Family Fee Determination Form

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(Provider Name)

Utah Department of Health Baby Watch Early Intervention Program

Child's Name: Last, First	☐ Parent declines to participate in the Family Fee Determination process, and will be billed for the full amount of $100 per month.
Date of Birth: MM/DD/YY	
Gender: ☐Male ☐Female	
Street Address:	(Child Medicaid/CHIP #______________________________) Optional
City & Zip	
Parent/Guardian:	Mark all services currently received by family. (If the family receives any of these services, stop here, mark the service, and sign below.) ☐FEP/TANF ☐WIC ☐PCN ☐Early Head Start ☐Medicaid
Home Phone:	
Daytime Phone:	**Annual Family Income**

If more than one child is enrolled in EI, please list names and date of birth each child:

Income verified by:
- ☐ Most recent tax return
- ☐ Last 3 consecutive pay stubs
- ☐ Other/program ID______________________

Annual Family Income

1. Gross Monthly Salary (1st wage earner) (gross before taxes, social security, insurance, union dues) $__________
2. Gross Monthly Salary (2nd wage earner) (gross before taxes, social security, insurance, union dues) $__________
3. Other Monthly Income (pensions, rentals, interest, dividends, alimony, child support) $__________
4. Total Monthly Income (Add 1 + 2 + 3) $__________
5. **Annual Income (Line 4 x 12) $__________**

Extenuating Circumstances

Extenuating circumstances are unexpected events that affect your family's financial situation and should be taken into consideration when determining the family's monthly fee:

______________________________ __________
Program Coordinator Signature Date

I verify that I have informed the parent(s) regarding their rights and responsibilities related to cost participation through family fees, and that I have utilized all the information provided to me by the family in calculating their fee:

______________________________ __________
Staff member signature Date

Allowable Deductions from Income

6. Medical/Dental expenses >5% of income (Worksheet on reverse side) -- __________
7. Child Care Costs $________/month X 12 months = -- __________
8. Child Support or Alimony payments $__________/month x 12 months = -- __________
9. **Modified Family Income Line 5 minus Lines 6, 7, and 8 $__________**

Family Size

10. Number of Adults in family ________
11. Number of children in family ________
12. Total family size (add 10 + 11) __________

Monthly Family Sliding Fee

13. **Using line 9 (income) and line 12 (family size), find fee on Sliding Fee Schedule $__________ Per month**

I understand that my financial responsibility is calculated based on the information I have provided. I also understand that non-payment of fees may result in the discontinuation of services and that a minimum penalty fee of $20 will be charged for returned checks. I certify to the best of my knowledge the information provided above is true and correct. I have received a copy of my parent rights and responsibilities related to cost participation through family fees and understand that I may ask for a review of my family fee if my financial situation changes.

Parent/Guardian Signature:______________________________ Date:______________

Form review dates:

______	______	______	______	______	______	______	______	______	______
EI staff	Date	EI Staff	Date	EI Staff	Date	EI Staff	Date	EI Staff	Date

Note: Change in circumstances requires a new form.

Revised 2/09

You may deduct qualifying medical/dental expenses that are greater than 5% of your annual income. Use this worksheet to determine if your qualifying expenses are greater than 5% of your income. Qualifying expenses must be directly related to the health or medical condition of a family member. Expenses must be out of pocket for the previous 12 months and for which you will not be reimbursed.

Medical/Dental Deductions Worksheet	
14. Health Insurance Premiums $__________ per month x 12 months =	$__________
15. Insurance Co-payments $__________ per month x 12 months =	$__________
16. Dental and Vision Expenses $__________ per month x 12 months =	$__________
17. Hospital Expenses $__________ per month x 12 months =	$__________
18. Prescriptions $__________ per month x 12 months =	$__________
19. Nutritional supplements ordered by physician $__________ per month x 12 months =	$__________
20. Medical equipment, Assistive Technology, or Adaptations expenses for the year	$__________
21. Specialized clothing required by medical condition $__________ per month x 12 months =	$__________
22. Specialized respite care or child care above typical costs not listed on front, line 7	$__________
23. Medical transportation cost $__________ per month x 12 months =	$__________
24. Other related medical costs (specify): $__________ per month x 12 months =	$__________
25. Total Medical Deductions (Add lines 14 – 24)	**$__________**

What can be included:

- Capital expenses for equipment or improvements to your home needed for medical care
- Cost and care of guide animals aiding the blind, deaf, and disabled
- Cost of lead based paint removal
- Expenses of an organ donor
- Hospital services fees (lab work, therapy, etc.)
- Birth control pills, legal abortion, legal operations to prevent having children
- Life-care fee paid to retirement home designated for medical care
- Meals and lodging provided by a hospital during medical treatment
- Medical and hospital insurance premiums
- Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)
- Oxygen equipment and oxygen
- Prescriptions, medicines, and insulin
- Psychiatric care at a specialty equipped medical center (includes meals and lodging)
- Social security tax, Medicare tax, FUTA and state employment tax for worker providing medical care
- Special items (hearing aids, wheelchairs, etc.)
- Special school or home for mentally or physically disabled person
- Travel and related expenses
- Treatment at a drug or alcohol center
- Wages for nursing services
- Diaper costs related to medical problem

Calculate Allowed Medical/Dental Deduction

A. Multiply front line 5 (annual income) x .05 = -- ________

If Line A is GREATER than Line 25:	If Line A is LESS THAN Line 25:
• You may not deduct medical/dental expenses from income as they are less than 5% of your income. Write “0” on Line 6 on front page.	Line 25 – Line A = $________ Write this amount on Line 6 on front page.

What cannot be included:

- Diaper services
- Health club dues
- Household help
- Stop smoking program
- Weight loss program
- Life insurance or income protection policies
- Maternity clothes
- Medicine bought without a prescription
- Nursing care for a healthy baby
- Surgery for purely cosmetic reasons