Menninger

Policies and Procedures

THE MENNINGER CLINIC
Finance & Access

Policy MC-241 **Financial Assistance Policy**

Effective Date: **October 2026**

Mission Statement

The Menninger Clinic (The Clinic) is a leading psychiatric center dedicated to treating individuals with psychiatric illness. In support of this mission, Menninger provides financial assistance for emergency and medically necessary care to individuals who are classified as "medically or financially indigent" and who meet The Clinic's Financial Assistance policy (FAP). Patient notices about Menninger's FAP will be available in applicable languages on the website, Access offices, outpatient offices, finance offices, and the general waiting area(s).

Purpose

The Menninger Clinic is committed to providing emergency and medically necessary care to individuals without the ability to pay. The Board of Directors, or authorized body, has adopted the following policy according to rules adopted by Internal Revenue Code 501(r) and the Texas Department of State Health Services. This policy outlines how to apply for financial assistance, including the eligibility criteria for free medically necessary care.

Policy

All patients/guarantors seeking medically necessary care will be provided with a copy of the Financial Assistance policy as part of the admission process. The Clinic will make reasonable efforts to orally communicate an offering of financial assistance to those patients throughout the course of treatment and after discharge, or until a determination is made regarding the patient's/guarantor's eligibility for financial assistance. The Clinic encourages every patient who is receiving medically necessary care to apply for financial assistance prior to admission. An individual who has been classified as "medically indigent" or "financially indigent" and who requires medically necessary care at The Clinic shall be provided care in accordance with this policy.

Emergency Medical Care

An individual who presents themselves at The Menninger Clinic stating they are seeking treatment, admission, or evaluation will be triaged by the Access department to ascertain services needed, if any. Individuals who evidence an emergency medical condition that is not within the scope of services for the Menninger Clinic will be transferred to the appropriate medical facility. Triage services are provided free of charge to all patients. MC 105 Patient Transfers Policy addresses the process for assessment and transfer of individuals who exhibit an emergency medical condition. A copy of the policy can be obtained free of charge from the Access department.

Definitions

1. ***Clinic*:** The Menninger Clinic
2. ***Emergency Medical Condition*:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could be reasonably expected to result in placing the health of the individual (or with respect to a pregnant

woman, the health of the woman or her unborn child) or others in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

3. ***Household:*** Defined as a group of two or more people who reside together and who are related by birth, marriage, adoption, guardianship or domestic partnership excluding non-relatives, such as housemates.
4. ***Financial Contract:*** Contract that every paying patient signs that outlines the services to be provided and financial responsibility of each patient/guarantor.
5. ***Financially Indigent:*** A patient whose household income is less than 300% of the Federal Poverty Level (FPL)
6. ***Medically Indigent***: A person whose household income is between 300% and 400% of the FPL and whose healthcare costs are greater than 20% of the household income.
7. ***Clinic Admission Criteria:*** Pre-established criteria that all patients must meet to be accepted into any inpatient or outpatient program. Examples of the criteria include, but are not limited to, presence of psychiatric or substance abuse diagnosis as principal diagnosis, voluntary status, the patient's level of aggression, ability to participate in their care, ability to provide activities of daily living with minimal assistance, and the level of general medical care needed.

Covered Services

The Menninger Clinic provides financial assistance in the form of free medically necessary services for both inpatient and outpatient care to adults and adolescents who require such care and who meet clinical and financial qualifications. Inpatient care for adults and adolescents is provided on separate inpatient units. Inpatient care is defined as medically necessary when an individual is experiencing a psychiatric crisis that requires 24/7 medical support and monitoring in a secure setting for at least one or more of the following reasons:

- An imminent risk of harm to self or others.
- An inability to meet basic needs such not eating, drinking, maintaining basic hygiene, or sleeping.
- Failed outpatient care due to the severity of worsening symptoms despite treatment.

Outpatient care for adults and adolescents is provided at The Menninger Clinic in its Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP). Outpatient care for adults and adolescents is defined as medically necessary treatment that does not require an inpatient level of care to recover from a psychiatric condition. Patients who initially admit to inpatient care typically step down to one of our outpatient programs to continue their recovery.

Financial Assistance Criteria

Once a patient meets the Clinic Admission Criteria and the required services are deemed medically necessary, as stated above, the patient must meet the financial or medically indigent criteria listed below. Once a favorable determination is made, the patient will be covered under this policy and will receive free medically necessary care, for the covered services, as stated above.

1. ***Resident Criteria***: Applicants/Patients being considered for financial assistance must meet all the criteria outlined below.

    a. Applicants/patients must be legal residents of the U.S.
    b. Applicants/patients must reside in the state of Texas for at least six months prior to the date of application.

2. ***Financial Criteria:*** Patients qualify as "financially indigent" based on their total household income on the date of admission.
    a. Household income includes the income of all members of the Household, as previously defined. Household income includes the following: earnings, unemployment compensation, workers' compensation, social security, supplemental security income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates and/or trusts, educational assistance, alimony, assistance from outside of the household, and other miscellaneous income. Household income excludes noncash benefits and capital gains. Household income is based on definitions used by the U.S. Bureau of the Census.
    b. Households with income more than $150,000 may self-report their income on the financial assistance application. Households with less than $150,000 must use their most recently filed tax return or documentation to support income, based on the Internal Revenue Service guidelines.
    c. Households with a significant change in income since their most recently filed tax return, may use appropriate documentation to support income, based on the definition stated above.
    d. Household income does not exceed 300% of the current HHS Poverty Guidelines. Current HHS Poverty Guidelines may be obtained at: https://aspe.hhs.gov/poverty-guidelines.

e. ***Additional considerations of Household:*** Applicants claimed as a dependent by a third party on his or her income tax return or financially supported by a third party (i.e. monthly living costs, etc.) may be considered a dependent for the purpose of determining eligibility for Financial Assistance. If an applicant is deemed a dependent of a third party, then the income of the third party may be included in determining eligibility for Financial Assistance. If the IRS tax documentation is not available, family size will be determined by the number of dependents documented on the Financial Assistance Application and verified by the Clinic in accordance with Internal Revenue Service guidelines.

3. ***Medically Indigent Criteria:*** Previous payments to The Menninger Clinic and/or future payment plans to other medical providers, for previous healthcare services, may be used to reduce the household income of the patient/guarantor. To be considered for financial assistance under medically indigent criteria, all of the following criteria must be met:
    a. Annual income between 300% and 400% of FPL.
    b. Previous payments to The Menninger Clinic, within the last 12 months, or future payment plans to other medical providers, for previous healthcare services, that exceed 20% of the annual household income.
    c. The verified payment amounts will reduce the reported income used to consider financial eligibility.
    d. The revised household income does not exceed 300% FPL as stated in the financial criteria.

4. ***Amounts Generally Billed (AGB):*** Once a patient qualifies for financial assistance, at no time will the patient be charged more than the amounts generally billed for medically necessary care. AGB is determined by using the prospective Medicare or Medicaid method.

5. ***Criteria Changes***: The financial assistance criteria will be reviewed at least annually and may be adjusted, depending on the resources of the Clinic and/or as necessary to meet the needs of the community. If changes to the financial criteria of this policy are made and once approved by the governing body of the Clinic, patients who are receiving care at that time will be re-evaluated and the most beneficial criteria will apply to their current episode of care. Any patients who have been discharged will be evaluated based on the policy at the time the application is completed. All other criteria will be based on the policy in place at the time of admission.

Procedures to Request Inpatient Care

Requests for Inpatient services under this policy will follow the procedures listed below:

a) Any applicant or their legally authorized representative (e.g., parent) may contact the Access Center to request inpatient care. Referrals on behalf of applicants can also be made by a licensed clinician, hospital or mental health affiliated agency, but the applicant/legally authorized representative will still need to contact the Access Center directly.
b) The Access Center will direct the applicant/guarantor to complete the Financial Assistance application which is available directly off the Clinic website and onsite if requested.
c) The Access Center will screen the potential patient according to the Clinic's admission criteria for inpatient care.
d) If the Access Center determines that the applicant meets the general clinical criteria for admission and is eligible for financial assistance according to the residency and financial requirements listed, they may be offered admission to inpatient care depending on bed availability.
e) If the applicant/guarantor provides false or incomplete information that would have excluded them from financial assistance, the Clinic reserves the right to retroactively exclude the applicant from financial assistance. This will result in the applicant/guarantor being financially responsible for all charges.
f) The applicant/guarantor is responsible for participating in the financial assistance determination process. If the applicant/guarantor does not actively participate in the process, they will not be covered under this policy. They will be responsible for payment of their full bill, and their account will be processed under the Clinic's Billing and Collection policy, starting 130 days after discharge.
g) It is recommended that the applicant complete the financial assistance application, and receive a determination prior to admission, however, an admission date will not be delayed due to an incomplete financial assistance application, unless requested by the applicant. Any patient who is admitted into the Clinic and is subsequently deemed to not meet the financial or clinic criteria will be responsible for payment of all charges incurred at a rate of 100% of billed charges. Normal billing and collections practices would apply.
h) If the applicant is denied admission to The Clinic, they may appeal The Clinic's decision by submitting a written request for review of such decision with The Clinic's Financial Assistance Review Committee within two (2) days of the receipt of notice of the initial rejection. The Financial Assistance Review Committee shall be comprised of

the Chief Medical Officer, the Chief Financial Officer and the Vice-President of Patient Access. The Financial Assistance Review Committee has full discretion as to when and how it should act on an appeal.

i) The decision of the Financial Assistance Review Committee is final.

Procedures to Request PHP/IOP Services

a) In general, PHP/IOP services will be available as a covered service only to applicants who are currently inpatients covered under FAP depending on program capacity.
b) Applicants who are currently covered under FAP as inpatients will generally not have to submit a new application for PHP/IOP services unless their financial status has significantly changed.
c) Inpatients who are currently covered under FAP are not obligated to accept a referral to our PHP/IOP service.
d) Other inpatients who are not currently covered under FAP may submit an application at any time.

Application Process

a) The application, along with any documentation that is needed to substantiate the information in the application, will be submitted to the Director or their designee of the Access Center.
b) Presumptive qualifications of financial criteria may be made, without requiring proof of income, if the patient/household meets any of the following conditions, and can provide documentation to support these conditions:
    i. Participation in a low-income benefit program, such as WIC, CHIP, Medicaid, food stamps, local assistance programs, etc. Proof of participation in a low-income benefit program presumptively qualifies a patient for financial assistance. No proof of income is required.
c) Documentation, to support Household Income reported on the financial assistance application, includes the following:
    i. A copy of the most recently filed federal tax return(s)
    ii. Last 2 paycheck stubs, current W-2, or written verification of wages from employer
    iii. Documentation to support other types of income as previously defined
    iv. Documentation to support medical payment plans (for medical indigence qualification)
    v. Death certificate, or documentation from a valid source
    vi. Documentation to support participation in a low-income benefit program.
    vii. A signed affidavit must be provided if there is no income or documentation to support no income.
    viii. Along with the requested documentation above, a soft credit inquiry may be made to verify the submitted documentation.
d) If the applicant/patient qualifies for financial assistance, based on the above-mentioned criteria, the following will apply:
    i. Eligibility for financial assistance is determined for each episode of care with exceptions as defined above.
    ii. The patient will not be billed more than Amounts Generally Billed, as defined above.
    iii. Once a patient no longer meets medical necessity criteria for continued treatment, and a referral has been processed for after-care, the patient is no longer considered eligible under this policy and as such is responsible for payment of all services rendered from that time forward. Normal billing and collections practices would apply.
e) In general, the Clinic does not use prior financial assistance application determinations to determine eligibility under this policy. Each admission for each episode of care will require a new application and determination of eligibility under this policy. This can be waived when a patient who is currently in treatment is recommended to transition to a higher or lower level of care that is a covered service under this policy.
f) Applicants not eligible for financial assistance are provided with contact information to an appropriate provider or facility in the Houston metropolitan area or a national mental health agency.

Where and How to Obtain an Application or Further Information

Access Center
The Menninger Clinic
12301 South Main Street
Houston, TX 77035
Attn: Financial Assistance

Phone 713-275-5400

https://www.menningerclinic.org/for-patients/financial-information

To notify members of the community about the availability of financial assistance, the Clinic will publicize the policy as follows:

- Post the Financial Assistance policy, financial assistance application and plain language summary on the Clinic's website at: **https://www.menningerclinic.org/for-patients/financial-information**
- Provide information on how to access, download and print copies of the documents upon request at the Access desk.
- Offer a copy of the plain language summary without charge in English (and in languages listed below) as part of the admission process:
    a) English, Spanish, Vietnamese, Chinese, including Mandarin and Cantonese and Tagalog,
    b) Additional translation is available upon request.

Billing and Collection Activity

Any covered services provided to individuals covered under this policy will be at no cost to the patient/guarantor. As such, no extraordinary collection actions will occur on the services and individuals covered under this policy.

If an application for financial assistance is not made prior to services being rendered, the Clinic will continue to communicate with the patient/guarantor to complete the application process and make a determination while services are being rendered, and up to 250 days after the patient discharges. After 250 days post discharge, collection actions under the Clinic's separate billing and collection policy will commence.

Billing and collections processes for any services provided outside of this policy, or any patients who are not covered by this policy, will be processed in accordance with the Clinic's Billing and Collection policy. Collection actions may include requiring a deposit (from individuals not covered by the Clinic's FAP), obtaining external collection assistance, possible denial of non-medically necessary services if a previous balance is owed, and reporting to credit bureaus.

Any services performed on patients who have incomplete applications will be treated as covered under this policy while the application is completed and a determination for financial assistance is finalized. Patients will be notified of any additional information needed to complete the application and will have no longer than 130 days after discharge to complete the application process. After 130 days post discharge, Billing and Collections will be processed in accordance with the Clinic's separate Billing and Collection policy. Once the application is completed and a favorable determination has been made, the patient's account, for this episode of care, will retroactively be treated as covered under this policy and any payments made by the patient for the episode of care will be refunded. Retroactive application of financial assistance based on presumptive qualification of the patient being deceased will only apply to past due charges, and not to the entire episode of care.

Non-Covered Providers

Occasionally, outside medical providers may see patients on The Menninger Clinic's campus. These services are generally paid for by the Clinic and may be billed to the patient, based on their financial contract. These services may include radiology, lab, physical therapy, or psychological testing. However, in some cases, the patient may be billed directly from the external provider. These providers may bill the patients separate from their Clinic bill and are not covered under the Clinic's FAP. The Clinic will pay for these services for patients covered under this policy, provided they are necessary for the core treatment. If the services are optional, patients may contact these providers separately for information regarding whether they have a FAP.

Occasionally, the Clinic will refer a current inpatient to an outside medical provider, for general medical and dental services. These services may include physical therapy, lab, radiology, dental, etc. These providers will bill the patient directly. The patient is responsible for the financial arrangements for each external provider. The patient does have the option to select a different provider, or to decline services. If there is a substantial out-of-pocket cost to the patient, the Clinic will review the situation and may provide payment to the external provider, on the patient's behalf, on a case-by-case basis, for individuals qualifying under this policy.