"Service with Excellence & Integrity"

Arkansas Department of Community Correction

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ADMINISTRATIVE DIRECTIVE: 10-08 HEALTH CARE CO-PAY PROGRAM

TO: DEPARTMENT OF COMMUNITY CORRECTION (DCC) EMPLOYEES)

FROM: DAVID EBERHARD, DIRECTOR

SUPERSEDES: AD 02-07

APPROVED: Signature on File **EFFECTIVE: October 29, 2010**

I. APPLICABILITY. Department of Community Correction (DCC) employees, residents confined in DCC residential centers, and contract health care providers.

II. POLICY. It is DCC policy that DCC residents participate in economic sanctions programs for health care services to encourage responsible use of medical services.

III. DEFINITIONS.

A. Chronic Care. Routine follow-up care for long-term medical conditions that may result in deterioration of one's general health condition, or possibly be life threatening if not monitored on a routine basis. Such conditions include, but are not limited to diabetes, cancer, heart disease, hypertension, and HIV.

B. Co-payment (co-pay). The amount set by the Board of Corrections to be charged for resident-initiated services.

C. Emergency. A condition or injury that may result in imminent risk of irreparable deterioration to body systems or death and requires immediate medical attention as determined by the health authority or responsible physician.

D. Follow-up. Follow-up refers to any appointment initiated by health care staff subsequent to a previous examination or treatment.

E. Prosthesis/Orthotic. An artificial device to replace or augment a missing body part or to compensate for a defective body function, including, but not limited to the following:

1. artificial limbs
2. eyeglasses
3. dentures
4. hearing aids
5. orthopedic shoes or shoe inserts
6. crutches, braces, support bandages, girdles, etc.

F. Reasonable and Necessary Health Care. Medical, dental or mental health treatment that, if not provided, can be reasonably expected to result in irreparable harm to an individual as determined by the responsible health authority.

VI. GUIDELINES.

A. Access to Services. Qualified health care personnel must act promptly on requests for health care services. Access to health care services must not be impeded or denied by a resident's inability to pay the co-pay fee.

B. Assessment of Fees. The DCC is authorized by the Board of Corrections to charge a fee for resident-initiated health care services as described below to encourage responsible use of medical services. Services must be provided or made available (in the case of a missed appointment) prior to assessment of a co-pay fee. Health care co-pay charges and exemptions are as follows:

1. Co-Pay Charges

- $3.00 for each resident-initiated request for medical or dental care unless an exemption applies.
- $3.00 each time a resident misses an appointment for, medical, dental or mental health care visits, including specialty referrals, unless the resident was not at fault
- Up to 100% of the REPLACEMENT cost for lost, stolen, damaged or destroyed prosthetic/orthotic devices excluding normal wear

Note: Medical staff should explain to the resident the estimated amount he/she is expected to pay for lost, stolen, damaged or destroyed prosthetic/orthotic devices before placing an order. For items such as eyeglasses, the resident may choose not to purchase the item. Charges for items such as a wheelchair must be assessed with an entry on the co-pay log.

2. Exemptions from Co-Pay Charges

- **INITIAL ASSESSMENTS** provided during the reception and classification process, classification, physical exams, intra-system transfer evaluations, pre-segregation screenings or periodic physical examinations.
- **EMERGENCY SERVICES** provided.
- **MENTAL HEALTH SERVICES**
- **INJURY** where the resident was NOT involved in horseplay, a fight or while committing a rule violation.
- **VISITS OR TESTS INITIATED BY A HEALTH CARE PROVIDER, INCLUDING THOSE BY MEDICAL, DENTAL AND MENTAL HEALTY STAFF**
- **PERIODIC HEALTH EXAMS** such as annual or other similar routine periodic examination, or routine preventative care tests such as mammography, PSA, eye or dental exam, etc., not due to an acute condition.
- **ANY PROVIDER-INITIATED HIV**
- **HEALTH CARE VISITS SCHEDULED BY THE HEALTH CARE PROVIDER, AS OPPOSED TO INITIAL CARE REQUESTS SUBMITTED BY THE RESIDENT**. Such visits include but are not limited to written referrals, lab tests, x-rays, EKGs, dressing changes, suture removal or other procedures related to the initial problem.
- **DESIGNATED CHRONIC CARE CLINIC VISITS, OR FOLLOW-UP TREATMENT FOR CHRONIC CARE CONDITIONS.**
- **VISIT REQUESTED BY THE PROVIDER OR THE RESIDENT TO ORDER MEDICATION RENEWALS.**
- **INFIRMARY OR HOSPITAL CARE.**
- **ANY CARE RELATED TO PREGNANCY.**
- **THE COST OF A PROSTHESIS** while confined and there is enough time remaining before release to schedule evaluation, fabrication, fitting and delivery appointments.

F. Charges and Deposits. Medical co-pay fees will be collected and deposited in a DCC account according to procedures established by the Deputy Director for Administrative Services.

1. When a medical co-pay fee is posted to the resident's account, the balance will not be reduced below five dollars ($5.00). Any amount not charged to the resident for medical services due to an insufficient balance will be established as a medical co-pay debt owed by the resident.

2. Medical co-payment debts or charges must be deducted before commissary charges are allowed.

3. "Christmas funds," "Gate Money" or other funds provided by the State as maintenance pay may not be taken to offset medical co-pay debts.

V. PROCEDURES.

A. Orientation.

1. During the medical segment of the orientation program, each new resident must be informed of the medical co-pay program and must sign AD 10-08, Form 1, Resident Co-Pay Program Notice and Acknowledgment" If the resident refuses to sign, the refusal must be noted on the form and signed by two DCC correctional or medical personnel (witnesses).

2. The signed copy of the Offender Co-Pay Program Notice and Acknowledgment form will be placed in the resident's institutional record.

B. Collection of Fees.

1. Residents will access, medical, dental, or mental health care services by completing and submitting AD 10-08 Form 3, "Health Service Request."

2. Upon completion of a medical, dental, or mental health care visit requiring a co-pay fee the resident's number, name, and co-pay charge, will be entered on AD 10-08 Form 2, "Health Care Services Co-Pay Log." The resident and Health Services Unit staff member will sign, attesting that the services were provided. If the resident refuses to sign, the Health Services Unit representative will enter "Refused to Sign" in the resident's signature block, and will sign after the entry. Another Health Services Unit representative (or if not available, a Residential Supervisor) will sign.

3. The Health Services Administrator (HSA) must ensure the Health Care Services Co-Pay Log is completed for each 24 hour period (from 00:00 to 23:59) and taken to the Center Business Manager the morning of the next working day where the appropriate charges will be made to the resident's account. A copy must be maintained in the Health Services Unit but must not be filed in the Medical Record.

4. When a resident or an inmate is transferred from one DCC or Arkansas Department of Correction (ADC) facility to another or to Parole/Probation status, the medical debt information will remain on the eOMIS banking record so that it may be collected.

C. Refund of Fees.

1. A resident who believes he/she was charged for medical services inappropriately should submit a written refund request to the HSA. The HSA will investigate the incident and determine if a refund is due. If the resident is dissatisfied with the findings of the HSA, he/she may follow the grievance process.

2. When a refund is necessary, the HSA will complete a separate Health Care Services Co-Pay Log sheet, annotate "REFUND ONLY," and enter the amount of the refund. The HSA will forward the original Log sheet to the Center Business Manager the morning of the next working day for adjustments to the resident's account. A copy of the Log sheet will be maintained in the Health Services Unit for reference purposes.

VI. FORMS.

AD 10-08 Form 1 Resident Co-Pay Program Notice and Acknowledgment
AD 10-08 Form 2 Health Care Services Co-Pay Log
AD 10-08 Form 3 Health Care Service Request From

Arkansas Department of Community Correction
RESIDENT CO-PAY PROGRAM NOTICE AND ACKNOWLEDGMENT

I understand that in accordance with the Arkansas Department of Community Correction Administrative Directive on the Health Care Co-Pay Program, I will be charged applicable health care co-pay fees and the amount will be deducted from my resident banking account. The fee amount is currently $3.00, but this may be adjusted by the Board of Corrections. (Please refer to the Administrative Directive on the Health Care Co-Pay Program for a more in-depth description of "applicable" charges.)

I understand that if I have insufficient funds to cover the charge(s), the amount of the co-pay fee will be considered as an outstanding debt. Any subsequent funds deposited to my resident account will be used to pay this debt before commissary charges are allowed when the balance of my account rises above $5.00.

I had an opportunity during orientation to ask questions concerning the co-pay policy. I understand that I will not be denied reasonable and necessary health care services because of inability to pay.

Resident's Name (Print)	Offender No.	Resident's Signature	Date
Witness Signature	Date	Witness Signature	Date

AD 10-08 Form 1

Arkansas Department of Community Correction
HEALTH CARE SERVICES CO-PAY LOG

Facility	Health Services Administrator	Date

The residents listed below incurred co-pay charges for health care services on this date.

Resident No.	Resident's Printed Name	Resident's Signature	Health Service Rep.	$ Charge

AD 10-08 Form 2

Arkansas Department of Community Correction
HEALTH CARE SERVICE REQUEST FORM

Name (Last, First, MI) _____ DCC # _____ Date of Birth _____ Date of Request _____

Job Assignment _____ Barracks/Wing/Pod _____

Description of the problem: _____

I consent to be treated by the Health Services Staff for the condition described.
I understand that in accordance with Department of Community Correction policy, I will be charged for applicable health care services through deductions of applicable co-pay charges from my resident bank account, and that if I have insufficient funds to cover the charge, the amount of the co-pay fee will be considered an outstanding debt.

_____
Resident's Signature

PLACE THIS REQUEST IN THE MEDICAL BOX OR DESIGNATED AREA AND DO NOT WRITE BELOW THIS LINE

List Protocol(s) Below: **NURSING DOCUMENTATION**

1) _____ 2) _____ 3) _____

Subjective Data:

Objective Data: BP: _____ Pulse: _____ Respirations: _____ Temperature: _____ Weight: _____

Assessment: _____

Plan by Nursing Care: _____

Body System Code (from problem list): _____ Patient Education: ☐ Handout ☐ Verbal Instruction Topic: _____

Refer to: ☐ Physician ☐ Mid-Level ☐ Mental Health ☐ Dental ☐ Other (List): _____

Signature	Title	Unit	Date	Time

AD 10-08 Form 3