ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Arkansas Department of Corrections

Department Division of Correction

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Statutory Authority for Promulgating Rules 12-27-105 and 12-27-114

Rule Title: AR 810 Inmate Emergency Medical Expenses Incurred While in County Jails

Intended Effective Date (Check One)		**Date**
☐ Emergency (ACA 25-15-204)	Legal Notice Published	_____
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	_____
☑ Other 12-03-2015 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	_____
	Adopted by State Agency	_____

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Takelia McDaniel | Takelia.McDaniel@arkansas.gov | 12/19/19

Contact Person | E-mail Address | Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

_____
Signature

_____
Phone Number **E-mail Address**

_____
Title

_____
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

ADMINISTRATIVE RULES STATE OF ARKANSAS BOARD OF CORRECTIONS	Section Number: 810	Page Number: 1 of 5
	Board Approval Date: 11-23-2015	
	Supersedes: AR 810	Dated: 08/29/1991
	Reference: N/A	Effective Date: 12-03-2015

SUBJECT: Inmate Emergency Medical Expenses Incurred While in County Jails

I. AUTHORITY:

The Board of Corrections is vested with the authority to promulgate administrative rules by, but not limited to Ark. Code Ann. § 12-27-105, and § 12-27-114.

II. PURPOSE:

This Administrative Rule 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.

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.

IV. DEFINITIONS:

A. Eligible - Inmates on whom ADC has received signed and correct commitment or sentencing orders and who, pursuant to that commitment or sentencing order are at the time of the illness or injury, housed in the county jail. Also, inmates placed in county jails that have been revoked to the custody of the Department of Correction are immediately eligible.

B. Appropriate Approval - approval must be obtained through the 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 is to be notified of such emergencies immediately after the emergency situation and provide approval for any necessary continued care.

C. Emergent Medical Need – illness or injury that threatens life or limb, causes undue or unavoidable suffering, subjects the inmate to further unacceptable health risks, or is likely to result in deterioration of health status if not promptly treated. Chronic conditions do not qualify, unless their progressions or developments present symptoms of an emergent threat as an emergent medical need is defined herein.

D. Medical Expenses – expenses associated with diagnosis and/or treatment of an emergent medical need, as billed by the health service provider.

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 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 will determine whether the seriousness of the condition and the potential expense to the county warrants bringing the inmate into the Department of Correction.

B. Should an inmate with a preexisting condition need treatment on an emergency basis (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. If the inmate is on furlough or is otherwise living in the community, the Department assumes no responsibility for any of the inmate's medical expenses.

D. A Health Service Request Form (HSRF) must be completed for an illness or injury requiring medical care to an inmate in the physical custody of the county and must be reported as promptly as possible to the ADC Administrator of Medical Services. A determination will be made as to whether the treatment is approved and the county will be informed. A recommendation for transfer to the Department of Correction may also be considered.

E. The sheriff shall cause a description of the incident and the types of medical services used to be logged on the HSRF. 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 and sent to the attention of the ADC Administrator of Medical Services. An inmate receiving treatment is to be asked to sign a Release of Medical Information form indicating that the primary service provider may release his/her medical records to the ADC Administrator of Medical Services. If the inmate refuses to sign for release of information, the form should be signed indicating that the inmate or some family member accepts responsibility for the bills.

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

G. 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 the cost.

H. Medical resources available to the Department shall be used to keep down the costs of providing medical care to inmates regardless of whether or not the Department can reimburse the county.

HEALTH **SERVICES REQUEST FORM (HSRF)**

JAIL STAFF: PLEASE PRINT FOLLOWING INFORMATION

Date: _____ Name of Jail or Detention Center: _____

Name of Jail Staff: _____ Phone #: _____Fax #: _____

Inmate Classification: □ Date of signed and correct commitment or sentence order: _____
□ Parole Violator Revocation Date: _____

Problem First Noted: Date_____ Time _____ by _____
(Name of **jail staff**)

HSRF submitted to ADC: Date _____ Time _____ by _____

INMATE: PLEASE PRINT FOLLOWING INFORMATION

Inmate Name: _____ ADC # _____ DOB: _____SSN #: _____

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

_____

_____

_____

_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize all Medical, Dental, and Mental Health entities providing health care services to me, to release copies of all Medical, Dental, and Mental Health Records documenting health care services they have provided to me, to be released to the Arkansas Department of Correction (ADC) for inclusion in my permanent ADC Medical and Mental Health Records.

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 _____

_____

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.