



# ADMINISTRATIVE REGULATIONS

STATE OF ARKANSAS

BOARD OF CORRECTIONS

Section Number:

810

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1 of 4

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8/28/91

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08/29/1991

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Reference:

Effective Date:

8/29/91

SUBJECT: Inmate Emergency Medical Expenses Incurred While in County Jails

## I. AUTHORITY:

The Board of ~~Corrections~~~~Correction~~ is vested with the authority to promulgate administrative regulations by, but not limited to Ark. Code Ann. § 12-27-105, Act 50 of 1968, First Extraordinary Session, as amended; and § 12-27-114 by the Administrative Procedures Act, (Act 434 of 1967 as amended).

Specific pieces of legislation implemented, in part, through this administrative regulation are re Act 309 of 1983; Acts 329, 574, and 1112 of the 1991, Regular Session.

## II. PURPOSE:

This Administrative Regulation establishes rules by which the Department of Correction may reimburse any county, which is required to retain an inmate awaiting delivery to the custody of the Department of Correction.

Establishes the criteria for payment of certain medical expenses, incurred with proper approval, associated with emergent medical needs for eligible felons serving sentences or assigned to designated programs in county jails, and outlines procedures to be followed by counties in submitting such bills for payment.

## III. APPLICABILITY:

This policy applies to the staff of the Arkansas Department of Correction (ADC), Arkansas sheriffs, county jail staff, and inmates housed in county jails, provided that ADC has received a signed **and correct** commitment or sentencing order. The staff of Field Services, all convicted felons with signed commitment orders incarcerated in county jails, county sheriffs and supervisors of county detention facilities.

## IV. DEFINITIONS:

A. Eligible - ~~Inmates~~those individuals, convicted of felonies, on whom ADC has received signed and correct valid commitment or sentencing orders ~~have been signed~~

## Inmate Emergency Medical Expenses Incurred While in County Jails

2 of 6

and who, pursuant to that commitment or sentencing order ~~are or through a program of the~~

~~Arkansas Department of Correction, are, at the time of the illness or injury, housed in~~carcerated in the county jail. ~~Also, inmates placed in (including individuals on work programs, whose residence is in the county jails that have been revoked jail). Felons newly committed to the custody of the Department of Correction~~Arkansas Department of Correction ~~do not become eligible until 30 days after the signing of the commitment order. Individuals transferred to the county jail contract program as a regular transfer (Act 309) or placed in the county jail by a parole officer are immediately eligible.~~

B. Appropriate Approval - approval must be obtained through the Office~~office~~ of the ADC Administrator of Medical Services prior to the rendering of health care. In true emergency situations, care may be rendered and reimbursed without prior approval. The ADC Administrator of Medical Services~~services~~ is to be notified of such emergencies immediately after the emergency situation—events within 24 hours and provide approval for any necessary continued care.

C. Emergent Medical Need ~~— illness—~~Illness or injury ~~that~~which threatens life or limb, causes undue or unavoidable~~avoidable~~ suffering, subjects the inmate~~individual~~ to further unacceptable health risks~~risk~~, or is likely to result in~~cause~~ deterioration of health status if not promptly treated. ~~Chronic Health conditions resulting from injuries or illnesses preceding eligibility (defined in section A, above), and chronic~~ conditions do not qualify, unless their progressions or developments present symptoms of the condition~~presents~~ an emergent threat as an emergent medical need is defined herein~~define above~~.

D. Medical Expenses ~~—~~ expenses associated with diagnosis and/or treatment of an emergent medical need~~injury or illness~~, as billed by the health ~~care~~-service provider.

E. ~~Designated Programs—programs established under Section 9 of Act 50 of the First Extraordinary Session of 1968; programs established by Act 309 of 1983; and Acts 329, 574 and 1112 of 1991. Inmates on county jail backup are not participating in a designated program (Act 574) until 30 days after their commitment papers are signed.~~

## V. POLICY:

The Arkansas Department of Correction shall upon establishment of its legal responsibility, and contingent on appropriation and availability of funds, pay certain medical expenses for eligible felons housed in county jails.

## VI. PROCEDURE:

A. ~~If an inmate~~~~a convicted felon~~ is known to have a preexisting health condition likely to necessitate treatment or requiring a level of monitoring not available in the county facility, the ADC Administrator of Medical Services should be notified. The Department~~A determination~~ will determine~~be made as to~~ whether the seriousness of the

### Inmate Emergency Medical Expenses Incurred While in County Jails

3 of 6

condition and the ~~potential~~<sup>potent</sup> expense to the county ~~warrants~~<sup>warrant</sup> bringing the ~~inmate~~<sup>individual</sup> into the Department of Correction ~~on the basis of a medical emergency~~.

B. Should an ~~inmate~~<sup>individuals</sup> with a preexisting condition need treatment on an emergency basis (~~loosely defined in terms of~~ a situation that would lead a prudent family member to take the affected family member to a hospital emergency room), the sheriff or deputy should notify the ADC Administrator of Medical Services as soon as possible.

C. Routine care for preexisting conditions is the responsibility of the agency having physical custody of the ~~inmate~~<sup>individual</sup>. If the ~~inmate~~<sup>convicted felon</sup> is on furlough or is otherwise living in the community, the Department assumes no responsibility for any of the ~~inmate's~~<sup>individual's</sup> medical expenses.

A Health Service Request Form (HSRF) must be completed for an illness—

D. ~~Illness~~ or injury requiring medical care to an ~~inmate~~<sup>individual</sup> in the physical custody of the county ~~and must~~<sup>shall</sup> be reported as promptly as possible to the ADC Administrator of Medical Services. ~~A determination, who will be made as to whether~~<sup>approve</sup> the treatment ~~is approved and the county will be informed. A recommendation for to be~~<sup>(being) rendered and/or recommend</sup> transfer to the Department of Correction ~~may also be considered~~.

~~The~~ E. ~~As a matter of record, the~~ sheriff shall cause a description of the incident and the types of medical services used to be logged on the HSRF, "Health Incident Form," (810-HIF). This form must be signed by the sheriff or deputy attesting that the services received are properly billed. This form shall be sent to the attention of the ADC Administrator of Medical Services.

F. All bills relating to diagnosis and treatment of a particular illness or injury should be attached to an approved HSRF 810-HIF and sent ~~to at one time. At the attention of same time,~~ the ADC Administrator of Medical Services. An ~~inmate~~<sup>individual</sup> receiving treatment is to be asked to sign a Release of Medical Information form ~~indicating that to~~ the primary service provider may release his/her, in order for medical records to ~~be sent to~~ the ADC Administrator of Medical Services. If the ~~inmate~~<sup>individual</sup> refuses to sign for release of information, the ~~other side of the form~~ should be signed, indicating that the ~~inmate~~<sup>individual</sup> or some family member accepts responsibility for the bills.

G. Bills will be handled through the department's Utilization Review mechanism and processed for payment directly to the provider.

H. Medical costs may be paid only to the limits of legal liability, legislative appropriation and the availability of funds for this purpose. Should either spending authority or fund availability be insufficient for a particular bill, that bill will be returned to the Sheriff with a letter of explanation as to why the Arkansas Department of Correction cannot undertake payment of~~encumber~~ the cost.

**Inmate Emergency Medical Expenses Incurred While in County Jails**

4 of 6

- ~~I. Medical — To the maximum extent possible, medical resources available to the Department shall be used to keep down the costs of providing medical care to inmates convicted felons. This shall be the case regardless of whether or not the Department can reimburse the county.~~

**HEALTH SERVICES REQUEST FORM (HSRF)****JAIL STAFF: PLEASE PRINT FOLLOWING INFORMATION FORM**

810 HIF

Date: \_\_\_\_\_ Name of Jail or Detention Center: \_\_\_\_\_  
Name of Jail Staff: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

~~This form must be submitted with all medical bills believed to be payable by the Arkansas Department of Correction. Send to: Medical Services Payment, P.O. Box 8707, Pine Bluff, AR 71611.~~

Inmate Classification: \_\_\_\_\_ ☐ Date of signed and correct \_\_\_\_\_  
Jail \_\_\_\_\_  
D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Address \_\_\_\_\_  
SS # \_\_\_\_\_ City/Zip \_\_\_\_\_

Inmate is ( ) new commitment or sentence order: \_\_\_\_\_ ( )  
parole violator \_\_\_\_\_ ( ) jail contract  
☐ Parole Violator Revocation Date: \_\_\_\_\_

Problem \_\_\_\_\_  
Injury or complaint \_\_\_\_\_  
\_\_\_\_\_

First Noted: Date \_\_\_\_\_ noted: Time \_\_\_\_\_  
\_\_\_\_\_:\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ by \_\_\_\_\_  
\_\_\_\_\_  
(name of jail staff) \_\_\_\_\_

Contact \_\_\_\_\_ Recommendation given \_\_\_\_\_  
(name of ADC staff) \_\_\_\_\_ ( ) Transport to ADC Diagnostic  
\_\_\_\_\_ ( ) Treat locally, bill ADC  
Date \_\_\_\_/\_\_\_\_ Time \_\_\_\_:\_\_\_\_ ( ) Responsibility of the County  
\_\_\_\_\_

If treated locally, have physician complete  
Treated at \_\_\_\_\_  
\_\_\_\_\_  
(Name of jail staff, hospital, clinic, doctor's office)

HSRF submitted to ADC: Date \_\_\_\_\_ Time \_\_\_\_\_ by \_\_\_\_\_

**INMATE: PLEASE PRINT FOLLOWING INFORMATION**

Inmate Name: \_\_\_\_\_ ADC # \_\_\_\_\_ DOB: \_\_\_\_\_ SSN #: \_\_\_\_\_

**Inmate Emergency Medical Expenses Incurred While in County Jails**

5 of 6

Describe your injury or illness; what is your complaint? (Be Specific):

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

~~I hereby authorize all Medical, Dental, and Mental Health entities providing health care services to me, to~~ Treated  
by \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Follow up needed \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Consent for release of medical information

~~I agree to allow copies of all Medical, Dental, and Mental Health Records documenting health care services they have provided to me, my medical records associated with the above mentioned treatment to be released sent to the Arkansas Department of Correction (ADC) for inclusion in my permanent ADC Medical and Mental Health Records. to become part of my medical record.~~

Inmate Signature \_\_\_\_\_

Date \_\_\_\_\_

If the inmate refuses to sign the above Consent for Release of Medical Information, the inmate or some family member accepts responsibility for the bills.

Inmate Signature \_\_\_\_\_

Date \_\_\_\_\_

Jail Staff Signature \_\_\_\_\_

Date \_\_\_\_\_

TO BE COMPLETED BY ADC

☐ Approved

If denied:    ☐ Responsibility of Jail        ☐ Not Medically Necessary

If deferred:    ☐ Need More Information        ☐ Fast-track into ADC

Comment: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ADC Staff Signature \_\_\_\_\_

Date \_\_\_\_\_

IF TREATED LOCALLY, HAVE PROVIDER COMPLETE

Treated at \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

(Name of hospital, clinic, doctor's office)

Treated by \_\_\_\_\_ Diagnosis \_\_\_\_\_

Treatment provided \_\_\_\_\_

\_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

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**Inmate Emergency Medical Expenses Incurred While in County Jails**

6 of 6

**Note:** All bills and copies of all medical records relating to diagnosis and treatment of an illness or injury should be attached to an approved HSRF and sent at one time to the Administrator of Medical Services, P.O. Box 8707, Pine Bluff, AR 71611.

\_\_\_\_\_  
(signed by inmate)

~~These bills may be evaluated more quickly if the medical records are attached.~~