



**DEPARTMENT:** Finance  
**POLICY NAME:** Financial Assistance Policy  
**DATE OF ORIGIN:** December 6, 2022  
**REVISED DATE:** June 1, 2023  
**APPROVED BY:** **Board of Directors** 04/27/2023  
**President/CEO**  
**Chief Financial Officer**

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**PURPOSE:** Radiant Health is committed to providing quality and affordable Behavioral Health Care services to those in need and to be transparent, consistent, and fair towards uninsured or underinsured persons seeking mental health services. Consistent with its mission to provide comprehensive clinical consultation and treatment to people with emotional, mental, behavioral and substance abuse, Radiant Health strives to ensure that a person's ability to pay does not prevent them from seeking or receiving care.

This policy will:

- Outline the eligibility criteria for which Radiant Health will use to provide discounted care.
- Describe how amounts are calculated and charged to those eligible for financial assistance.
- Provide instruction on how persons may apply for financial assistance.
- Describe how Radiant Health will notify and inform individuals of the availability of financial assistance.
- Residential housing rents will be excluded from this policy.

**POLICY:** It is the policy of Grant-Blackford Mental Health, Inc. dba Radiant Health Services, a 501(c) 3 tax exempt charitable organization, to provide care without regard to a person's race, color, religion, creed, sex, age, national origin, marital status, mental or physical disability, genetic information, sexual orientation, gender identity, veteran status or any class of individuals protected from discrimination under state or federal law.

Financial Assistance is not considered to be a substitute for personal responsibility. Applicants are expected to cooperate with Radiant Health's procedures for obtaining assistance and to contribute to the cost of their care based on their ability to pay.



Individuals with financial capacity to purchase health insurance or apply for state funded health insurance shall be encouraged to do so to assure access to other health care

services and or the overall personal health of the individual. For the purposes of this policy, the terms below are defined as follows:

**Financial Assistance:** Behavioral health services provided at a discount to individuals who meet the established criteria.

**Application Period:** Period that begins on the date the care is provided to an individual and ends 30 days after Radiant Health provides the individual with a notice that collection action may be initiated.

**Gross Charges:** Total charges that are applied consistently and uniformly to all individuals before applying any contractual allowances, discounts, or deductions.

**Household:** Using the Census Bureau definition, an individual or a group of two or more people who reside together and who are related by birth, marriage, or adoption. If the person is filed as a dependent on another's income tax return, that person may be considered a dependent for purposes of the provision of financial assistance.

**Income:** Income includes gross income from salary and wages, unemployment compensation, worker's compensation, Social Security, Supplemental Security Income, public assistance, VA pensions/payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, disability payments, payments received from the state for legal guardianship or custody, business income (IRS Schedule C), farm income (IRS Schedule F). Rental property and farm income will be determined by gross profits after deductions. NOTE: Non-cash benefits such as food and housing subsidies will not be considered as income.

**Insured:** A person who has third party coverage, worker's compensation, automobile insurance or is involved in a health cost-sharing program.

**Uninsured:** A person who has no level of insurance or third-party assistance to assist with meeting his/her payment obligations

**Underinsured:** A person who has some level of insurance or third-party coverage who may have out of pocket expenses that exceed his/her ability to pay due to household income.

**PROCEDURE:** An application process will be used to determine a person's eligibility for financial assistance. Applications will be completed when the client receives services. When all supportive documentation is received and it is determined the client meets guidelines, they will be considered eligible for a period of one year.

Recertification applications will be available with all Customer Relations Professionals, registration sites, within the Finance Office, and online at [GetRadiant.org](http://GetRadiant.org).

Once the recertification application has been completed, application and appropriate income documentation should be dropped off to any Customer Relations Professional, a registration site, or mailed to the Attention: Finance Department, 505 N. Wabash Avenue, Marion, Indiana 46952. Once received by the Finance Department, the individual should receive a letter within 14 calendar days providing the status of their recertification application as either approved, denied or a request for additional information. There are times the notifications may take a longer period to complete due to volumes.

Individuals with balances after insurance or that have exhausted their policy limits are eligible for financial assistance if the eligibility criteria are met. Individuals with financial assistance will be billed the same amounts as those individuals that have insurance; they will never be charged more.

**Income Verification:** In determining eligibility, the following items will be used for income verification:

- Current year's tax return or W-2's—If self-employed, include Schedule C from tax return
- Unemployment income, (provide a recent Indiana Workforce Wage Report)
- 3 pay stubs (one most recent and two previous) for all household members.
- Social Security Entitlement Letter
- Retirement Income
- Investment Income
- Individuals' ineligible for Medicaid or other affordable health care coverage may be required to provide proof of denial.

There are times that individuals may be eligible for assistance without completing a Financial Assistance Application. These are identified below:

- A person files for bankruptcy and the final decision is there are not any assets to satisfy the individuals bills.
- The person expires and there is no estate.
- The person is homeless.



Radiant Health may determine eligibility for financial assistance at its sole discretion based on other supportive information, i.e., a person qualifies for a federal or state program; or a person or information is not reasonably available.

Financial Assistance information will be included on billing statements and posted on the Radiant Health website at [GetRadiant.org](http://GetRadiant.org). In addition, information will be provided by a Customer Relations Professional.

**Payment Plans:** Interest-free payment plans are available for variable lengths of time, depending on the remaining balance.

Failure to apply for assistance or pay the set fees through a payment plan may result in the account being referred to a collection agency and be subject to the collection agency's policies.

### RADIANT HEALTH

2023 Federal Poverty Levels			120%	140%	160%	180%	>200%
Household Size	Federal Poverty Level	100% Discount = or < FPL	80% Discount	60% Discount	40% Discount	20% Discount	No Discount
1	14,580	14,580	17,496	20,412	23,328	26,244	29,161
2	19,720	19,720	23,664	27,608	31,552	35,496	39,441
3	24,860	24,860	29,832	34,804	39,776	44,748	49,721
4	30,000	30,000	36,000	42,000	48,000	54,000	60,001
5	35,140	35,140	42,168	49,196	56,224	63,252	70,281
6	40,280	40,280	48,336	56,392	64,448	72,504	80,561
7	45,420	45,420	54,504	63,588	72,672	81,756	90,841
8	50,560	50,560	60,672	70,784	80,896	91,008	101,121
For ea. add'l person, add	5,140		6,168	7,196	8,224	9,252	10,281

**Review Responsibility:** Director of Revenue Cycle

**References:** Reference: (HRSA) Health Resources and Services Administration: (NHSC) National Health Service Corps.

The policy will be updated annually with new Federal Poverty Level guidelines.



Application Date: \_\_\_\_\_

## ELIGIBILITY DETERMINATION FOR SLIDING FEE DISCOUNT & FINANCIAL ASSISTANCE APPLICATION

Radiant Health is committed to being your trusted partner in life's journey toward well-being. As well as, to provide quality and affordable behavioral healthcare to those in need at a sliding fee discount based on information you provide.

### Required Information for Application

Client Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Spouse/Guarantor Name: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### Dependents in Household

Dependent: \_\_\_\_\_ DOB: \_\_\_\_\_

Dependent: \_\_\_\_\_ DOB: \_\_\_\_\_

Dependent: \_\_\_\_\_ DOB: \_\_\_\_\_

Dependent: \_\_\_\_\_ DOB: \_\_\_\_\_

Dependent: \_\_\_\_\_ DOB: \_\_\_\_\_

Dependent: \_\_\_\_\_ DOB: \_\_\_\_\_



**Income Information**

Monthly Income Source – complete all that apply and indicate the amount.

<b>Earnings</b> (wages from your job) _____	_____	_____
	Weekly	Monthly      Annually
<b>Unemployment Compensation</b> _____	_____	_____
	Weekly	Monthly      Annually
<b>Self-Employment Income</b> _____	_____	_____
	Weekly	Monthly      Annually
<b>Social Security</b> _____	_____	_____
	Weekly	Monthly      Annually
<b>Social Security Disability (SSDI)</b> _____	_____	_____
	Weekly	Monthly      Annually
<b>Pension or Retirement Income</b> _____	_____	_____
	Weekly	Monthly      Annually
<b>Veterans' Payments</b> _____	_____	_____
	Weekly	Monthly      Annually
<b>Worker's Compensation</b> _____	_____	_____
	Weekly	Monthly      Annually
<b>Other Income</b> _____	_____	_____
	Weekly	Monthly      Annually

Other Income could be interest dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household.

Documentation to support income would be check stubs, bank statements, W—2, tax return, or unemployment information.

*I understand that the statements I have made on this form are subject to verification. I understand I will be asked to provide proof of the information provided. I agree to help Radiant Health obtain the necessary information.*

\_\_\_\_\_  
Signature of Client or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse/Guarantor

\_\_\_\_\_  
Date

**NOTE:** This application is good for a period of one year.