



# Family Fee Determination Form

( Provider Name )

Child's Name: _____ Last, First	<input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female																							
Street Address: _____	(Child Medicaid/CHIP # _____ ) <div style="text-align: right;">Optional</div>																						
City & Zip _____	Mark all services currently received by family. (If the family receives any of these services, stop here, mark the service, and sign below.) <input type="checkbox"/> FEP/TANF <input type="checkbox"/> WIC <input type="checkbox"/> PCN <input type="checkbox"/> Early Head Start <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP																						
Parent/Guardian: _____																							
Home Phone: _____																							
Daytime Phone: _____																							
If more than one child is enrolled in EI, please list names and date of birth each child:	<table style="width:100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center; background-color: #cccccc;">Annual Family Income</th> </tr> <tr> <td style="width:70%;">1. Gross Monthly Salary (1<sup>st</sup> wage earner) (gross before taxes, social security, insurance, union dues)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>2. Gross Monthly Salary (2<sup>nd</sup> wage earner) (gross before taxes, social security, insurance, union dues)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>3. Other Monthly Income (pensions, rentals, interest, dividends, alimony, child support)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>4. Total Monthly Income (Add 1 + 2 + 3)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><b>5. Annual Income (Line 4 x 12)</b></td> <td style="text-align: right;"><b>\$ _____</b></td> </tr> </table>	Annual Family Income		1. Gross Monthly Salary (1 <sup>st</sup> wage earner) (gross before taxes, social security, insurance, union dues)	\$ _____	2. Gross Monthly Salary (2 <sup>nd</sup> 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)	\$ _____	<b>5. Annual Income (Line 4 x 12)</b>	<b>\$ _____</b>										
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Income verified by: <input type="checkbox"/> Most recent tax return <input type="checkbox"/> Last 3 consecutive pay stubs <input type="checkbox"/> Other/program ID _____	<table style="width:100%; border-collapse: collapse;"> <tr> <th colspan="2" style="text-align: center; background-color: #cccccc;">Allowable Deductions from Income</th> </tr> <tr> <td style="width:70%;">6. Medical/Dental expenses &gt;5% of income (Worksheet on reverse side)</td> <td style="text-align: right;">-- _____</td> </tr> <tr> <td>7. Child Care Costs \$ _____/month X 12 months =</td> <td style="text-align: right;">-- _____</td> </tr> <tr> <td>8. Child Support or Alimony payments \$ _____/month x 12 months =</td> <td style="text-align: right;">-- _____</td> </tr> <tr> <td><b>9. Modified Family Income Line 5 minus Lines 6, 7, and 8</b></td> <td style="text-align: right;"><b>\$ _____</b></td> </tr> <tr> <th colspan="2" style="text-align: center; background-color: #cccccc;">Family Size</th> </tr> <tr> <td>10. Number of Adults in family</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>11. Number of children in family</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>12. Total family size (add 10 + 11)</td> <td style="text-align: right;">_____</td> </tr> <tr> <th colspan="2" style="text-align: center; background-color: #cccccc;">Monthly Family Sliding Fee</th> </tr> <tr> <td><b>13. Using line 9 (income) and line 12 (family size), find fee on Sliding Fee Schedule</b></td> <td style="text-align: right;"><b>\$ _____ Per month</b></td> </tr> </table>	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 =	-- _____	<b>9. Modified Family Income Line 5 minus Lines 6, 7, and 8</b>	<b>\$ _____</b>	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		<b>13. Using line 9 (income) and line 12 (family size), find fee on Sliding Fee Schedule</b>	<b>\$ _____ Per month</b>
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Staff member signature _____ Date _____																							

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.**

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		What can be included:	
14. Health Insurance Premiums \$ _____ per month x 12 months =	\$ _____	<ul style="list-style-type: none"> <li>• Capital expenses for equipment or improvements to your home needed for medical care</li> <li>• Cost and care of guide animals aiding the blind, deaf, and disabled</li> <li>• Cost of lead based paint removal</li> <li>• Expenses of an organ donor</li> <li>• Hospital services fees (lab work, therapy, etc.)</li> <li>• Birth control pills, legal abortion, legal operations to prevent having children</li> <li>• Life-care fee paid to retirement home designated for medical care</li> <li>• Meals and lodging provided by a hospital during medical treatment</li> <li>• Medical and hospital insurance premiums</li> <li>• Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)</li> <li>• Oxygen equipment and oxygen</li> <li>• Prescriptions, medicines, and insulin</li> <li>• Psychiatric care at a specialty equipped medical center (includes meals and lodging)</li> <li>• Social security tax, Medicare tax, FUTA and state employment tax for worker providing medical care</li> <li>• Special items (hearing aids, wheelchairs, etc.)</li> <li>• Special school or home for mentally or physically disabled person</li> <li>• Travel and related expenses</li> <li>• Treatment at a drug or alcohol center</li> <li>• Wages for nursing services</li> <li>• Diaper costs related to medical problem</li> </ul>	
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 =	\$ _____		
<b>25. Total Medical Deductions (Add lines 14 – 24)</b>	<b>\$ _____</b>		
<b>Calculate Allowed Medical/Dental Deduction</b>			<b>What cannot be included:</b>
<p>A. Multiply front line 5 (annual income) x .05 -- _____ = _____</p> <p>If Line A is GREATER than Line 25:  <ul style="list-style-type: none"> <li>• 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.</li> </ul> </p> <p>If Line A is LESS THAN Line 25:            Line 25 – Line A = \$ _____            Write this amount on Line 6 on front page.</p>			<ul style="list-style-type: none"> <li>• Diaper services</li> <li>• Health club dues</li> <li>• Household help</li> <li>• Stop smoking program</li> <li>• Weight loss program</li> <li>• Life insurance or income protection policies</li> <li>• Maternity clothes</li> <li>• Medicine bought without a prescription</li> <li>• Nursing care for a healthy baby</li> <li>• Surgery for purely cosmetic reasons</li> </ul>