

(3) Clients whose cost of service is being paid by the Medicaid program shall pay fees from client earnings in accordance with Medicaid rules and regulations to the extent that the earnings are based upon an hourly rate at or above the minimum under the Federal Fair Labor Standards Act.

(4) A client who was employed prior to admission and who has earnings as a result of that employment, such as from self-employment or sick or annual leave, shall be assessed on such earnings.

c. Court Ordered Alimony.

(1) If the court has ordered a spouse or former spouse to pay alimony for a client who is in one of the Department's residential facilities, the Department is entitled to receive the alimony and apply amounts to cost of care.

(2) The direct service worker should inform the fee collection unit of any orders for alimony and, if possible, provide a copy of said order to the fee collection unit.

d. Gross (Unearned) Income. Client gross income is defined as income from pensions, annuities, retirement or disability insurance payments (other than SSA, SSI, VA, Railroad retirement and Black Lung which are classified as benefit payments), unemployment or workers' compensation, alimony, net rental and royalty income, gain from the sale of assets (in the years recognized for income tax purposes), capital gain distributions, interest, dividends from stocks, bonds and other securities, and income from estates or trusts. Gross income is assessed and conditioned upon whether or not the client has other dependents to support.

4-4. Fee Assessment in Court Ordered Placements.

a. Placement in Emergency Shelter. Emergency shelter care is used when a child has been removed from home due to neglect or abuse.

(1) When a child is placed in emergency shelter care under Chapter 39, F.S., the court can order one or both parents to pay for the cost of care under s. 39.402(11), F.S.

(2) Because these are generally short term placements, Children's' Legal Services usually requests the court to assess fees at the adjudicatory or dispositional hearing when either the child is being returned to the family or being placed in the custody of the Department or alternative placement. Sometimes the court may order a daily rate per child to be paid for the time the child is in emergency shelter care.

(3) The CW/CBC referral to fee collection should include a copy of the court order and should include the number of days the client was in shelter care, if that information is available at the time of the referral.

b. Fee Assessment for Emergency Shelter. In order to assess fees to parents for emergency shelter care, the court must have ordered fees to be paid. If the court does not order one or both parents to pay fees (child support) for their child in emergency shelter, the Department cannot assess the parent's fees for emergency shelter care. (The Department can receive benefit payments for the child and apply to cost of care.) The fee collection unit must have a copy of the court order establishing the parent's liability to pay fees so that proper billing can be done. The fee collection unit shall collect fees directly from the parent unless the court order provides otherwise. A Notice of Maintenance Fee To Be Charged – Court Order (form CF 285C, available in DCF Forms) should be used to notify the parent or parents of their liability to pay fees to the Department. A copy of the court order should be included with the notice.

(1) If the court establishes one amount for the total time the client is in emergency shelter, a one time billing shall be set up in the accounts receivable system (if used), using revenue source "02", responsible party.

(2) If the court orders a daily rate to be paid for the time the child is in shelter care, the fee collection unit must determine the number of days the client was in shelter care for the month in order to set up the "02" account and to bill the parent each month the child is in care.

(3) If clients are in emergency shelter care more than two months, the fee collection unit should contact the FSP direct service staff regarding the status of the case. An adjudicatory hearing should have been held and the client placed in the legal custody of the Department by this time. Children placed in the legal custody of the Department are considered in the foster care program even if they continue to reside in an emergency shelter home.

(4) The Department cannot bill parents for cost of emergency shelter care unless the court has ordered the one or both parents to pay part or all the cost of emergency shelter.

(5) Benefit Payments. Benefit payments, such as SSA, SSI, or VA, should be used for the care and maintenance of the child in emergency shelter. If the Department or lead agency is representative payee of benefits or receives a lump sum retroactive benefit for the period of time the child is in emergency shelter, those benefits, less a personal allowance, must be used to recoup cost of care (any amounts received in excess of cost of care are placed in the client's trust account). If the fee collection unit becomes aware that the parent is representative payee of benefits for a child in emergency shelter care, notification should be sent to the direct service worker to request the court to order the parent or parents pay the Department for benefits received, less a personal allowance, up to the cost of care. (If the child is subsequently placed in foster care, the direct service worker should apply to be representative payee of benefits.)

c. Non-Title IV-E Foster Care Programs.

(1) Placement in Foster Care. If a child has been determined by the court to have been abused or neglected under Chapter 39, F.S., the court will determine if the child should remain in the home (or be returned to the home if the child was in emergency shelter) or whether alternative arrangements should be made for the child. If the court determines that it is in the best interest of the child to be placed in foster care, the child will be placed in the temporary legal custody of the Department.

(2) Funding for Foster Care. Various types of funding are available to pay for cost of care. Fee assessment may differ depending upon the source of funding. Fee collection staff can

determine the source of funding by examining the expenditure type code used to pay cost of care. Refer to 3 APM 2, Appendix A, Child Welfare Services.

(3) Title IV-B Foster Care. Foster care programs not funded from Title IV-E grant funds are generally classified as "Title IV-B" programs. Most of the funding for these programs is state general revenue. Most foster care programs are considered "Non-Title IV-E" if not specified otherwise. Fee collection units collect fees and refer cases to Department of Revenue Child Support Enforcement units to recoup general revenue funds paid for cost of care for these programs. Child Support Enforcement classifies these cases as "NA (Non Public Assistance) Foster Care."

d. Title IV-E Foster Care. This program is intended to fund foster care for children who have been removed from families who would have been eligible for Temporary Cash Assistance (TCA) if they had applied. The revenue maximization specialists determines whether to claim Title IV-E federal grant funding for an eligible child or receive SSI if a child is eligible for both. (If SSI is chosen, the case should be classified as IV-E/non-reimbursable.)

(1) Florida received federal approval of the first statewide waiver providing flexibility for foster care funds in March 2006. The U.S. Department of Health and Human Services' Administration for Children and Families (ACF) authorized the five-year waiver under Title IV-E of the Social Security Act, allowing Florida to demonstrate that flexibility in funding will result in improved services for families.

(2) The waiver allows federal foster care funds to be used for any child welfare purpose rather than being restricted to out-of-home care as generally required under federal law. It also enables funds to be used for a wide variety of child welfare services including prevention, intensive in-home services to prevent placement of children outside the home, reunification and foster care. Refer to CFOP 175-71, "Title IV-E Foster Care and Adoption Subsidy."

(3) Fee Collection Units are NOT responsible for collecting fees (child support) for Title IV-E cases, sometimes referred to as "AFDC (Eligible) Foster Care".

(4) Revenue maximization units refer potential Title IV-E cases to ACCESS/Economic Self-Sufficiency (ESS) Child In Care (CIC) units to determine eligibility for Title IV-E funding. If CIC determines the case to be eligible for Title IV-E funding, CIC will refer the case directly to a DOR Child Support Enforcement unit to collect child support.

(5) The Department of Revenue (DOR) Child Support Enforcement Program (CSE) has the responsibility for collecting child support in Title IV-E foster care programs and for transmitting collections directly to DCF Headquarters to be deposited in the Federal Grants Trust Fund.

(6) Collections are used to recoup Title IV-E and possibly Title IV-A payments (AFDC), and are used to reduce claims for reimbursement of grant funds from the federal government.

(7) CSE also classifies these Title IV-E foster care cases as "PA (Public Assistance) Foster Care."

e. Non-Title IV-E Adoption Subsidy Program. Some children in foster care are subsequently determined to be eligible for adoption subsidy. The court has severed parental rights or the parents have signed a release for the child to be adopted. The Department has programs where potential adoptive parents receive a subsidy to assist them in caring for the child. Prior to the adoption being finalized, the Department can recoup cost of care from sources available to support the child, such as benefit payments. The Department will not collect child support from parents when the child is in the adoption placement program. (In addition, after the adoption is finalized, no further fee assessment is done from benefit payments even if the adoption subsidy is continued.)

f. Fee Assessment for Non-Title IV-E Programs. Revenue maximization staff submit referrals directly to the local fee collection unit. Fee collection units will not assess fees directly against parents in foster care. Parents have a legal obligation to support their children. The circuit court has jurisdiction to order one or both parents to pay child support for children placed in the legal custody of the Department.

(1) Referrals to the Fee Collection Unit. Referrals should include the following information:

(a) Form CF-ES 2626A. This form includes information on both parents and the child in foster care. The form is also used by CIC programs to determine client eligibility for Title IV-E and Medicaid.

(b) A copy of the court order placing the client in the legal custody of the Department.

(c) Copies of any court orders regarding paternity, child support, or arrearage due (delinquent court ordered child support).

(d) Identification of potential third party benefits and copies of any applications made for benefits.

(2) Revenue maximization or direct service staff should notify the fee collection unit within 7 days of any changes such as the transfer, discharge or death of the client.

g. Other Court Ordered Commitments. In the case of a client placed in a FSP residential facility, the direct service worker must ensure that the Department's recommendation to the court includes a provision for the payment of fees. The recommendation shall be specific as to the person liable for fees and the amount. It should also address the use of benefit payments to offset the cost of services. A copy of the court commitment shall be transmitted to the fee collection unit. If the fee cannot be determined promptly, the recommendation to the court must include a statement such as:

"Fees shall be paid by _____ in accordance with the procedures established pursuant to section 402.33, F.S."

4-5. Court Orders in Foster Care Cases.

a. Court Ordered Child Support under Chapter 39, Florida Statutes.

(1) When a child is placed in the custody of the Department under Chapter 39, F.S., the court is empowered to order one or both parents to pay child support for the child under s. 39.521(1)(b), F.S.

(2) It is very important that the fee collection unit obtain a copy of the court order requiring child support in order to take prompt action to refer the case to CSE to collect amounts due.

b. Existing Order for Child Support not under Chapter 39, F.S.

(1) The circuit court may have already ordered a parent to pay support in, for example, a paternity or divorce proceeding. That court order has precedence in establishing the parent's liability to support a child. The Department, as legal custodian of the child, has a right to receive such payments on behalf of the child while the child is in the care of the Department.

(2) The revenue maximization or direct service worker should inform the fee collection unit of any orders for support and, if possible, provide a copy of said order to the fee collection unit.

c. Court Ordered Custody under Chapter 39, F.S., without Court Ordered Child Support.

(1) If the direct services worker is not prepared to submit a recommendation for child support (or child support is not appropriate) at the juvenile court hearing placing the child in the legal custody of the Department, the Children's' Legal Services attorney representing the child should reserve jurisdiction for the purpose of ordering support at another time.

(2) The fee collection unit should receive a copy of the dispositional court order placing the child in the custody of the Department whether or not child support has been ordered.

4-6. Fee Collection Referral of FSP Cases to Child Support Enforcement. Fee collection staff should refer all appropriate non-Title IV-E foster care cases to the Department of Revenue Child Support Enforcement Program (CSE) to collect child support for children in care. It is imperative that the fee collection unit refer cases with court ordered child support to the appropriate CSE unit within 7 days of receipt.

a. Criteria for Referrals to Child Support Enforcement (CSE):

(1) All cases with existing child support orders shall be forwarded to CSE within 7 working days of receipt or knowledge of court order. The following conditions may exist:

(a) The custodian of the home from where the child was removed due to neglect or abuse may be receiving child support payments from an absent parent. If these payments are being paid through the court, CSE can redirect the payments to DCF.

(b) The court may have recently ordered a parent to pay child support. A quick referral is needed to redirect any payments made through the court to DCF and to send notice to the parent to reinforce the parent's liability to pay before past due amounts accrue.

(c) Other cases shall be evaluated on an individual basis to determine if referral to CSE is appropriate.

(2) Referral Package: Each parent referred to CSE shall be a separate referral. If more than one child is involved, one referral is submitted for all children related to that parent. (If both parent's cases are referred, they should be cross referenced to each other on the referral.) The referral package to CSE should include the following:

(a) A referral memorandum describing the action requested. Attachment 1 to this chapter provides a suggested format to use in making referrals to CSE.

(b) A copy of form CF-ES 2626A which provides detailed information on the parents and child in care.

(c) Cost of care for the months up to the date of the referral.

(d) Copies of available court orders.

(e) A request that child support payments be made payable to DCF on behalf of the child; those payments should be sent to the DCF Headquarters, Cash Receipts Section in Tallahassee.

b. Cases That May Not Be Appropriate for Referral to Child Support Enforcement.

(1) If the parent is disabled and the only source of income is benefit payments, the Department should become representative payee of the benefit payment for the child and not refer that parent's case to CSE.

(2) If no court order for child support exists and the Department is recouping all of cost of care from another source, such as from a benefit payment, it is not recommended that the parents be referred to CSE (unless extenuating circumstances exist).

(3) Adoption Placement. If parental rights have been terminated to free the child for adoption, the case shall not be referred to CSE for the collection of ongoing child support. If the Department is already receiving child support, notice should be sent to CSE to cease the collection of on-going child support. However, child support enforcement may collect (or continue to collect) past due amounts owed to the Department that were incurred prior to parental rights being terminated.

c. Foster Care Client Discharged or Moved to Another Circuit. It is very important to notify DOR, child support enforcement unit, within 7 days of notification that a client has been discharged so that CSE can redirect any child support payments to the appropriate party. Fee collection staff may have to contact direct service staff as to the appropriate place to redirect court ordered child support. The Department is entitled to continue to receive any payments ordered on past due amounts owed. However, monthly ongoing child support must be satisfied first before any amounts collected can be applied against past due amounts, unless a court order provides otherwise.

d. Foster Care Case in a Different Circuit From Where the Court Order For Child Support Exists. If a foster care case, and the fee collection case, is being handled by a different circuit from where the court order for child support exists, the child support collections should be sent to the circuit responsible for the client's fee collection case. CSE needs to be advised immediately to contact the other circuit to redirect child support to the current circuit fee collection unit.

4-7. Duties of Department of Revenue Child Support Enforcement Program (CSE).

a. The Department of Revenue (DOR) Child Support Enforcement Program is charged with the responsibility of collecting child support for dependent children under Title IV-D of the Social Security Act. The program was created initially to collect child support for families receiving Aid to Families with Dependent Children (AFDC) and Title IV-E foster care. Later the program was expanded to provide services to all families needing child support collection, including collecting child support for children in the non-Title IV-E foster care programs.

b. The CSE program is responsible for the establishment, modification, or enforcement of the non-custodial parent's child support obligation. Any collections received by CSE will be forwarded to the Department of Children and Families in Tallahassee. The CSE program provides the following services:

(1) Accepts referrals to collect and enforce child support obligations for children in non Title IV-E foster care, and to enforce obligations for children in emergency shelter where the court has ordered child support to be paid to the Department and the parent has failed to pay.

(2) Locates the parent(s) liable for support and determine liability for support.

(3) Establishes paternity, if necessary.

(4) Obtains court orders to establish and collect child support and to recoup unreimbursed cost of care where no court order exists.

(5) Directs child support collections (from the court) to the DCF Headquarters in Tallahassee.

(6) Enforces existing court orders for support to collect amounts due for the months the child was in care.

c. The circuit court uses statutory criteria set forth in s. 61.30, F.S., called child support guidelines, to determine a parent's liability to pay child support. The statutory child support guidelines used by the court supersede the fee schedule used by fee collection staff in determining a parent or other responsible party's liability to pay fees in FSP residential care programs.

d. When CSE obtains a court order for support or support and payment on past due amounts (arrear), CSE should promptly send the referring fee collection unit a copy of the court order.

e. Fee collection units should stay in communication with CSE units to determine the status of referrals. CSE staff may need assistance, such as in locating absent parents or in determining the current amount of cost of care in order to prepare for a court hearing. Fee collection staff may want to verify the amount of collections paid by the absent parent, determine if IRS intercepts were received, etc. CSE should periodically provide a summary statement of collections received to the fee collection unit.

4-8. Child Support Collections.

a. When child support is ordered by the court, the payments are directed to be paid to CSE at Florida State Disbursement Unit, P. O. Box 8500, Tallahassee, Florida 32314-8500. CSE will mail the payments for child non-Title IV-E cases, to the DCF Headquarters in Tallahassee.

b. When copies of CSE child support collections are received from Tallahassee by fee collection staff, those collections should be applied to cost of care.

c. For those units using the Accounts Receivable System, an account shall be set up using revenue source "13" – Child Support Collections, as the last two digits of the account number.

d. For FSP non-Title IV-E programs, deposits are made by DCF Headquarters in Tallahassee. The deposits will be processed using the following accounting codes:

(1) Children and Family Services Budget Entity – 60910304.

(2) Operations and Maintenance Trust Fund 20–2–516015.

(3) Revenue Object Code – 001021 (Dependency Child Support – Non AFDC).

(4) Other Cost Accumulator (OCA) – VLM08.

e. Any amounts collected in excess of cost of care will be placed in the client's individual trust account. It is important to evaluate all income sources for the child, such as child support and benefit payments, to ensure that the Department is not recouping more than cost of care from all sources.

4-9. Responsible Party Income Subject to Fee Assessment. For individuals such as a parent of a minor or a spouse with a legal responsibility to support a client, the following apply as appropriate:

a. Gross income subject to fee assessment includes salaries, wages commissions, tips, net rental and royalty income, net income from self-employment, alimony, pensions, annuities, gain from the sale of assets, capital gain distributions, retirement or disability insurance payments, Social Security, and Veterans' Administration payments, interest and dividends from stocks, bonds, and other

securities, estates or trusts. [NOTE: Any benefit payments received by the responsible party on behalf of the client are not considered to be part of gross income.]

b. If the responsible party is under a court order to pay fees or cost of care such as in emergency shelter and foster care programs, or to pay child support or alimony for a client, the court ordered amount is considered to be the fee to be collected (up to the cost of care). For Family Safety programs, all assessments to parents should be by court order. The court already has jurisdiction over the child in these programs. If the court has not ordered child support for a child in residential care in one of these programs (except emergency shelter), the fee collection unit will refer the case to the Department of Revenue's Child Support Enforcement Program to establish an order for support.

c. In other situations, such as spouse of a client at a state mental hospital, the sliding fee scale shall be used to determine liability of the responsible party to pay fees.

(1) This schedule is used for determining liability to pay fees for residential services from the gross income of the following parties:

(a) Spouse of a client in residential care; and,

(b) Adult client who has dependents.

(2) This schedule can also be used to determine liability to pay fees for other services, unless the fee, or the criteria for determining the fee, is set by statute.

(3) The sliding fee schedule is based on gross income (before payroll deductions) and family size, including the client.

d. Client benefits are applied to the cost of care and are not considered to be part of gross income.

e. Wages earned by the client while in residential care require special treatment. Only a portion of client earnings, under certain circumstances, is considered as part of gross income.

f. If a parent or spouse is only receiving SSI for him or herself, that income is NOT subject to fee assessment.

g. If a parent liable to pay fees remarries, a step-parent's income shall not be subject to fee assessment. However, the number of dependents used in determining ability to pay shall be in proportion to the parent's contribution to total family income.

h. Responsible parties acting in a fiduciary capacity (as guardian, representative payee, or trustee of client funds) are only liable to the extent of fee assessment that is based upon the client income for which they are responsible.

4-10. Title XVI Supplemental Security Income (SSI) Payments.

a. SSI payments may not be used for the care and support of any person other than the beneficiary.

b. In most cases, SSI payments, less a personal allowance, are applied to cost of care.

c. SSI and Institutional Care.

(1) Medicaid Certified Institutional Care Programs (ICP).

(a) Mental health facilities have Medicaid certified ICP facilities or units.

(b) SSI eligible clients that reside in ICP facilities are only eligible for \$30 per month SSI. That amount must be given to the client as personal allowance (along with a \$5 supplement provided by the state).

(2) Non-Medicaid Certified Institutional Care.

(a) The majority of units at mental health hospitals are not Medicaid certified for various reasons.

(b) SSI eligible clients lose SSI when admitted to these facilities. Clients can continue to receive SSI benefits for 90 days after admission to the receiving facility. However, all benefits must be conserved for the client and, therefore, placed into the client's trust account.

(3) Excess Resources. The SSI program imposes a resource limit of \$2000 in assets. If a client has greater than \$2000 in assets, that client loses SSI and Medicaid. (The client may be able to become eligible for Medicaid coverage under other programs.) It is important that client trust fund balances be monitored to ensure that client funds do not exceed \$2,000 in assets for clients eligible for SSI.

4-11. Lump Sum Retroactive Benefit Payments.

a. When the Social Security Administration approves benefits or representative payee status, the approval is generally retroactive to the date of application. A lump sum retroactive award is involved.

b. In accordance with Social Security regulations, when the representative payee, such as the department or contract provider, is also a creditor, Social Security Administration approval is required to reimburse payee for amounts payee used for the client's current needs, which would include maintenance fee assessment.

c. Social Security Administration approval for disposition of lump sum awards should be in writing and in the fee collection file or in the contract provider's records.

d. The department is entitled to appropriate reimbursement back to the date of application if the client was in residential care during that same period of time.

e. Social Security offices vary in the application of policy as to the handling of lump sum awards. One of two methods is usually applied:

(1) In one method, the personal allowance is deducted from each retroactive month's amount in the lump sum award and the balance is available to be applied to cost of care.

(2) An alternative method is to demonstrate to the Social Security Office that a total of two month's benefits are preserved for the client, usually in the client's trust account. The balance would then be available to be applied to cost of care.

f. See attachment 2 to this chapter for a sample letter format that may be used with the Social Security Administration in order to document in writing approval to apply lump sum benefits toward cost of care.

g. After the appropriate amounts have been deducted for the client's use, the balance of the lump sum award may be applied to unreimbursed cost of care for the months involved. For example, if a lump sum award of \$1,500 was received for the months of January, February, and March of 2005 based upon a monthly award of \$500 per month for those three months, the following would apply:

(1) Under the first method described in paragraph 4-11e(1):

(a) The first \$78 (for example) from each month's benefit would be deducted as personal allowance for the client, totaling \$234; and,

(b) For the months of January, February, and March, \$422 (\$500-78) per month would be available to apply to cost of care. If unreimbursed cost of care exceeded that amount for each of the three months (for example, cost of care was \$550 per month), the total balance of \$1,266 (\$422 X 3 months) would be applied to cost of care.

(2) Under the second method described in paragraph 4-11e(2):

(a) Assuming the client had no funds in the client trust account, two month's worth of benefits or \$1,000 (\$500 x 2 months) would be set aside for the client; and,

(b) The remaining month's benefits, in this case \$500 for September, could be applied to unreimbursed cost of care for September.

h. The department is not entitled to amounts for which the client was eligible prior to entering residential care.

NOTE: Prior written approval from the Social Security Administration is not required to apply lump sum retroactive awards when a client is in a Medicaid certified ICP facility. The Medicaid notice of case action should reflect the monthly patient responsibility amount that should apply to cost of care. If the patient responsibility amount does not appear to factor in amounts received in the lump sum retroactive award, fee collection staff should consult with the adult payments staff member referenced on the notice.

4-12. The Department as Representative Payee for Client Benefits.

a. In community programs, direct service workers should apply to become representative payee of client benefits when a client enters residential care. In most institutional programs, fee collection staff apply for benefit payments when appropriate.

b. All benefit payments shall be directed to the appropriate region or institution fiscal (or business) office.

c. Fee collection staff is responsible for correctly applying amounts received in benefit payments.

(1) A personal allowance is deducted, if appropriate, first from each month's benefits received;

(2) The balance shall be applied to unreimbursed cost of care for the same month as the benefit payment; and,

(3) Any amounts received in excess of the monthly cost of care shall also be placed in the individual client's trust account.

d. Three examples from FSP programs follow:

(1) The department receives SSA in the amount of \$480 per month for a child in foster care. The monthly board payment for the child is \$473.

Monthly Income:	\$480#
LESS personal allowance:	<\$30 >
Income available for assessment:	\$450*
Cost of Care:	\$473
MAINTENANCE FEE ASSESSED:	\$450 * (lesser amount)
CLIENT TRUST FUND DEPOSIT:	\$30

(2) The department receives SSI in the amount of \$458 per month and cost of care is \$332 per month.

Monthly income	\$458#
LESS personal allowance:	<\$30>
Income available for assessment:	\$428
Cost of Care:	\$332 *
MAINTENANCE FEE ASSESSED:	\$332 * (lesser amount)
Income in excess of cost of care:	\$96
+ Personal allowance:	\$30
CLIENT TRUST FUND DEPOSIT:	\$126

(3) The department receives SSI in the amount of \$458 per month and child support collections from the Child Support Enforcement Unit (CSE) in the amount of \$100 per month. Cost of care is \$407 per month.

Monthly income (458+100):	\$558#
LESS personal allowance:	<\$30>
Income available for assessment:	\$528
Cost of Care:	\$407*
MAINTENANCE FEE ASSESSED:	\$407 * (lesser amount)
Income in excess of cost of care:	\$121
+Personal allowance:	\$30
CLIENT TRUST FUND DEPOSIT:	\$151

e. Medicaid Cards.

(1) When the department is representative payee for SSI benefits, the client is also eligible for Medicaid. The client's Medicaid card is directed to the same region or institution fiscal or business office.

(2) Fee collection staff must forward Medicaid cards to the client's residential location or to the direct service worker immediately upon receipt.

(3) Direct service workers must keep fee collection staff advised of the current location of clients in order to not delay the receipt of Medicaid cards.

4-13. Payer Priority. When more than one payer is responsible for the payment of fees, the following will be the priority for payment:

- a. Commercial insurance, CHAMPUS/VA, other third parties;

- b. Medicare;
- c. First and second party payers; and,
- d. Medicaid.

4-14. Termination of Legal Responsibility.

a. When a client becomes 18, is emancipated, or joins the military, parents are no longer legally obligated to pay fees based on their income, unless a court order provides otherwise.

b. Divorce also terminates a spouse's legal obligation for fees unless there is a court order to the contrary. The last billing will be prorated according to the date the divorce decree becomes effective.

c. When a child in out-of-home care is being placed for adoption, the natural parents should be assessed fees until parental rights are severed.

4-15. Exclusions from Liability. The following parties shall not be liable for the payment of fees:

a. Indigent parties whose only sources of income are from state and federal aid, except when payment has been court ordered. For purposes of this operating procedure, income from state or federal aid shall be defined as cash assistance or cash equivalent benefits based on an individual's proof of financial need, such as Temporary Cash Assistance and Food Stamps.

b. Recipients of Supplemental Security Income (SSI) (other than for residential services), unless a court order is involved.

c. Parents of minor clients, when the client has been permanently committed to the Department and parental rights have been permanently severed. [Benefit payments can continue to be received and used to offset cost of care until the adoption has been finalized.]

d. Parents of a minor child, when the child has requested and is receiving services without parental consent. This provision does not apply to fees established pursuant to Chapter 39, F.S. (emergency shelter, etc.).

e. Clients in residential care receiving wages from employment as part of discharge plans or preparing for independent living who have requested and been granted a fee waiver or reduction.

f. A step-parent's income when a parent of a minor remarries. However, when determining the parent's liability to pay fees, the number of dependents used shall be in proportion to the parent's contribution to total family income.

g. Any responsible party following the death of a client. Any benefit payments received for the month in which the death of the client occurred must be returned to the granting agency.

4-16. Voluntary Payers.

a. There may be instances when an individual who is not liable for fees or who has been determined to have no ability to pay will volunteer to make payments for all or part of the cost of care. Examples are:

- (1) Payments made by the divorced spouse of an institutionalized client;
- (2) Payments made by the parent of a client 18 years of age or older; or,

(3) Payments made by clients or responsible parties who have been assessed a fee of zero.

b. Voluntary payments will be accepted, but the individual will be billed only upon request. These individuals will not be held liable for fees or be processed as delinquent payers or charged interest if they choose to stop paying. If a voluntary payer receiving courtesy bills discontinues paying, courtesy billing will be discontinued and the account credited to remove the receivable from the records.

SAMPLE FORMAT for making referral to CSE

(use letterhead paper)

DATE:

TO: DOR Child Support Enforcement Unit

SUBJECT: Referral for Legal Action County: _____
Program: _____

Type of Legal Action Requested:

- Establish Paternity
- Establish Court Order for Support
- Collect Court Ordered Child Support, including Arrears
- Redirect Court Ordered Child Support to HRS
- Enforce Past Due Amounts Owed - Arrears Only
- Establish Order to Recoup Cost of Care
- Other: _____

Child's Name: _____ SSN: _____ Acct#: _____
Date of Admission: _____ Date of Discharge: _____

Child's Name: _____ SSN: _____ Acct#: _____
Date of Admission: _____ Date of Discharge: _____

Child's Name: _____ SSN: _____ Acct#: _____
Date of Admission: _____ Date of Discharge: _____

Parent:
Name: _____ SSN: _____
Address: _____

Other relevant information on parent:

Amount owed:\$ _____ Period of Time: _____

The following documents are enclosed for your information:

- (1) Form CF-ES 2626A on child and parents
- (2) Type of court order attached: _____
- (3) Cost of care by month
- (4) Record of payments received by the Department
- (5) Calculation of amounts due.
- (6) Other information on the parent attached: (yes/no)

Additional information or comments regarding the account:

DIRECT CHILD SUPPORT PAYMENTS TO THE FOLLOWING PAYEE AND ADDRESS:
DCF for _____ (Child's name) DCF Region/Circuit Fiscal Office Address

Fee Collection Manager
Address
Phone Number

SAMPLE LETTER TO SSA
to request approval to apply lump sum benefit toward cost of care
(use letterhead paper)

Social Security Administration

Dear

The Department of Children and Families is currently meeting the needs of the following client and is requesting approval to use retroactive benefits received to offset prior cost of care and maintenance in the following manner:

NAME:

SOCIAL SECURITY NUMBER:

DATE OF ADMISSION:

AMOUNT OWED ON PAST CARE AND MAINTENANCE CHARGES _____ FOR THE PERIOD OF TIME _____

MONTHLY BENEFIT RECEIVED:

AMOUNT OF RETROACTIVE BENEFIT RECEIVED:

CURRENT BALANCE IN CLIENT'S TRUST FUND:

DISTRIBUTION IF APPROVED:

CLIENT'S TRUST FUND:

CARE AND MAINTENANCE:

Chapter 5

FEE ASSESSMENT AND BILLING PROCEDURES

5-1. Introduction. This chapter describes the procedures for billing first and second parties for fees based on ability to pay, and for fees based on third party or benefit payments received by persons other than the department or its contract providers.

5-2. Cost of Care and Fee Assessment.

a. The fee shall be adjusted so that the total amount billed on behalf of a client does not exceed the cost of care. For example, if the sum of client benefits applied to cost of care and ability to pay exceed the cost of care, the fee based on ability to pay shall be reduced accordingly. (If the computed fee is less than ten dollars (\$10) no fee will be assessed.) If benefits, less a personal allowance, exceed cost of care, only the amount for cost of care can be assessed. See chapter 4 of this operating procedure for details regarding benefit payments.

b. Per Diem Rates – Facilities.

(1) Medicare or Medicaid Certified Facilities. Certified sections of institutions are governed by HCFA regulations as to the establishment of daily cost of care or per diem rates. Refer to chapter 7 of this operating procedure for further details on the procedures for establishing these rates.

(2) Non-Certified Units at Facility.

(a) Per diem rates for non-certified beds at mental health treatment facilities shall be established in accordance with Establishing Institutional Per Diem Rates.

(b) Per diem rates must be updated at least annually. A copy of the most current per diem rate must be sent to the Office of Financial Management (ASFMR), Cash Management Section at the time the rate is established.

c. Cost of Care – Community Programs. Because cost of care can vary depending upon the type of facility, level of care, or other variables, the fee collection staff must verify the exact cost of care monthly, using one of the methods described.

d. Family Safety Programs. In FS programs, actual foster care board payments must be used to determine cost of care.

5-3. Worksheet for Computing Fee.

a. A Worksheet for Computing Fee shall be completed on every case where fee assessment is done by fee collection staff.

(1) The worksheet shall document the calculations used to determine the fee assessment from all sources of income.

(2) The worksheet will also reflect the provision of the personal allowance from benefit payments.

(3) The worksheet can be used to reflect amounts received in excess of cost of care that was placed in the client's trust account.

(4) Worksheet for Adult Client with No Dependent – Disposable Income should be used to evaluate client wages and other client income.

b. A new worksheet shall be completed any time the assessment changes and shall be in the client's file.

5-4. Notice of Fee Assessment.

a. The client and any responsible party assessed must be notified in writing of the fee assessment.

(1) Form CF 285, Notice of Maintenance Fee To Be Charged (available in DCF Forms), shall be used to provide notice to a client or responsible party when they are expected to pay fees assessed based upon their own resources or based upon receiving client benefits. A copy of the notice shall be filed in the client's file.

(2) Form CF 285 requires manual preparation unless it meets the following conditions for generation by the automated fee collection accounts receivable system (this only pertains to those using the Fee Maintenance system):

(a) An account is added to the master record file, has an amount in the recurring charge field, and has a statement code of "1" (issue monthly billing statement); and,

(b) There is a change in the recurring charge field of an existing account that has a statement code of "1".

(3) All clients or responsible parties assessed a fee will be notified using form 285 within 30 days of receipt of completed form CF 280.

(4) Notice of Maintenance Fee To Be Charged – Benefit Payments (form CF 285B, available in DCF Forms) should only be prepared when the department is representative payee of client benefits.

(5) Fee collection staff should direct the notice to the client if possible or reasonable.

(6) For minor clients or incompetent clients, the direct service worker should be consulted as to the appropriate person to which to direct the notice.

(7) Notice of Maintenance Fee To Be Charged – Court Order (form CF 285C, available in DCF Forms) should be used in the case of court ordered fees directed to DCF. This notice is NOT appropriate in the case of court ordered child support directed through the court; confusion could result in the parent understanding to where to direct the payments. See chapter 4 of this operating procedure for further details on court ordered child support activities.

(8) This notice is NOT a bill. Billings should be generated by the Accounts Receivable System (only for those that use the system) as described in paragraph 5-5 of this operating procedure.

b. If the computed fee is less than \$10, the assessment will be \$0; and no client account should be established.

(1) All documents pertaining to clients who have been assessed \$0 fee will be reviewed at least annually or when new financial information is obtained.

(2) In the case of \$0 assessment, voluntary payments shall be encouraged. Attachment 1 to this chapter displays a suggested format to notify responsible parties of the \$0 assessment and to solicit voluntary participation. This letter should be used instead of form CF 285 in applicable cases.

c. The client or responsible party is required to report changes in gross income or expenses in excess of \$50 a month, in the number of individuals dependent upon that income, or in the availability of third party benefits or benefit payments within 15 days of such changes. The fee collection unit must then recompute the fee and adjust the account of the client or responsible party retroactively to the date of the change.

5-5. Billing Procedures – General. If a fee is assessed, a case can be established in the accounts receivable system (only for those using the Fee Maintenance System).

a. A unique account number should be established and master file created in the fee collection accounts receivable system for accounts assessed fees.

b. Billing Statements Generated from the Fee Maintenance System. In order for the accounts receivable system to issue monthly billing statements to the client or responsible party, the following steps should be taken:

(1) Record the assessed fee in one of two ways:

(a) The assessed fee should be recorded in the accounts receivable as a recurring charge if the same amount is expected to be paid each month.

(b) For one time billings or billings of different amounts, each billing will be manually entered on the activity file associated with the client's account, using transaction code "1" – Billings.

(2) On the second page of the master file for the account in the "Statement Code" field, record "1" which means "issue monthly billing statements."

c. When an account is established with a revenue source code of "01", client, or "02", responsible party, the account should be established as described in paragraphs 5-5b(1) and (2) above; the statement code should be "1" (issue monthly billing statements). This means that the client or responsible party is expected to pay fees from either benefits received or from other income as assessed.

d. When the department is representative payee of client benefits, the account is established with the appropriate revenue source, such as "10 – VA", "11 – SSI", or "12 – SSA" in accordance with paragraph 5-5b(1)(a) as a recurring charge. No statement should be issued.

e. For court ordered child support collected by the Child Support Enforcement unit, revenue source code "13" should be used:

(1) The assessed fee should be recorded as referenced in paragraph 5-5b(1) above.

(2) The "statement code" field should have "2" (no statement) recorded. The local DOR Child Support Enforcement units are charged with notifying the parent of delinquent accounts in these cases.

5-6. Billing the Responsible Party Acting as Representative Payee for Client Benefits. The representative payee will be billed for the benefit amount less any authorized personal allowance. If the amount applied does not cover the cost of care, the responsible party will be assessed a fee based on the ability to pay but not to exceed the remaining cost, in accordance with chapter 4 of this operating procedure.

EXAMPLE: A client, age 2, is entitled to SSA benefit payments of \$500 a month. The authorized personal allowance has been set at \$66. The parent is representative payee for the SSA check and has ability to pay \$150 a month, based on income other than the client’s SSA benefit.

The following table illustrates how the total amount billed is determined. The benefit payment is applied first. The fee assessed on ability to pay is adjusted in Example B so that the total amount billed does not exceed the cost of care.

		Example A	Example B
Cost of Care	a.	\$800	\$509
Less:			
SSA benefit applied (\$500 less \$78 personal allowance)	b.	-422 *	-422 +
Remaining Amount (item a – item b)	c.	378	87
Assessment based on ability to pay (maximum ability is \$150)	d.	150 *	87 +
Total amount of fee billed to parent (item b + item d)		\$528 *	\$509 +

5-7. The Client as Payee. The amount of the benefit payment (less the personal allowance) must be applied towards the cost of care. If the client has other income, an additional assessment may be made on income other than the SSA benefit.

EXAMPLE: Client receives a \$520 SSA benefit payment, and is authorized a \$50 personal allowance. Client also has ability to pay (based on other income) of \$100.

The following table illustrates how the total amount billed is determined. The total amount billed does not exceed the cost of care.

		Example A	Example B
Cost of Care	a.	\$700	\$540
Less:			
SSA benefit applied (\$520 less \$50 personal allowance)	b.	-470 #	-470 @
Remaining Amount (item a – item b)	c.	230	70
Ability to pay on other income (maximum ability is \$100)	d.	100 #	70 @
Total amount of fee billed to client (item b + item d)		\$570 #	\$540 @

5-8. Other Representative Payees. A payee other than the department, contract provider, client or responsible party will be billed only for the amount of the benefit payment less the personal allowance.

5-9. Third Party Benefits. An individual other than the department or a contract provider who receives third party payments shall be billed for the amount of the benefit up to but not exceeding the cost of care. This situation should be rare.

5-10. Billing Clients and Responsible Parties. When third party benefits or benefit payments are not sufficient to pay the cost of care, the client or responsible party will be assessed a fee for the unreimbursed cost or the ability to pay, whichever is less. See chapter 4 of this operating procedure.

a. Unmarried Adult Client with No Dependents.

(1) Benefit payments specifically designated to meet the needs of the client will first be applied to the cost of care, after providing for the personal allowance.

(2) The fee assessment will be made for the unreimbursed cost, or ability to pay, whichever is less. The client’s ability to pay will be based on income other than third party or benefit payments.

(3) For example: Client is an unmarried adult, with no dependents, and receives a monthly SSA check for \$570. The client is payee. In addition, client has income from the XYZ Motor Company pension fund and from dividends. Cost of care is \$1,000 month. Personal allowance from SSA check is \$50.

(a) The SSA check less the personal allowance equals \$520.

(b) Ability to pay is computed in accordance with chapter 4 of this operating procedure based on income from the pension fund and dividends. Assume ability to pay is \$300.

(c) Client is billed for \$820 [SSA check less personal allowance (\$520) plus ability to pay (\$300)].

b. Married Adult Clients. If the client is married, the client's spouse is the responsible party. The fee assessment shall be based on: (1) gross income of the client and the spouse; and (2) the number of dependents. Benefit payments received by the client, less a personal allowance, are excluded from gross income and are applied to the cost of care. If this amount does not cover the cost of care, the sliding fee schedule is applied to other income of the client and spouse. Should application of this method create a hardship, a fee review should be requested (see chapter 8 of this operating procedure).

c. Unmarried Adult Clients with Dependents. If a client has a legal responsibility to support a minor dependent, one of two methods should be used to determine the client's responsibility to pay fees from income other than client benefits.

(1) The fee formula found in chapter 4 of this operating procedure may be used, giving a deduction for court ordered child support payments that the client must make for the dependent; or,

(2) Client benefits, less a personal allowance, must be used to apply to cost of care. A guardian or custodian of a minor dependent of a client receiving SSA or VA benefits would also be authorized to receive a separate benefit payment to support the minor dependent.

d. A client or responsible party who fails or refuses to submit financial information within thirty days of the client's admission to residential care may be assessed and billed for the maximum cost of care. If the client or responsible party subsequently submits a completed Maintenance Fee Information form, and the ability to pay is determined to be less than the cost of care, the account will be adjusted retroactively to the first billing.

(1) Exception to this procedure is provided for a client with no income. To qualify for an exception, the following conditions must be met:

(a) The client has no responsible party; and,

(b) The client is incapable of completing form CF 280; and,

(c) Based on all available information, the client has no income.

(2) The direct service worker will determine whether all three conditions are met. A statement to that effect shall be forwarded to the fee collection unit. In institutional facilities, the statement should be signed by the direct service worker and immediate supervisor. In community facilities, it should be signed by the direct service worker and the immediate supervisor.

(3) Upon receipt of the signed statement, the fee collection unit will assess a fee of zero.

e. If all diligent efforts to reach a responsible party fail, an account should not be established in the accounts receivable system. If the responsible party is located subsequently, an account should be established and billed retroactively to the date of the client's placement in the residential facility.

f. Court Ordered Payments. Court ordered payments shall be applied to the cost of residential care in the same manner as benefit payments.

(1) Placements in emergency shelter may result in a fee ordered by the court. Fees charged in this programs are based on a fixed rate established by the department. Parents may be assessed fees by the court regardless of eligibility for assistance programs, i.e., Cash Assistance.

(2) Due to the short-term nature of such placements, a one time billing upon the client's departure is all that should be required. However, situations exist where more than one month's billing will be necessary.

(3) The direct service worker will notify the fee collection unit of such placements within 7 working days of the client's departure from the facility. The notification shall include but not be limited to date of release, number of days in care and rate per day. The court order should be attached, which documents the daily rate to be charged or total amount owed.

(4) The assessed amount will be determined by the number of days in the facility less the last day, times the daily fixed rate unless the court order specifies otherwise.

(5) It is extremely important that the notification process be followed by the responsible units so that charges are accurately computed.

(6) A notice of maintenance fee to be charged should be sent to the parent along with a copy of the court order.

5-11. Discontinuing Billing. Billing statements and accumulation of accounts receivable should be discontinued under certain circumstances. A six month limit on the accumulation of recurring charges will establish a delinquent record which will be sufficient for collection enforcement through legal action without the accumulation of unrealistic accounts receivable. Any enforcement action, however, should provide for the collection of the total liability from date of admission to current date or date of discharge, plus any accrued interest.

a. If maximum billing is due to failure to complete or sign form CF 280, and the payer has not paid for the last six months, the fee collection unit may discontinue recurring charge and billing statements.

b. If a payer fails to pay fees assessed, the fee collection unit may discontinue recurring charge and billing statements after six months of non-payment. In addition, if billing is for client benefits, initiate procedures to become representative payee after 60 days of non-payment and enforce collection of delinquent amount (see paragraph 6-1 of this operating procedure). Initiate action to become representative payee immediately when clients are re-admitted and have made no demonstrated effort to repay prior delinquent fees.

c. The last bill should include a notice of this action. For example: "For the past six months we have sent you monthly statements, but your account remains unpaid. Future statements will be suspended to cut costs but your obligation will continue until paid in full. Interest will be charged on any amount that remains unpaid over six months."

d. If billing statements are returned as undeliverable or due to incorrect address, statements should not be sent to the same address a second time. If another address is not available, discontinue

sending statements immediately. The fee collection unit may also discontinue recurring charges after six months of non-payment.

e. Collection should be enforced in accordance with chapter 6 of this operating procedure.

f. Billings are discontinued by removing the recurring charge amount from the appropriate master record field in the accounts receivable system, as well as changing the "print statement" indicator to "2" (no statement).

5-12. Partial Billings and Leave of Absence.

a. Proration of Charges. The client or responsible party is obligated to participate in the cost of care from the day of admission. A charge is made for the day of admission but not for the day of discharge. For example, a client admitted on 4/29 and discharged on 5/15 of the same year is charged for two days in April and 14 days in May.

b. Leave of Absence; Institutional Facilities.

(1) A client on leave of absence for ten days or less will be billed for those days on the assumption that the bed is being held for the client. However, on the eleventh day, if the client has not returned, the administrator of the facility or designee shall determine whether billing should continue and advise the fee collection unit.

(2) When a client goes on pass or leave of absence from a facility that charges the client for the stay, such as an adult congregate living facility (ACLF), the client should NOT be billed by the institutional facility for that period of time.

c. Leave of Absence; Community Residential Facilities. Billings will be made in accordance with the number of days that the department pays the contract provider. This will require the fee collection staff to verify the number of days included in the contract provider's voucher for any client on leave of absence.

d. Runaway Status and Benefit Payments. When a client has been in a Family Safety Program facility and the client is in runaway status, the fee collection unit should handle client benefit payments received in the following manner:

(1) Until it can be determined if the child will return, client benefit payments should be placed in the client's individual trust account.

(2) If SSI benefits are involved and the client is gone more than one full calendar month, the benefits received for months with no cost of care incurred by the department should be refunded to the Social Security Administration.

(3) For other benefits (SSA or VA) involved, if more than three months pass without the client returning to the department's care, the department should contact the direct service worker regarding the disposition of funds accumulating in the client's trust account. If appropriate, the federal agency involved should be notified and amounts returned.

5-13. Other Billing Adjustments. When a client transfers to or from another facility for which fees are not assessed, fees must be prorated to reflect charges for the number of days the client is in the residential facility subject to fees.

EXAMPLE: A child may be placed first in psychiatric care and later transferred to a facility under the Family Safety non-psychiatric residential group program. The direct service worker shall indicate on the admission and movement form the date on which the child terminated psychiatric care status.

Liability for fees in the Family Safety non-psychiatric residential group program shall commence on the following day.

5-14. Out-of-State Fees.

a. A parental or spousal responsible party whose residence is out of state shall be requested by the department to apply for interstate transfer of the client.

b. If the responsible party applies for interstate transfer within 90 days of the department's request, fees will be assessed based on the responsible party's ability to pay or referred to court if applicable to pay court ordered fees or support.

c. A responsible party who does not apply for interstate transfer within 90 days of the department's request shall be assessed the cost of service or referred to court as applicable to pay court ordered fees or support.

d. The appropriate region program staff should contact the interstate compact office for assistance with out-of-state transfers.

**SAMPLE LETTER to notify responsible parties of the \$0 assessment
and to solicit voluntary participation**
(use letterhead paper)

Date:
Client Name:
Facility/Program:
Cost of Care:
Date Admitted:

Dear

Based upon information available on your income and resources, your responsibility to contribute to the cost of care has been determined to be \$0, effective _____.

However, in an effort to defray the escalating costs of providing care and services, the department encourages you to make voluntary contributions.

Your consideration and support of this request is greatly appreciated and we look forward to your positive response.

Contributions may be mailed to:

Sincerely,

Fee Collection Manager

Chapter 6

ENFORCEMENT OF DELINQUENT ACCOUNTS

6-1. Collection Enforcement.

a. General. For enforcement of delinquent accounts, a distinction should be made between amounts owed by the client and amounts owed by some other party. For clients who are still in the care of the department, the lead agencies should consider carefully the approach to take in collecting amounts that are past due directly from the client. The suggestions that follow as to collection of delinquent accounts should be mitigated when dealing with amounts owed directly by the client.

b. Delinquent Accounts.

(1) If payment is not received within 30 days from the date of billing a client or responsible party for assessed fees, the lead agency will notify the client or responsible party of the amount that is past due.

(2) Every effort will be made to collect accounts prior to declaring them delinquent. An account is considered delinquent when a charge for fees remains unpaid for 61 days from the date the charge was made to the account.

(3) If payment is not received (and an extended payment agreement is not reached) within 60 days from the billing date, the lead agency will notify the client or responsible party that the account is delinquent. If no response is received within ten days, the lead agency may contact the delinquent payer by phone to discuss the account and determine the reason for non-payment.

(4) The automated accounts receivable system (this applies to units using the Fee Maintenance System) will generate past due and delinquent letters for accounts with a statement code of one "1" [statements printed]. These letters are printed when an account becomes past due and delinquent. Although new balances may continue to accumulate as past due or delinquent, no further letters are printed until the account is paid up and arrears re-occur. A review should be made prior to mailing to determine if any payment has been made or any other action taken which would render the letters inappropriate.

c. Interest.

(1) Interest shall be charged on amounts which remain unpaid for over six months from the date the amount was charged to the account.

(2) The interest charged shall be in accordance with Section 65-6.023(2), F.A.C. Every year in January, the Office of Financial Management (ASFM) shall contact the State Treasurer's Office to determine the average rate of interest earned by the State Treasurer on state funds deposited in commercial banks for the previous year. That amount shall be programmed into the automated accounts receivable system before January 31 of each year by the Office of Information Systems. The accounts receivable system will then automatically calculate the proper monthly interest charge on delinquent accounts.

(3) Payments received on accounts which have been charged interest shall first be applied to the interest charges. Any remaining amounts shall be applied to the oldest billing(s).

d. If payment is not received (and an extended payment agreement is not reached) within 30 days of the notification as referenced in paragraph 6-1b(3) above and the client or responsible party's whereabouts are known, the account should be referred to legal counsel for appropriate action.

6-2. Representative Payee of Benefits.

a. When a client or responsible party is assessed a fee based on the client's entitlement to payments or benefits from SSA, SSI, VA, or any third parties, and the account becomes delinquent, the department or contract provider will initiate action to become representative payee for such payments or benefits.

(1) The request for a change in payee should include the following:

- (a) An explanation of the costs of providing care and maintenance to the client;
- (b) The period of time the client has been in care;
- (c) The reasons (if known) given by the payee for refusal to pay fees;
- (d) The dates for which fees are owed; and,
- (e) Any other information to show that the current representative payee is not fulfilling his/her obligations.

(2) When preparing a request to become representative payee of benefits, consider what the Social Security Administration (SSA) or Veterans Administration (VA) looks for when making a determination on such a request.

(a) The federal agency considers demonstrating concern for a client's well-being as one of the most important factors in selecting or changing a representative payee. The person who demonstrates the most concern for the client's well-being will generally be preferred as the representative payee, provided he/she is otherwise qualified and willing to serve.

(b) Considerations for selecting or changing the representative payee go beyond handling the benefit payments. When reviewing a current representative payee, the federal agency looks for such things as: providing a home for the client; visiting; writing letters; giving gifts; attempting to meet the client's current needs; making efforts to improve the client's situation; and planning for his/her future.

(c) "Attempting to meet the client's current needs" may include using some of the benefit payments for a visit to the client, or for the purchase of an item for the home (for example; radio, television,) for use by the client on home visits, etc.

(d) It is important to show that the current representative payee not only does not use the benefit payments properly, but does not demonstrate concern for the client's well-being. The more information provided to the federal agency, the better the chances that the agency will approve a change in representative payee.

(3) A cover letter for the request should also be prepared. The letter should request a response by a specified date (allowing sufficient time for the federal agency to conduct the review).

b. If the agency rejects the request for a change in payee, continue billing at the same rate unless the situation is as described in paragraph 6-2c below.

c. If the agency rejects the request for a change because the payee was able to document use for current needs of the client, the matter should be referred to a fee review committee for consideration of reduction of fees in accordance with the Social Security or Veteran's Administration determination as referenced in the written notice of rejection.

6-3. Negotiating and Settling Accounts.

a. The Regional Director shall designate the person(s) authorized to negotiate settlement of accounts with the client or responsible party. This person may not be a member of the lead agency.

b. An account may be negotiated or settled for less than the full amount of the debt if, in the opinion of the negotiator for the department, a comparison of costs and benefits of legal enforcement justify negotiating or settling the account.

c. Amounts negotiated may include waiver of accrued or future interest.

d. Negotiation may begin any time after an account becomes delinquent.

e. Any amount negotiated or settled which is less than the full amount of the debt must be approved by the Regional Director or designee (designee should not be the same person negotiating settlement).

6-4. Legal Action.

a. Referral to Region, Circuit, or Facility Legal Counsel.

(1) The lead agency should refer all appropriate delinquent accounts to the region, circuit or facility legal counsel. The referral shall be in writing and include all supporting documentation to establish the delinquency. Attachment 1 to this chapter provides a suggested format to use in making referrals for enforcement of delinquent accounts.

(2) The region, circuit or facility legal counsel in conjunction with the lead agency will determine the method of enforcing collection for accounts referred to them for legal action.

(3) Cases involving court ordered child support should be referred directly to the appropriate DOR Child Support Enforcement unit. Refer to paragraph 6-5 of this operating procedure for further details.

b. The region, circuit or facility legal counsel will notify the client or responsible party in writing of the legal consequences for failure to pay amounts owed and of the intent to take further legal action, if appropriate.

c. Types of Legal Action.

(1) Referral for Collection.

(a) The Department has engaged the services of a collection agency to assist in the collection of delinquent accounts receivable. This referral should be undertaken prior to any additional legal actions when funds are due from second party payors, who may be the representative payee for the client, and are responsible for paying the assessments incurred by the client.

(b) Regional Directors, Hospital Administrators, and their designees may refer other accounts for collection at their discretion. Such referrals should consider the likelihood of a successful recovery in the referral decision.

(c) All referrals for collection should be coordinated with the Director of Financial Management for formats and data collection.

(2) Liens.

(a) Lead agency staff should consult with region, circuit or facility legal counsel regarding the filing of liens. Legal counsel should approve the legality and appropriateness of the notice of lien form used.

(b) Liens may be filed in the county or counties where property is owned by the party and/or in the county of residence of the party owing a debt to the department under section 402.33, F.S. As the clerk of the circuit court will charge the department for the recording of the lien, the action taken should be cost effective for the department to incur this cost.

(c) When a lien is to be filed with the courts, use form CF 540, Notice of Lien (available in DCF Forms). When completing the form 540, ensure that the name, title, address and telephone number of the individual filing the lien appears in the lower left-hand corner. The lien number should be prefaced with the appropriate region name and circuit number; facilities should use the facility's initials, i.e., FSH, NFETC, etc. The notice of lien is also to be notarized. Legal counsel should approve the legality and appropriateness of the notice of lien prior to submission to the clerk's office.

(d) When a lien has been satisfied, file a Satisfaction of Lien, form CF 560 (available in DCF Forms).

(e) If a lien is filed in error, use a Cancellation of Lien, form CF 561 (available in DCF Forms), to cancel the lien.

(f) Whether filing a lien is appropriate is dependent on the circumstances of the specific case. Some examples are provided below, with appropriate action(s) for each.

EXAMPLE 1: The client or responsible party is making payments on a regular basis; however, the payments are only partial payments. In this instance, a lien should not be filed. This is especially true if the department has accepted these payments. Even if such payments have not been accepted and have been returned, the lead agency should contact the individual to discuss an extended payment plan and/or a fee review first.

EXAMPLE 2: The client or responsible party requested a fee review. The fee review committee recommended a reduced fee, which was approved. However, the client or responsible party still makes no payments. Filing a lien would be appropriate in this case once the account becomes delinquent based on the reduced fee.

EXAMPLE 3: The client or responsible party is making payments, but the payments are sporadic and, at times, only partial payment. In this instance, a lien should not be filed. The lead agency should contact the individual to discuss a fee review and/or an extended payment plan first.

EXAMPLE 4: If the amounts due were based upon a client owing amounts from benefit payments such as SSA, SSI, or VA received directly by the client, a lien may not be filed for those amounts due. If a responsible party has been representative payee of benefits and does not pay assessed fees from those amounts, a lien against the responsible party is permissible, if appropriate.

(g) Liens do not apply to property exempt by section 4, Article X of the State Constitution. This provision generally applies to:

1. A homestead of up to 160 contiguous acres and improvements thereon, which is outside a municipality, even if subsequently included in a municipality;

2. A homestead of up to one-half contiguous acres within a municipality, and is limited to the residence of the owner; and,

3. Personal property up to a value of \$1,000.

(h) Liens should not be filed on minor clients.

(3) Legal Action for Trusts, Estates, Inheritances.

(a) When a client or responsible party owes amounts to the department for care and maintenance under s. 402.17, F.S. and the client has substantial assets such as in a trust or estate, legal counsel can take action under s. 402.17(1)(a)2., F.S., to collect amounts owed.

(b) S. 402.17(1)(a)5., F.S., provides for petitioning “the court for the appointment of a guardian or administrator for an otherwise unrepresented client or former client should the financial status report or other information indicates the need for such action. The cost of any such action shall be charged against the assets or estate of the client.”

(c) These measures should be taken only in situations where the client has substantial assets with which to pay amounts owed and no mitigating circumstances exist.

(4) Small Claims Court. Delinquent accounts may be enforced in small claims court. Region, circuit or facility legal counsel should be consulted, if possible, when deciding to take this action. The Regional Director, or designee, shall appoint the person(s) authorized to represent the department in small claims court.

(5) Caveats.

(a) Upon the death of a client or responsible party who owed an obligation to the department, the department may file such caveats as are in the best interest of the state.

(b) Lead agency staff should consult with region, circuit or facility legal counsel regarding the procedures to follow in filing caveats.

d. Court costs incurred for legal assistance to a lead agency should be paid from the program specific region, circuit or facility trust fund where the collections are deposited.

e. Medicare regulations forbid taking or threatening to take court action for receivables related to Medicare coinsurance and deductibles owed by Medicare clients. However, the procedures established in this chapter should be followed for the collection of receivables for amounts in excess of deductibles and coinsurance (e.g., non-covered charges).

6-5. Legal Action – Court Ordered Child Support.

a. The lead agency shall notify the appropriate DOR Child Support Enforcement unit (CSE) or supervising court, as appropriate, of any delinquent amounts owed by a client’s appointed guardian or by a payer under court order to make payments for the support and maintenance of a client. DCF foster care cases should be referred to CSE to collect delinquent amounts owed. Chapter 4 of this operating procedure has further details on handling referrals to child support enforcement.

b. Chapter 4 of this operating procedure provides a suggested format to use when making referrals to CSE. If the lead agency manager has information as to the current whereabouts or employment of the parent, that information should also be supplied to CSE.

6-6. Account Write-Off. The amount of the debt, cost of collection, and amount of the delinquent payer's assets will dictate whether the department will seek enforcement or write off the account.

a. S. 402.33 (8)(a), Florida Statutes, authorizes the department to write off accounts determined to be uncollectible after diligent efforts have been made to collect.

(1) For delinquent accounts with a balance less than \$1,000, the past due notice, delinquent letter, and letter from region, circuit or facility legal counsel to the client or responsible party may constitute diligent effort.

(2) For delinquent accounts with a balance of \$1,000 or above, region, circuit or facility legal counsel and the lead agency will make a determination on the collectability of the account.

b. Once it has been determined that diligent effort has been made and that the account is uncollectible, the lead agency shall prepare a request to write off the account and forward to region, circuit or facility legal counsel for sign-off.

(1) The section "Circumstances under which it is predicated account is uncollectible" must include a narrative of the effort which has been made to collect. Examples of the narrative are:

(a) Explain how the amount of the fee was computed:

1. Maximum fee assessments – briefly explain why;
2. Assessment based on SSA or other benefit;
3. Assessment based on ability to pay; and,
4. Court ordered payments.

(b) Explain efforts to locate or contact payer by mail or phone or through the tracking procedures described in paragraph 6-4 below.

(c) Indicate result of past due notices, delinquent letters, or letters from circuit or region legal counsel.

(d) Indicate if a fee review has been requested or extended payment agreements considered.

(e) Indicate if the four year statute of limitations has expired.

(f) Explain if it has been determined that judicial enforcement would not be cost effective.

(g) Indicate if lien has been filed; if not, explain why.

(2) Secure the required signatures from: the lead agency manager, region or circuit legal counsel, hospital administrator, region manager or administrator for administrative services.

c. Also use the above procedures for uncollectible amounts arising from the settlement, negotiation or compromise of a delinquent account.

d. An account write-off does not constitute discharge of a debtor's responsibility for payment; it merely removes the account receivable from the general and subsidiary ledgers of the department. However, if subsequent to write-off, collection of an account appears feasible, collection of an account

shall be enforced. This may occur, for example, upon the discovery of assets or upon locating a responsible party.

e. For those that use the Fee Maintenance System, at least semi-annually, by February 28 and August 31 of each year, circuit, region or lead agencies shall review the Account Status Reports (FM 115) and insure that for every delinquent account, appropriate enforcement action has been taken. Accounts over 120 days old (aging period 5) should be either actively enforced or, at the direction of legal counsel, in the process of negotiation, or determined uncollectible.

SUGGESTED FORMAT
for making referrals for enforcement of delinquent accounts
(use letterhead paper)

Memorandum

DATE:

TO: Region/Facilities Legal Counsel

SUBJECT: Delinquent Account Referred for Legal Action

Client Name: _____ SSN: _____ Acct#: _____

Facility/Program: _____ County: _____

Date of Admission: _____ Date of Discharge: _____

Responsible Party:

Name: _____ SSN: _____

Address: _____

Relationship to Client: _____

Other relevant information on responsible party:

Amount owed: \$ _____ Period of Time: _____

The following documents are enclosed for your information:

- (1) Cost of care by month
- (2) Record of payments received by the department
- (3) Calculation of amounts due including interest
- (4) Financial Information on the responsible party (yes/no)

Additional information or comments regarding the account:

 Lead agency Manager
 Address
 Phone Number

Chapter 7

MEDICARE, MEDICAID, AND OTHER THIRD PARTY BENEFITS
FOR RESIDENTIAL CARE AND TREATMENT

7-1. Introduction. This chapter addresses claims for reimbursement from Medicare, Medicaid, and other third party payers for residential care. First party payers who are institutionalized Medicaid recipients shall be governed by Medicaid regulations. A person acting as payee or assignee of third party benefits for the client shall be billed for those benefits.

7-2. Medicare (Title XVIII) – General. The Medicare program is a federal health insurance program for people 65 or older and for certain disabled people. It is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). Local Social Security Administration offices handle applications for Medicare.

a. Two types of Medicare exist: Part A (Hospital Insurance) and Part B (Medical Insurance).

(1) Medicare Part A. Clients eligible for SSA or Railroad Retirement and disabled for two years or over 65 years old are automatically eligible for Medicare Part A. No premium is required.

(2) Medicare Part B. Not all clients are eligible for Medicare Part B. If a client is eligible for Medicare Part B, a monthly premium must be paid.

(a) The premium is usually deducted from Social Security (SSA) benefits, with the client or representative payee's permission. It is always advantageous to the department to have the Medicare Part B premium deducted from Social Security benefits.

(b) Medicaid will pay the monthly Medicare Part B premium for clients who are eligible for both Medicaid and Medicare Part B.

b. In order for Medicare to pay claims, a facility has to have a Medicare provider number and have Medicare licensed beds for inpatient care (for Part A).

c. All the state mental health treatment facilities have Medicare provider numbers and some Medicare certified beds.

d. Florida State Hospital has three distinct Medicare provider numbers for three specialized units providing inpatient care:

(1) A Medical/Surgical (Med/Surg) Unit (i.e., general hospital setting).

(2) A Psychiatric Hospital Unit. A client has to require "skilled psychiatric care." Most patients admitted to state psychiatric hospitals need more than custodial care. Custodial care alone is not eligible for reimbursement under Medicare Part A. However, a patient needing custodial care and skilled psychiatric care should be classified at the higher level (needing skilled psychiatric care).

(3) A Skilled Nursing Facility (SNF). A client has to require skilled nursing care in order for Medicare to reimburse the facility for care and treatment.

e. Medicare Billing – General.

(1) Medicare billing is done retroactively after services are provided.

(2) Medicare Part A and Part B billings are submitted electronically U.S. Department of Health and Human Services, Centers for Medicaid and Medicare Services (CMS)

(3) Emphasis should be placed on maximizing Medicare billing. The department receives 100 percent federal funding in reimbursement for approved costs (after deductibles, co-insurance, and TEFRA limitations for Part A claims are subtracted). In contrast, Medicaid reimbursement to a state facility is at the prevailing FFP rate, approximately 55 percent. The state has to provide the remaining (approximately) 45 percent of allowable costs from state funds.

f. Training. Facility staff use web-based training and attend seminars for ongoing training needs.

7-3. Medicare Part A (Hospital Insurance).

a. Medicare Part A pays for inpatient hospital care, including psychiatric hospital care, and for some inpatient care in a skilled nursing facility if the Medicare eligible client is in a Medicare certified bed and has not exhausted benefits.

(1) State government psychiatric hospitals are considered all inclusive rate providers. Medicare Part A reimburses hospitals under an "all inclusive" per diem rate.

(2) Per Diem Rate for Inpatient Care.

(a) The Medicare intermediary determines the per diem rate for each licensed facility (or provider number) based upon the hospital interim rate change reports submitted by the facility.

(b) The per diem rate used for Medicare certified units in a psychiatric hospital setting is an all inclusive rate. The rate includes physicians' services, lab work, x-rays, EEG, EKG, medication, etc.

b. Medicare Part A Billing.

(1) Billing Format and Submission.

(a) The Uniform Billing Form UB-92 (updated in 1992) is used for all inpatient services. This form is also referred to as HCFA 1450.

(b) Direct Data Entry (DDE).

1. DDE is the Medicare Part A electronic billing process.
2. Facilities must obtain direct lines to the Medicare Part A Intermediary in order to use this system.
3. DDE allows a facility to enter all Medicare Part A billings through computer software formatted to capture the same data as the UB-92 form and file the data electronically directly with the Medicare Intermediary.
4. Each facility receives a printout monthly confirming the electronic filing for editing purposes.
5. DDE is an automated system used to track Medicare patient benefits, deductibles, etc.

(d) Common Working File (CWF). This is an automated system used by Blue Cross and Blue Shield of Florida, Inc (BCBS) to track Medicare patient benefits, deductibles, etc. Every Medicare Part A claim is submitted to the common working file for processing by BCBS.

(2) Deductibles and Co-Payments.

(a) Medicare Part A has an annual deductible and required co-payment.

(b) Cross-over. For **Medicaid** eligible clients, Medicaid should pay the deductible and co-payment.

1. The billing submitted to the Medicare Intermediary should automatically “cross over” to Medicaid to pay the necessary amounts.

2. The client’s Medicaid number must be entered on the UB-92 Medicare claim form in order for this automatic process to work successfully.

(3) Medicare Part A will pay for more than one stay in a general hospital setting under certain circumstances. If a client has exhausted benefits, the client should be discharged for Medicare purposes only, even though the client remains in the facility. After 60 days (on the 61st day), the client would be eligible again for a coverage in a medical hospital setting.

(4) Medicare Part A has a lifetime limit of 190 psychiatric days of care. These days can be claimed intermittently to the advantage of the facility.

(5) Section 434 of the Medicare Hospital Manual (HCFA Publication 10) contains information specific to all inclusive rate billing and payment methodology. Fee collection staff should consult with the Medicare Intermediary for any clarification on covered charges.

c. Discharges.

(1) A facility should process a discharge billing to Medicare when Medicare Part A inpatient billings had been submitted for an eligible patient and one of the following conditions are met:

(a) The client has been discharged to the community.

(b) The client has been transferred from a Medicare certified bed or unit to a non-Medicare certified bed.

(c) Effective 10/1/92, a long term patient in a hospital setting in a Medicare certified bed can be discharged when Part A benefits are exhausted even though the patient remains an inpatient in the state hospital. This is considered a discharge for Medicare purposes only. A discharge billing must be submitted on a timely basis using patient status code “05”.

(d) The client has been sent to another hospital in the community for inpatient treatment. The state hospital can “administratively discharge” the client for Medicare purposes only, even if the client is still under court ordered commitment to the state facility.

(e) Some situations of therapeutic leave of over 30 days from the hospital can qualify for discharge.

(2) The number of discharges can directly affect the amount of reimbursement to a facility. Therefore, it is always advantageous to the facility to

process discharges. See paragraph 7-3d of this operating procedure for further details on cost reports.

d. Cost Reports.

(1) After the end of the state fiscal year, each Medicare certified facility must prepare cost reports to summarize all billing activity for the year under Medicare Part A.

(a) All billings submitted under Medicare Part A are included in the cost reports.

(b) Physicians services and ancillaries billed to the Medicare Part B carrier on HCFA Form 1500 are not included in the cost reports. Therefore, Part B reimbursements are not limited by TEFRA target rates.

(2) TEFRA Limitations on Reimbursement under Medicare Part A. TEFRA stands for the Federal Tax Equity Financial Responsibility Act. Procedures were adopted in 1983.

(a) Currently, on an annual basis, Medicare Part A reimbursement is based upon by two factors:

1. The number of discharges of any type (including those for exhausted benefits) processed during the year directly affect reimbursement. For each discharge, up to the number of discharges in the target year and capped by TEFRA rate limitations as described below, the facility receives additional reimbursement of actual costs.

2. The amount of reimbursement per discharge for the year is capped by the current TEFRA rate as determined by the Medicare Intermediary. The original or base rate was established in 1983 and has been increased annually based upon an inflation factor. The rate established was calculated from actual Medicare inpatient costs for 1983 divided by the number of discharges for that year.

(b) The established TEFRA rate for the year times the number of discharges (up to the number of discharges for the target (1993) year) is the maximum reimbursement the facility receives from all billings during the fiscal year.

(c) If actual costs are lower than the current TEFRA rate times the number of discharges, actual costs will be reimbursed. This situation is rare. In most cases, actual costs are higher than the TEFRA rate times the number of discharges.

(d) Below is displayed an example of how TEFRA limitations reduce the amount of reimbursement to a facility:

Comparison of Medicare Part A Costs With TEFRA Limitations

Provider Name: State Hospital Medicaid Certified Unit
 Provider Number: 7-9999* (fictitious)

	TEFRA Base Yr FYE 6/30/83	Recent Yr FYE 6/30/89
	Costs	Costs
Actual Medicare Inpatient (I/P) Cost:	\$383,937	\$359,737 (a)
# of Medicare Discharges:	41	14
Average Cost/Discharge:	\$9,364	\$25,695
	TEFRA	TEFRA
TEFRA Limit: Average Cost Per Discharge Adjusted For Inflation	(No limit in base year)	\$12,536
# of Medicare Discharges:		x 14
Total TEFRA Amount:		=\$175,502 (b)

Difference in Actual Costs(a) to TEFRA Limitations(b)

Amount actually reimbursed TEFRA Limit	\$175,502
Unreimbursed actual costs (\$359,737-175,502):	<\$184,235>

NOTE: If the number of discharges were greater (up to 41), the facility would have received a higher percentage of its costs reimbursed.

7-4. Medicare Part B (Medical Insurance).

a. Physicians Services.

(1) Medicare Part B pays for physicians services on an inpatient basis under any of the following conditions (for clients eligible for Medicare Part B):

(a) A client is in a Medicare certified bed but Medicare Part A benefits have been exhausted.

(b) A client is in the general psychiatric hospital setting in a non-certified bed.

(c) A facility has an outpatient clinic to treat clients residing in non-Medicare certified sections of an institution.

(d) A client is in a Medicaid bed, receiving Medicaid reimbursement for cost of care. (If physicians services are included in the Medicaid per diem rate, any Medicare reimbursement would be credited as revenue on the Medicaid cost report.)

(2) Fee For Service.

(a) Costs are billed to the Medicare Part B carrier on a fee for service basis. Each specific type of treatment and evaluation must be identified and recorded in the medical records to be eligible for reimbursement.

(b) Each type of service event is associated with a CPT code and set fee (CPT 4 with place of service coded as "21 – hospital") that are used when requesting reimbursement.

(c) Psychiatric inpatient treatment associated with a hospital is not subject to special payment rule limitations (only reimbursing 50 percent) associated with other types of outpatient treatment of mental illness.

(3) For clients currently receiving Medicare Part A reimbursement for inpatient care, physician's services are included in the "all inclusive" per diem rate paid by Medicare. Medicare Part B is NOT billed for physicians services.

(4) If a client is Medicaid eligible for inpatient services and Medicaid is billed monthly, Medicare Part B can also be billed for physicians services.

b. Outpatient "Ancillary" Services.

(1) These services include x-ray, lab, EKG, EEG, and emergency room services (a facility must have a certified emergency room in order to bill for emergency room services).

(2) Most services are billed on an outpatient basis. Services can be billed on an inpatient basis after Medicare Part A benefits have been exhausted for "all inclusive rate" providers if the client still resides in a Medicare certified bed.

c. Medicare Part B also helps pay for durable medical equipment and a number of other medical services and supplies.

d. Medicare Part B Billing.

(1) The form HCFA 1500(U2)(1290) is used to submit Medicare Part B billings to the Medicare Part B Carrier.

(2) Various computer software programs are available to electronically file these claims.

(3) Deductibles and Co-Insurance.

(a) Medicare Part B requires a 20 percent co-insurance and a deductible for physician's services.

(b) Medicaid Cross-Over Payment. For Medicare and Medicaid dually eligible clients, Medicaid will pay the co-insurance. Bills are submitted to the Medicare Part B carrier and billings will "cross over" to Medicaid for payment. The Medicare billing must contain a Medicaid indicator and the client's Medicaid number in order for the claim to cross over.

e. Medicare Part B reimbursement is not limited or capped by TEFRA rates that affect Medicare Part A reimbursement.

7-5. Medicaid (Title XIX) – Institutional Care Program (ICP). The state of Florida, through funds made available under the Medicaid program, authorizes payment for certain Medicaid certified institutional care services for eligible clients. Payments for institutional care are made to skilled nursing homes, intermediate care facilities and certain sections of mental hospitals.

a. Client Eligibility for ICP Programs.

(1) DCF adult payments staff determine Medicaid eligibility for clients in Medicaid licensed institutional care (ICP) facilities.

(a) A Medicaid eligible client has to be in a Medicaid certified bed to receive payment.

(b) Mental health treatment facilities and some community residential programs have Medicaid licensed facilities or units within the facilities.

(2) An adult client has to be disabled or over 65 years of age and financially limited to qualify for eligibility under Medicaid ICP programs. Additional restrictive requirements exist for clients in mental health treatment facilities. See paragraph 7-6 below for details.

(3) A client who is eligible for Supplemental Security Income (SSI) is automatically eligible for Medicaid. See paragraph 7-6 for mental health treatment facilities restrictions.

b. Patient Responsibility For Paying.

(1) The DCF adult payments unit has the responsibility for evaluating client income to determine the client's responsibility to pay fees toward cost of care in accordance with Medicaid rules and regulations.

(a) A client participating in the Florida Medicaid program is considered a family of one.

(b) The liability for the client to pay fees for cost of care from available income is called "patient responsibility." Medicaid regulations treat client income differently than DCF rules on assessing fees for residential care.

(c) The monthly patient responsibility for each Medicaid eligible client is determined by deducting from the client's gross income all allowable disregards and deduction, an amount for the client's personal needs (personal allowance), a community spouse income allowance (if applicable) and a family allowance (if applicable), and any income which is to be diverted to meet the maintenance needs of dependents outside the facility.

(d) Medicaid regulations generally take precedence in making fee assessments (with some exceptions as referenced below).

(2) Personal Allowance.

(a) \$35 per month is reserved from benefit payments as a personal allowance for the client's use in purchasing personal need items.

(b) SSI recipients only receive \$30 per month in benefits when they reside in a Medicaid licensed facility. The state of Florida provides a monthly \$5 supplement to the client so that the client may receive the full \$35 personal allowance.

(c) For clients with therapeutic wages, \$35 per month plus 1/2 of earnings not to exceed \$146 is protected for personal needs.

(d) Single veterans or surviving spouses with no dependents who receive a VA Improved Pension of \$90 (or less) are entitled to a personal needs allowance equal to the amount of the VA Improved Pension.

(3) Benefit Payments.

(a) After the monthly personal allowance of \$35 is deducted from the monthly benefit amount, the balance is applied toward cost of care as patient responsibility.

EXAMPLE: A client receives SSA in the amount of \$605 per month. \$35 will be set aside for the client's personal allowance; the balance of \$570 is established as the patient responsibility amount that the client should pay to the facility as the client's share of cost of care. The monthly billing to Medicaid for cost of care for this client shall be reduced by the \$570 established as patient responsibility. Fee collection staff shall collect that amount from the client's benefit payments.

(b) SSI. As referenced above, when a client who received SSI in the community enters a Medicaid certified ICP facility, the Social Security Administration reduces the SSI to \$30 per month, all of which is to be given to the client as personal allowance.

(4) Client Wages. 1/2 of wages (plus \$35) up to \$146 is deducted and the balance is applied as patient responsibility. If wages are earned at a rate below the minimum hourly rate, the department is prohibited by s. 402.33(2), F.S., from collecting that portion of patient responsibility from the client. However, the total amount determined to be patient responsibility must be used to reduce the billing to Medicaid.

EXAMPLE: A client has monthly therapeutic wages of \$80 and SSA of \$425. Adult payments staff will set aside \$35 from the SSA and \$40 from client wages (1/2 of the \$80) for a total of \$75 for personal allowance.

SSA:	\$425
Less Personal Allowance:	<u><\$ 35></u>
	\$390
Client Wages:	\$80
Less 1/2 (for personal allowance):	<u><\$ 40></u>
	\$ 40
Patient Responsibility:	\$430

The patient responsibility amount is determined to be \$430. The monthly billing to Medicaid for this client will be reduced by \$430. The department can recoup \$390 from the SSA but cannot collect the \$40 from client wages.

(5) Spousal Impoverishment Program. In the community spouse impoverishment program, the adult payments unit may reserve part of a benefit amount for the spouse not institutionalized. Therefore, patient responsibility may be less than originally computed because of the additional budgeted amount for the spouse outside of the institution.

(6) VA Aid and Attendance and Unreimbursed Medical Expense Benefits. Effective July 1, 1994, VA aid and attendance and unreimbursed medical expense benefits are no longer considered available income in determining patient responsibility.

(7) Notice. A Notice of Case Action (AE01) is prepared by adult payments staff (in the client's name) which reflects total income, amount of personal allowance, and the patient responsibility amount.

(8) Fee Assessment for Medicaid Certified Facilities. Fee collection staff should understand how the patient responsibility amount was determined and what sources and amounts were used in order to assess and collect fees. The Medicaid program counts income as available in the month in which it is received. Any income received on behalf of a Medicaid client must be counted as available to pay the department or contract provider in the month in which it is received.

(a) With some exceptions, fee collection staff should use the amount of patient responsibility determined by adult payments as the amount to bill the client or responsible party as representative payee of client benefits. The client should not be assessed an additional fee.

(b) In a few instances, the department will collect less than the assessed amount as reflected as patient responsibility. For example:

1. The department will not collect from client wages earned at a rate lower than the minimum wage rate.

2. If a fee waiver committee has ruled in favor of reducing the assessed fee, the fee collection unit will only collect the reduced fee.

(c) However, the total amount determined to be patient responsibility must be used to reduce the request for reimbursement from Medicaid.

(9) Discrepancies in Sources or Amounts of Income Used to Determine Patient Responsibility. Sometimes the department (or contract provider) is representative payee for the client's benefits and notes that the amount reflected as client income differs significantly with known amounts of client income. Discrepancies of more than one (1) dollar (benefit payment amounts reported to adult payments staff can differ by one dollar to actual amounts received due rounding) must be reconciled with adult payments staff. Sometimes, adult payments is considering a source of income, such as VA, that the fee collection unit was not aware was available to the client.

c. Medicaid Billing Procedures.

(1) Florida Medicaid Institutional Services Claim Form is used to submit monthly billings for clients in ICP facilities.

(a) The forms are usually preprinted with known clients and per diem rates entered. Patient responsibility amounts are also reflected from data supplied from DCF adult payments and reduce DCF's claim for reimbursement. New clients and any changes, such as in number of days, etc., are added.

(b) Billings are submitted to the Medicaid Fiscal Agent which processes the claims.

(2) Per Diem Rate.

(a) The Agency for Health Care Administration (AHCA), the Florida Medicaid Agency, determines the per diem rates to be paid for the various types of units.

(b) Currently, hospital providers are reimbursed prospectively; that is, actual costs from a prior year are inflated forward to the current rate semester using a nationally recognized inflation index.

(c) The reimbursement or per diem (per day) rate can be determined every January 1 and July 1, based upon cost reports received by October 15 and April 15, respectively.

d. Medicaid Reimbursement for State Operated ICPs.

(1) The Medicaid Fiscal agent determines the total amount to be reimbursed to a state provider for a particular month. The remittance voucher is prepared by client name, dates of service, daily (per diem) rate paid (net of patient responsibility), covered days and amount "paid by Medicaid."

(2) The last page of the voucher reflects 100% of the approved reimbursement amount. However, the state facility does not receive that amount.

(3) A treasurer's receipt worksheet is also sent to the facility with the remittance voucher which lists each state operated Medicaid facility (and other Medicaid programs operated by DCF). Only the federal financial participation (FFP) portion of the claim is deposited into the applicable DCF trust fund.

EXAMPLE: Florida State Hospital is eligible for reimbursement in the gross amount of \$77,213.49 for care of clients on a Medicaid certified unit for the month of June 1994. Only \$42,297.55 (\$77,213.49 times 54.78% FFP for 1994) is deposited into the Mental Health Treatment Facilities Operations and Maintenance Trust Fund as reflected on the treasurer's receipt worksheet. The other 45.22% of costs has to be paid by the state of Florida in state matching funds. General revenue used in support of mental health treatment facilities programs is used as state match.

Only the 54.78% Medicaid FFP amount is transferred from AHCA to DCF; the amount being recorded in the State Comptroller's records (state accounts) for DCF as revenue category 001500 (transfer receipts). The applicable institution will need to record the transferred amount in FLAIR, using revenue category 001500.

e. Medicare/Medicaid Dual Eligibility and "Cross Over" Claims for Payment.

(1) For Medicaid eligible clients, Medicaid will pay Medicare deductibles and co-payments for clients also eligible for Medicare.

(2) "Cross Over" of Claims Processing. The Medicare intermediary for Part A payments and the Medicare Part B carrier are to forward claims submitted to them for payment to the Medicaid fiscal agent for payment of any deductible or co-insurance payments due. **The Medicaid claim number must be recorded on the claim form submitted to Medicare Part A or Part B for reimbursement.**

(3) 100% of Medicaid reimbursement for crossover claims is received **directly** by the state facility. The total amount is deposited into the state treasury and recorded in FLAIR by the facility.

f. Cost Reports. Cost reports must be submitted annually to the Agency for Health Care Administration.

(1) The cost reporting year shall be the same as for Medicare(i.e., the state fiscal year).

(2) Cost reports must be submitted not later than five (5) calendar months after the close of the cost reporting year.

7-6. Medicaid – Mental Health Treatment Facilities. Conditions referenced in paragraph 7-5 of this operating procedure apply. The following additional factors must be considered.

a. Client Eligibility in Mental Health Treatment Facilities. Federal Medicaid regulations restrict the eligibility requirements of clients who enter mental health institutions.

(1) Clients (who also meet financial eligibility requirements) must be under 21 or over 65 years of age or require skilled nursing treatment in order to be eligible for Medicaid in a mental health treatment facilities.

(2) Adult clients between the ages of 21 and 65 who were eligible for Medicaid living in the community will lose Medicaid eligibility when they are admitted to the institution.

(3) Adult clients who were receiving SSI in the community will lose SSI benefits when admitted to the state hospital unless placed in a Medicaid certified section of the hospital and determined eligible for Medicaid payment for that particular type of treatment.

b. Certified Units.

(1) In order for Medicaid to pay for client inpatient care, an eligible client must be in a Medicaid certified unit.

(2) Mental health treatment facilities can have up to three different types of certified units with a distinct Medicaid provider number for each different type of unit:

(a) Distinct Part (DP) or Psychiatric Unit. This type of unit provides psychiatric care and treatment for patients over 65 years of age.

(b) Skilled Nursing Facility (SNF). This unit serves clients requiring skilled nursing care. A client does not have to be over 65 years of age to qualify for Medicaid if a physician certifies that the client needs skilled nursing care. According to the Florida Medicaid State Plan, Medicaid will pay up to the Medicare per diem rate for state hospital skilled nursing facilities.

(c) General Hospital (Med/Surg) Unit. This unit is a general hospital setting for patients needing medical treatment.

7-7. Medicaid Billing for Medical Treatment.

a. Medicare is billed first for medical treatment for dual eligible clients. The Medicare Part A Intermediary or Part B carrier has the responsibility for crossing over the claims to Medicaid to pay any deductible or co-payment due. **The Medicaid claim number must be entered on the Medicare claim form in order for Medicare to send or “cross over” the claim to Medicaid to pay any covered deductible or co-insurance.**

b. For Medicaid eligible patients not covered by Medicare, Medicaid may be billed for covered services using the universal billing form UB-92.

c. Refer to paragraph 7-8c below for outside medical services provided to clients.

7-8. Third Party Benefits – General.

a. Third party benefits are not considered income to the client or responsible party; but when applied toward the cost of care they reduce the client's or responsible party's liability for the cost of services. **A personal allowance may not be deducted from third party benefits.**

b. Reimbursement claims for third party benefits should be filed in accordance with the following manuals:

- (1) Commercial Insurance. Hospital UB-92 Billing Manual.
- (2) Medicare. HIM 10 Medicare Hospital Manual.
- (3) Medicaid. Florida Medicaid Manual for Mental Health Hospitals.
- (4) CHAMPUS.

c. Referrals for Medical Services Outside the Facility or Institution. When a client is referred to a provider of medical services in the community, that provider should bill Medicare or Medicaid (or any other available insurance) **directly** for reimbursement.

d. Non-Certified Sections of Mental Health Treatment Facilities.

(1) Non-certified sections of mental health treatment facilities are considered to be part of a psychiatric hospital setting for the purpose of filing commercial insurance.

(2) The per diem rate is established in accordance with 4 APM 4, Establishing Institutional Per Diem Rates, and shall be updated at least annually.

e. If payments from a third party payer and client or responsible party exceed the cost of care, the client or responsible party must be refunded the excess recovered.

f. Accounts Receivable for Third Party Benefits.

(1) Routine Claims. When a claim filed with a third party payer is routine in nature, or when prior experience indicates that the claim will be paid, the receivable should be recorded in the accounts receivable system at the time the claim is filed. The client or responsible party may be billed for the difference between the established cost of care and amount claimed from the third party and any amount received by the department from benefit payments. The amount billed is not to exceed the ability to pay as discussed in chapter 7 of this operating procedure.

(2) Non-Routine Claims. When a non-routine claim is filed with a third party payer, the receivable should not be recorded in the accounts receivable system unless there is reasonable certainty that the claim will be paid. When payment is received, the billing and payment will be recorded simultaneously.

Chapter 8

REVIEW OF ASSESSED FEES

8-1. Purpose. A child in licensed foster care or responsible party has the right to request a fee waiver or a change in personal allowance. However, if the fee or allowance is based upon a court order, only the court has the authority to change the amount.

8-2. Notice of Right to Request a Fee Waiver or a Change in Allowance.

a. Any child in licensed foster care pursuant to Chapter 39, F.S., must be informed by the direct service worker of his/her right to request a fee waiver or a change in personal allowance.

b. Notice about the child's right to request a fee waiver or a change in personal allowance must be provided through form CF 285D, Notice of Fee Assessment and Rights of Foster Child Regarding Government Benefits (available in DCF Forms). The notice must be provided at the time of each judicial review to the child, the child's guardian ad litem (if appointed), the child's attorney (if appointed), the child's parents (unless parental rights are terminated), and the child's foster parents. A copy of notice is also filed with the court.

8-3. The Review Committee.

a. Each circuit administrator or designee will establish at least one fee waiver and change in personal allowance committee. Large circuits may choose to establish review committees at the sub circuit level. The purpose of the committee is to receive and review requests, and by majority vote, recommend to the circuit administrator or designee, whether a fee waiver or reduction should be granted. Recommendations of the committee must be approved by the circuit administrator or designee before they become effective. Institutions generally establish their own committee to review institutional cases.

b. The committee must be made up of no less than three members appointed by the circuit administrator or designee. The direct service worker assigned to the child's case, an individual acting as an advocate of the child, or any person who may have a conflict of interest shall not serve on the committee. The committee composition must be balanced to include representation from fiscal, program, and operations staff. One member will be appointed to serve as chairman of the committee. The chairman of the committee will be responsible for the management of the review, including the audio taping of the proceedings, and ensuring confidentiality for the child. Non-departmental participants must sign the Certification and Affidavit of Understanding on the last page of form CF 285D (available in DCF Forms).

c. The decision must be made within 30 days of receipt of the request and required documentation. The committee will make a recommendation to the circuit administrator or designee whether or not to grant the request. The circuit administrator or designee will ensure the requesting party receives notification, in writing, within 10 days of the decision.

d. The committee shall meet as often as necessary in order to meet the 30-day requirement described in paragraph 8-3c above.

e. The review committee must also specify when the case is to be reviewed again, if the decision results in a fee waiver or change in personal allowance. This should be done at least annually.

f. Recommendations of the committee shall be approved by the regional director/circuit administrator, hospital administrator, institution superintendent, or designee.

g. If the fee waiver or change in personal allowance request is denied, the party requesting the waiver has the right to appeal the decision within 30 days of the date of denial, according to Chapter 120, Florida Statutes.

8-4. Review Process. The fee waiver or change in personal allowance review is conducted according to Rule 65C-17.004, Florida Administrative Code (F.A.C.)

a. When the direct services staff notifies a client or responsible party of the right to request a fee review using form CF 284 (available in DCF Forms), the notification must state that:

(1) The request must be submitted to the fee collection unit in writing. If the client or responsible party cannot provide a written request, a verbal statement may be taken. The direct service staff must provide a written account of such statements to the review committee.

(2) Supporting documentation must be submitted to substantiate a request for fee waiver or reduction (e.g., receipts, tax records, bills, or certified statements).

b. Once a written request, with substantiating documentation, is received the chair of the review committee will check the packet to ensure the packet has the necessary information for the review. If there is missing information or documents, the chair will ask for them. If the packet is complete, the chair will set a date and time for the review.

c. The review committee shall notify the client or responsible party of the date and time the request will be reviewed. The client or responsible party has the right to appear in person and may testify before the committee. The direct service worker or any other individual may serve as an advocate and may assist in the preparation of the request for review, but may not be involved in the decision of the committee.

d. A decision will be made within thirty days of receipt of the request and required documentation. The committee will meet as often as necessary in order to meet the 30-day requirement.

e. If the request with the required documentation is submitted later than three months after the date shown on form CF 284, depending upon the committee's recommendation, the fee may be adjusted retroactively to the month in which the request was received.

f. If the circuit administrator, hospital administrator, institution superintendent, or designee, denies the request for a fee waiver or reduction, the client or responsible party shall be informed of his right to appeal the decision pursuant to the provisions of Chapter 120, Florida Statutes within 30 days of the date of denial. (Chapter 120 is the Administrative Procedures Act and provides the payor with an opportunity for appeal through an administrative hearing.)

8-5. Review Guidelines. The review committee shall inform persons requesting a fee review of the criteria used to evaluate such requests. The criteria for evaluating requests and the procedures for processing requests are described in Rules 65C-17.004 and 17.005, F.A.C.

8-6. Fee Assessment Based Upon a Court Order.

a. Court Ordered Fees. If the fee assessment is based upon a court order, such in the emergency shelter program, and the party billed requests a fee waiver or reduction, the direct service staff shall notify the party in writing, including the following information:

(1) Mention that the assessment was based upon a court order and that only the court has the authority to review a request waiver of court ordered fees or support; and,

(2) Enclose a copy of the court order; and,

(3) Refer to Notice of Maintenance Fee to be Charged – Court Order, form CF 285C (available in DCF Forms), which should have been used to provide notification to the responsible party of the assessed fee in the emergency shelter program and explain that the Department can only consider a fee review of specific factors as listed in the notice (refer to paragraph 8-6c below); and,

(4) Request that the party state the specific reason(s) for the request for review of assessed fee in order to evaluate whether the Department has jurisdiction to hear the matter or whether the party should be referred to the court that entered the order.

b. Court Ordered Child Support. In situations involving court ordered child support, the fee collection unit should not be billing the party involved. The DOR Child Support Enforcement Program should be handling notice to parents of their liability to pay court ordered support. The fee waiver rule does not apply in cases where the court ordered support amount is being questioned except as noted in paragraph 8-6c below.

c. Responsible parties may question how court ordered fees and support payments that are collected are applied to cost of care. For example, a party may feel that the Department is retaining more of the support payment than the cost of care of the client. The responsible party must pay the total court ordered child support payment even if the child support is more than the cost of care. However, the Department must deposit collections that exceed the cost of care into the individual client's trust account for the use and benefit of that client only.

8-7. Educational/Vocational Planning for Older Children Receiving SSI.

a. If the committee decides to approve a fee waiver, the direct services worker must refer to CFOP 175-59, Master Trust for Benefit of Family Safety Program Clients, for procedures in establishing a PASS account (Plan to Achieve Self-Support) for the client.

b. This plan is for older children who are disabled and are conserving funds to meet a vocational goal. The child and his/her direct service worker must complete a PASS plan that has to be approved by the Social Security Administration.

c. For children receiving SSI benefits, this subaccount is revocable so that the representative payee may access the child's money or property in connection with expenditures related to the child's approved PASS plan, or for the reimbursement to the Social Security Administration or SSI benefits payments that were received in connection with the funding of the PASS plan prior to its transfer amendment, abandonment or termination.

d. As long as the approved PASS plan is in effect, funds placed in this subaccount do not count toward the SSI asset limit.