THE GUIDANCE CENTER **POLICY #: Finance-101**

CONSUMER ELIGIBILITY FOR BENEFITS

I. **POLICY:**

The Guidance Center will assist consumers in determining qualification for and accessing their potential benefits under TXIX, TXXI and SSI for SMI consumers or other consumers with disabling conditions.

II. **PURPOSE:**

To ensure consistent documentation of the consumer eligibility application process.

III. **PROCEDURE:**

A. **SSI Eligibility**

1. **CLS staff assists adult consumers who are psychiatrically disabled with the application process for SSI when the consumer does not already have this benefit.**

2. **Staff assists the consumer to complete the DES Eligibility Determination Services Administration Medical Documentation Packet and the Social Security Consent for Release of Information.**

3. **Forward these documents with the SSI Screen Form to the Social Security Office, 1609 South Plaza Way, Flagstaff, AZ, 86001. (928-556-7477).**

4. **Following the Social Security Field Office review, the Case Manager is contacted by phone to schedule an appointment for a telephone discussion of the claim. The SSI Field Office officially schedules the appointment and copies the Case Manager with written notice of the appointment, which is placed in the consumer's record.**

5. **The SS Field office initiates the telephonic conference on the appointment date, and following clarification of any remaining questions, completes the SSI application by phone. Once the form is complete, the form is faxed to the Case Manager for obtaining appropriate Guidance Center signatures.**

6. **The Case Manager returns the signed material to the SS Field Office for processing.**

7. **The consumer is notified of the results of the application by the SS Field Office if the consumer has a signed consent for release of information on file, and TGC is notified as well.**

B. Title XIX

1. Eligibility for Title XIX funding is determined in accordance with TGC Policy PC-303: *Requirements for Determining Member Financial Eligibility.*

C. Title XXI (KidsCare) Eligibility

1. Title XXI referrals are accepted as per TGC Referral Policy including 18 year- old SMI referrals. Availability of this funding source is subject to legislative approval and eligibility requirements may vary from year to year based on available funds.

2. The applicant for service is screened for eligibility using the following eligibility requirements:

a. Must be an Arizona Resident 18 years old or younger.
b. Must be a citizen or a legal resident.
c. Eligibility is limited to those under 200% of the Federal Poverty Guidelines, which change on or around April 1st of each year.
d. Exclusions are:

i. Eligible for insurance coverage due to parents/self employment with the state.
ii. Medicaid or Medicare eligible.
iii. Currently covered by employer group or consumer health insurance or in the prior 6-month period (COBRA). This does not apply to the following:

- **Newborn**
- **Title XIX member**
- **MI/MN member**
- **EAC member**
- **ELIC member**
- **State Funded SSI MAO non-qualified alien, residing in the U.S. under color of law, on or before 8/21/96.**
- **IHS members.**
- **Inmate of a public institution.**

e. If screening determines potential eligibility, the consumer is provided with assistance in applying for AHCCCS Title XXI benefits. An Account Representative provides the application form, assists the consumer/parent/ guardian in completing the form and faxes the form to DES. An Account Representative will document all referrals and assistance provided to the consumer in his/her Electronic Medical Record.

References:

HCIC 3.1
Joint Commission: CTS.01.01.01

FORMS: **DES Eligibility Determination Services Administration Medical Documentation Packet**
Social Security Consent for Release of Information
Application for Medical Assistance
Appointment Notice

Signatures:

M D. Nellis — 12/24/15

Mark Nellis
Finance Director
Date

Jack Callaghan, Ph.D. — 12-24-15

Jack Callaghan, Ph.D.
CEO
Date

THE GUIDANCE CENTER	POLICY #: Finance-102
DETERMINING CONSUMER FINANCIAL ELIGIBILITY	

I. **POLICY:**

It is the policy of The Guidance Center and a HCIC contractual obligation to assist individuals seeking behavioral healthcare services in determining their eligibility and/or potential eligibility for HCIC-funded services and to assist individuals with the AHCCCS application process when necessary.

The Guidance Center's Account Representatives inform the treating clinician or program manager of the outcome of a consumer's AHCCCS application and track and inform individuals of their ongoing eligibility status following intake and annually until discharge.

II. **PROCEDURES:**

The Guidance Center performs the following financial screening activities:

A. **Proper identification and monitoring of the financial eligibility of persons for HCIC-funded services begins at the time of initial contact with TGC and request for behavioral healthcare services. HCIC-funded services include, but are not limited to, Title XIX and KidsCare (Title XXI), priority substance users/abusers, etc. Documentation of all required eligibility assessment forms is included in the consumer record. The availability of state funding sources are subject to legislative approval and may vary in amount and availability from year to year.**

B. **Upon receipt of a telephone request for behavioral healthcare services, the Intake Coordinator arranges for an intake appointment with the appropriate department clinician and conducts a brief telephone screening for AHCCCS eligibility and runs a report from AHCCCS Online.**

C. **At the time of intake, an Account Representative conducts a more in-depth face-to-face interview (screening) with the person to further determine eligibility for HCIC-funded services. Initial identification of the clinical and programmatic (i.e., Child, Alcohol, Drug Abuse, Mental Health and Seriously Mentally Ill) eligibility of persons for HCIC-funded services is made by the Intake Specialist and entered in the electronic medical record and the Financial Eligibility Screens are completed. Adult consumers are also assessed to determine if they appear to meet SMI criteria.**

D. **Eligibility for HCIC-funded services is discussed with the individual and assistance with the online AHCCCS eligibility application is provided as necessary. A TGC Account Rep will assist the individual as necessary to ensure that all required information and documentation is obtained to complete the AHCCCS application or to solicit additional information to assist in determining an appropriate funding source. Completed forms are faxed directly to the appropriate agency (AHCCCS, Arizona Department of Economic Security) to make the final Title XIX or Title XXI determination.**

E. The following information is collected and documented in the consumer's record:

1. AHCCCS ID
2. Family size
3. Income sources
4. Adjusted monthly income
5. Financial eligibility
6. Benefit/eligibility
7. Primary pay source
8. Health Plan name
9. Special Populations (SMI/SED; IV drug user; Pregnant: Drug dependant woman with dependant child).

F. Individuals who screen as potentially eligible for Title XIX or Title XXI funding but are not yet on AHCCCS complete the intake and enrollment process and sign two fee agreements. The first fee agreement covers service provision should a determination be made that the individual is eligible for HCIC-funded services. If approved by the 25th of the month in which the application is received, coverage is made retroactive to the first day of that month. The second fee agreement stipulates that in the event an AHCCCS application is denied and the individual does not appear to meet SMI criteria or otherwise meet criteria for inclusion in a special population, financial responsibility for services may fall to the individual should an alternate funding source remain unidentified. If subvention funds are available, PM Form 3.4.1 is used to calculate the applicable co-payment. Lastly, a sliding fee scale may be applied for Non-Title XIX eligible individuals or families who meet pre-determined income levels.

G. The case manager or treating clinician, with assistance from an Account Representative when necessary, reassesses the financial eligibility of each consumer annually (or more often if a person's situation changes).

References:

HCIC 3.1
Joint Commission: CTS.01.01.01

Signatures:

M D. Nellis — 12/24/15

Mark Nellis
Finance Director
Date

Jack Callaghan, Ph.D. — 12-24-15

Jack Callaghan, Ph.D.
CEO
Date

THE GUIDANCE CENTER **POLICY #: FIN 208**

Center for Mental Health Services Block Grant (MHBG)

I. **Policy:** It is the policy of The Guidance Center to ensure access to services for the Seriously Mentally Ill (SMI) and Seriously Emotional Disturbed (SED) members who qualify for Federal Block Grant funding, through the Center for Mental Health Services Block Grant (MHBG) program.

II. **Purpose:** To assure compliance with the requirements of the Center for Mental Health Services Block Grant (MHBG) program.

III. **Procedure:** TGC will pursue opportunities to assure that the five Grant Criteria are met with this funding:
(1) Comprehensive Community-Based Mental Health Service Systems;
(2) Mental Health System Data Epidemiology;
(3) Children's Services;
(4) Targeted Services to Rural and Homeless Populations and to Older Adults; and
(5) Management Systems

A. TGC will coordinate with external Agencies to obtain those services and resources to be provided, within the comprehensive system of care provided with Federal, State and other public/private resources, which may function outside of TGC's inpatient and/ or residential programs, to include:
- Health, mental health and rehabilitation services;
- Employment services;
- Housing services;
- Educational services;
- Substance abuse services;
- Mental and dental services;
- Support services;
- Services provided by the local school system under the Individuals with Disabilities Education Act (IDEA);
- Case management services;
- Services for persons with co-occurring (substance abuse/mental health) disorders; and
- Other activities leading to reduction of hospitalization.

B. TGC will seek to assure that MHBG Block grant funding is not used for the following:
- To provide inpatient hospital services;
- To make cash payments to intended recipients of health services
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodelling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (Maintenance of Effort);
- To provide financial assistance to any entity other than a public or nonprofit private entity;

- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year;
  See http://grants.nih.gov/grants/policy/salcap_summary.htm;
- To purchase treatment services in penal or correctional institutions of the State of Arizona.
- To provide acute care or physical health care services including payments of co-pays.

C. TGC recognizes that Services for SED children are targeted to those not covered by Medicaid for TXIX children. These services may include flex funds, traditional healing, acupuncture, or room and board, etc. As funding is available, non-TXIX children with SED may be served. MHBG funds may be used to support transition services for SED children in juvenile detention centers. These services include case management, family support, and other appropriate services identified by the child and Family Team. The MHBG is to be used as the payor of last resort for such services.

D. TGC acknowledges that, for Adults with Serious Mental Illness, the funding is available for both TXIX and NTXIX individuals:
   - TXIX: services not covered by Medicaid except for Room and Board
   - NTXIX Service Package (see http://www.azdhs.gov/bhs/provider/forms/pma3-13-1 .pdf).

E. TGC further acknowledges that Flex Funds may only be used for non-medically necessary goods and/or services that are described in the person's service plan and that cannot be purchased by any other funding source. Furthermore, the member receiving flex funds must meet the population requirements of the respective Block Grant of which the funds originated. The goods and/or services to be provided using flex funds must be related to one or more of the following outcomes:
   a. Success in school, work or other occupation;
   b. Living at the person's own home or with family;
   c. Development and maintenance of personally satisfying relationships;
   d. Prevention or reduction in adverse outcomes, and/or;
   e. Becoming or remaining a stable and productive member of the community.

F. Such Flex funds must and shall not be used for:
   a. The purchase or improvement of land;
   b. The purchase, construction or permanent improvement of any building or other facility (with the exception of minor remodeling consistent with this Section); and
   c. The purchase of major medical equipment.
   d. Any other prohibited activity as detailed in 45 CFR Part §96.135 et seq.

G. Flex funds must be used for the direct purchase of goods and/or services and cannot be direct cash payments to behavioral health recipients or their families.

H. Flex fund services are limited to $1,525 per individual/family per year. Requests for approval of flex fund expenditures exceeding $1,525 per individual/ family can be requested through NARBHA.

IV. Monitoring: TGC acknowledges that all documentation supporting the need and utilization of flex funds including, yet not limited to, original receipts for goods or services purchased, and the related service plan indicating how the good or service relates to the treatment goals, must be made accessible to NARBHA for auditing and financial tracking purposes.

Signatures:

Mark Nellis, Finance Director — Date: 10/7/14

John (Jack) Callaghan, CEO — Date: 10-12-14

THE GUIDANCE CENTER

POLICY #:FIN # 209

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT (SABG)

I. **Policy:** It is the policy of The Guidance Center to make Pregnant and Parenting Women with Substance Abuse and IV Drug Users a priority for access to treatment and interim services, as specified in the Substance Abuse Prevention and Treatment (SABG) Federal Block Grant, and to ensure that services occur within the time frames specified by the SABG Federal Block Grant.

II. **Purpose:** To assure compliance with the requirements of the Substance Abuse Prevention and Treatment Block Grant (SAPT) program.

III. **Procedure:** TGC will pursue opportunities to assure that the Substance Abuse Prevention and Treatment Block Grant (SABG) funds are used to address the following populations (in order of priority):

(1) Pregnant females who use drugs by injection;
(2) Pregnant females who use substances;
(3) Other persons who use drugs by injection;
(4) Substance using females with dependent children and their families, including women who are attempting to regain custody of their children; and
(5) As Funding is Available - all other clients with a substance use disorder, regardless of gender or route of use.

A. TGC will seek to assure that SAPT Block Grant funding is not used for the following:

- To provide inpatient hospital services;
- To make cash payments to intended recipients of health services;
- To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
- To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
- To provide financial assistance to any entity other than a public or nonprofit private entity;
- To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS;
- To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year; see http://grants.nih.gov/grants/policy/salcap_summary.htm, and;
- To purchase treatment services in penal or correctional institutions of the State of Arizona.
- To provide acute care or physical health care services including payments of co-pays

B. TGC Recognizes that Room and Board (H0046 SE) services funded by the SAPT Block Grant are limited to children/ adolescents with a Substance Use Disorder (SUD), and adult priority population members (pregnant females, females with dependent children, and intravenous drug users with a SUD).

C. TGC acknowledges that Flex funds may only be used for non-medically necessary goods and/ or services that are described in the person's service plan, and which cannot be purchased by any other funding source. Furthermore, the member receiving flex funds must meet the population requirements of the respective Block Grant from which the funds originated. The goods and/or services to be provided using flex funds must be related to one or more of the following outcomes:
(1) Success in school, work or other occupation;
(2) Living at the person's own home or with family;
(3) Development and maintenance of personally satisfying relationships;
(4) Prevention or reduction in adverse outcomes, and/or;
(5) Becoming or remaining a stable and productive member of the community.

D. Such Flex Funds must and shall not be used for:
a. The purchase or improvement of land;
b. The purchase, construction or permanent improvement of any building or other facility (with the exception of minor remodeling consistent with this Section); and
c. The purchase of major medical equipment.
d. Any other prohibited activity as detailed in 45 CFR Part §96.135 et seq.

E. Flex funds must be used for the direct purchase of goods and/or services and cannot be used as direct cash payments to behavioral health recipients or their families.

F. Flex fund services are limited to $1,525 per individual/family per year. Requests for approval of flex fund expenditures exceeding $1,525 per individual/ family can be requested through NARBHA.

IV. Monitoring: TGC acknowledges that all documentation supporting the need and utilization of flex funds including, yet not limited to, original receipts for goods or services purchased, and the related service plan indicating how the good or service relates to the treatment goals, must be made accessible to NARBHA for auditing and financial tracking purposes.

Signatures:

Mark Nellis, Finance Director — Date: 10/7/14

Jack Callaghan, CEO — Date: 10-12-14

THE GUIDANCE CENTER **POLICY #: FIN 210**

Financial Assistance

I. Policy: Uninsured Individuals receiving medically necessary care and exhibit financial need according to the Federal Poverty Guideline are eligible to receive financial assistance.

II. Purpose: The Financial Assistance Program policy, in accordance with federal and state regulatory guidelines, ensures financial assistance is available for Individuals unable to meet their financial obligations based upon their care need.

a. Definitions:
   i. Amounts generally billed (AGB): For each hospital, the AGB Percentage is a percentage derived by dividing the sum of all claims for Medically Necessary services provided at such Hospital paid during the Relevant Period by all private health insurers as primary payors, together with any associated portions of these claims paid by insured individuals in the form of co-pays, co-insurance or deductibles. The AGB Percentage is calculated by January 31 and is effective until the next annual calculation. The calculation shall comply with the "look-back method" described in Treasury Regulation §1-501(r)-5(b) (1) (B).
   ii. Bad Debt: A balance no longer deemed collectable.
   iii. Elective: Service deemed by a physician to be non-emergent and safe for delay.
   iv. Federal Poverty Level (FPL) : The minimum amount of gross income required to sustain a family as determined by the United States Department of health and Human Services.
   v. Medically Necessary Services: Medical care required to ensure the well-being of the patient as defined by generally accepted medical practice. TGC's Flat Rate: TGC's provides flat rate self-pay fees for specific services to uninsured Individuals.

III. Eligibility: To be eligible for consideration, an applicant must be an uninsured patient receiving medically necessary care and exhibit financial need in accordance to the Federal Poverty Guideline (FPL) are eligible to receive financial assistance.

a. To be eligible for consideration, an applicant must be:
   i. Ineligible for Medicaid;
   ii. Approved for Medicaid postdate of service;
   iii. Medicaid eligible but service is not a covered benefit;
   iv. Less than 400% of the FPL.
b. TGC's flat rate fees and co-pays are not eligible for consideration.
c. Eligible balances will be adjusted according to the FPL calculation based upon household number and income. In the event that the patient receives a tiered discount under this policy, the patient will not be billed more than the amounts generally billed for care, calculated using the Amounts Generally Billed method as described in applicable IRS regulations.
d. This policy is communicated via the following:
   i. TGC's website;
   ii. The guarantor billing statement;
   iii. Available throughout the covered facilities and upon request without ;charge via mail;
   iv. Customer Service team members.

Procedures:

1. Charges for all emergency or other medically necessary services provided by entities covered by this policy are eligible for financial assistance consideration, excluding elective care. Care provided by physicians not employed by The Guidance Center are not eligible for financial assistance consideration under this policy.
2. Encounters for which a third party is liable for care are not eligible for consideration. If the third party does not accept liability for the cost of the services, the applicant may reapply.
3. The Financial Assistance Applications are not processed if received after the 240th day after the first bill to the individual for the most recent episode of care. If an application is received within that time but after the encounter has been sent to bad debt, the account will be recalled to the hospital to review and act on the application in accordance with this policy.
4. Financial Clearance (FC) can be done prospectively, concurrently, and retrospectively.
    a. Prospective and Concurrent Review:
        i. Individuals are reviewed for the ability to pay by Patient Access Services (PAS) after confirmation from clinical staff that the patient has received an appropriate medical screening examination by a qualified medical professional, and either
            - no emergency medical condition exists or;
            - if an emergency medical condition exists, such condition has been stabilized as defined by the Emergency Medical Treatment and Active Labor Act. The hospital will not delay or deny emergency medical care to an individual on the condition that an individual submit information to determine whether the individual qualifies for third-party coverage or financial assistance for the care being delayed or denied.
        ii. The financial clearance process will be performed in accordance with the procedural requirements outlined in the job aids indicated in the reference section of this policy.
    b. Retrospectively, the Revenue Cycle staff review requests for assistance submitted post discharge.
    c. If the patient is unable to meet his or her financial obligation for care, the FC reviews the patient for eligibility for Arizona Medicaid (AHCCCS).
        i. Individuals that do not provide the necessary documentation to determine eligibility for AHCCCS will not be considered for financial assistance.
        ii. If the proof of income indicates it is in excess of the limits for AHCCCS eligibility, the financial assistance process may continue without completing the AHCCCS application.
        iii. If the patient has AHCCCS or other insurance coverage, the financial class is changed on the encounter and financial clearance is concluded.
        iv. If the patient does not have AHCCCS or other insurance coverage, and proof of income indicates possible eligibility, the FC engages the patient in the AHCCCS application process (see MECS AHCCCS eligibility procedure):

- If patient is awarded AHCCCS coverage but coverage is not retroactive to the date of service, the patient will be considered eligible for financial assistance (see Presumed Financial Assistance);
- If the patient is denied coverage, the FC will provide the patient with the Financial Assistance Application.

d. The Financial Assistance Application is completed by the patient/guarantor. The application supporting documents include the following:
   i. Complete copy of the signed prior year federal tax returns;
   ii. Determination letter from AHCCCS (valid denial or acceptance of a completed final application for AHCCCS) or other government-funded program for the patient's individual state, such as Medicaid or proof of ineligibility based upon FPL calculator;
   iii. The patient/guarantor must prove total household income as defined below:
      - Household income is required for all adults (18 years or older or full times students under 24);
      - 3 months of personal bank statements for all account types (savings, checking, etc.);
      - Proof of employed patient/guarantor income;
        - Employed applicants: 3 consecutive check stubs or a letter from the applicants Human Resources Dept.
        - Self-employed applicants: A copy of the federal tax form schedule C.
      - Unemployed applicant: Copies of Unemployment payments or statement for means of support;
      - A copy of the SSA 1099 form if retired and/or on Social Security;
      - Copy of any pension benefit letters;
      - Other income to include rent, alimony, child support or other source.
   iv. Eligibility for charitable assistance will be based on the income and family size of the patient/guarantor.
      - Income levels are based on the FPL published by the Federal Register annually (Financial Assistance Scale).
        - Household members are defined as all dependents and adults residing with the patient.
        - Applicants with household income of 400% of FPL or lower may receive financial assistance based upon a tiered discount (Financial Assistance Scale).
   v. Financial Assistance Applications are processed within 5 business days of receipt :
      - Incomplete applications will be returned to the patient/guarantor, along with written notice identifying the missing information or documentation needed to process the application. This notice must describe the collection activities that may occur if the individual does not provide

the missing documentation or make arrangements to pay the bill within the later to occur of (i) 30 days from the date of notice or (ii) 120 days after the first bill to the individual for the most recent episode of care.
    - Patient/Guarantor has 30 days to provide missing information or documentation;
    - Failure to respond to missing information or documentation request within 30 days may result in denial.

vi. Under no circumstances will a determination that an individual is not eligible for assistance under this policy be based on information that there is reason to believe is unreliable, incorrect or obtained from the individual under duress.

vii. The patient/guarantor is notified of approval or denial of application in writing:
    - Financial Assistance less than 100% requires an established payment plan to remain in good standing;
    - Assistance is applicable to all current outstanding balances excluding elective cosmetic procedures for 6 month postdate of approval;
    - The patient/guarantor is responsible to notify the Central Business Office of new balances eligible for approved financial assistance adjustment.

e. Presumed Financial Assistance

i. Eligibility:
    - If patient is awarded AHCCCS coverage but coverage is not retroactive to the date of service, the patient will be considered eligible for financial assistance;
    - Patient had AHCCCS coverage the month preceding and the month post services;
    - Indigent based upon residency validation;
    - Patient's services are covered under a grant that has exhausted funding;
    - Patient is incarcerated and the care is not the financial responsibility of the local, state, or federal institution;
    - Patient provides an invalid social security number;
    - AHCCCS covered Individuals who exceed maximum allowable days;
    - Deceased;
    - Bankruptcy.

ii. Presumed Financial Assistance is by encounter only and cannot be used for future balances.

f. Exception/Financial Assistance Committee:

i. Individuals/Guarantors requesting exceptions can appeal an outcome by escalation to the Financial Assistance Committee.

ii. The Financial Assistance Committee is comprised of the Executive Director of Revenue Cycle, Controller, Director of

Patient Financial Services, and Clinical Department Director for the affected areas of care.

iii. Committee findings are documented and mailed to the patient/guarantor.

iv. Remaining balances after committee findings require an established payment plan to remain in good standing.

Poverty Level*	0 - 100 %		101 - 125 %		126 150 %		151 - 175 %		176 - 200 %	
Percent Discount	100% Discount		80% Discount		60% Discount		40% Discount		20% Discount	
Family Size	Minimum Fee		20% Pay		40% Pay		60% Pay		80% Pay	
1	$0	$12,140	$12,141	$15,175	$15,176	$18,210	$18,211	$21,245	$21,246	$24,280
2	$0	$16,460	$16,461	$20,575	$20,576	$24,690	$24,691	$28,805	$28,806	$32,920
3	$0	$20,780	$20,781	$25,975	$25,976	$31,170	$31,171	$36,365	$36,366	$41,560
4	$0	$25,100	$25,101	$31,375	$31,376	$37,650	$37,651	$43,925	$43,926	$50,200
5	$0	$29,420	$29,421	$36,775	$36,776	$44,130	$44,131	$51,485	$51,486	$58,840
6	$0	$33,740	$33,741	$42,175	$42,176	$50,610	$50,611	$59,045	$59,046	$67,480
7	$0	$38,060	$38,061	$47,575	$47,576	$57,090	$57,091	$66,605	$66,606	$76,120
8	$0	$42,380	$42,381	$52,975	$52,976	$63,570	$63,571	$74,165	$74,166	$84,760
For Each Additional person, add	$4,320									

*Based on 2018 HHS Poverty Level Guidelines (https://aspe.hhs.gov/poverty-guidelines)