Michigan Department of Health and Human Services - Children's Special Health Care Services

## INCOME REVIEW /PAYMENT AGREEMENT

**Instructions for Completion (MSA-0738)** 

The Income Review/Payment Agreement (MSA-0738) is used to determine if a payment agreement for the enrollment fee is required of the family to receive coverage by the Children's Special Health Care Services (CSHCS) program.

#### **General Instructions:**

- Please PRINT clearly in ink.
- This form must be completed for the client.
- Do not write in the gray/shaded areas (official use only).
- Upon completion, keep a copy for your records.

Fax: 517-335-9491

 Mail a copy, and additional page(s) (if applicable) to:

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES CSHCS DIVISION PO BOX 30734 LANSING MI 48909-8234

• If you have any questions, contact a CSHCS representative at your local health department, or call 1-800-359-3722.

### SECTION 1 – Client and Household Information (Adult or Minor Client)

- 1. Enter the name of the client applying for CSHCS services.
- 2. Enter the client's county of residence.
- 3. a. Enter the client's ID number (CSHCS or Medicaid). b. Enter the client's social security number.
- 4. Enter the client's home address.
- Enter the client's date of birth.
- 6. List other immediate family members in the household with CSHCS coverage (attach additional pages if needed).
- 7. Check all that apply to the **client**. **Note:** If you check **any** box in # 7, a payment may not be required **once documentation is verified**. Go to #10, enter \$0.00, and continue to Section 3.

#### SECTION 2 - Income Information

(STOP: Contact a CSHCS representative at your local health department to complete this section if you did not file a federal tax return, had a change in family size, loss of income, or other similar circumstance.)

- 8. Enter your total family size. This includes you, your spouse if filing jointly, and all dependents listed on your federal tax return.
- 9. Enter the total Adjusted Gross Income from your current federal tax return or line 8 from Financial Worksheet (MSA-0742). If no federal tax return is available, contact a CSHCS representative at your local health department, or call 1-800-359-3722. Note: Clients age 18 or older are legal adults; therefore, only their income is considered and not that of the family or guardian.
- 10. Enter the **Yearly Payment Agreement Enrollment Fee Amount** according to the enclosed **Payment Agreement Guide** (MSA-0738-B).

### **SECTION 3 – Payment Agreement**

Read each statement carefully. This is your yearly Payment Agreement of the enrollment fee for the CSHCS program. Contact a CSHCS representative at your local health department for assistance.

- 11. Signature of the parent of minor client, court-appointed legal guardian, foster parent, **or** adult client and the date signed.
- 12. Print the name of the person signing #11. Phone number including area code.
- 13. Social Security Number for the parent of minor client, or adult client.
- 14. Check box which identifies the person signing #11.

### **Payment Instructions**

When your payment agreement notification comes in the mail, the total amount will be due at that time. If you cannot pay the total amount right away, you can make payments according to the monthly coupon instructions you receive with your notification. Contact a CSHCS representative at your local health department if you do not receive the payment instructions after submission of this form. Payments are non-refundable and required even if CSHCS services are not used, CSHCS coverage is voluntarily ended, the client ages out of the program, or the client moves out of the State of Michigan.

## **INCOME REVIEW / PAYMENT AGREEMENT**

SECTION 1 – Client and Household Information (Adult or Minor Client)		3a. Client ID Number		
1. Client's Name (Last, First, Middle)	2. County	3b. Client Social Security #		
1. Officites (Valine (Last, 1 list, Wildale)	2. Oddrity	35. Giletti Gociai Geculity #		
			Suffix	
4. Client's Home Address (Street, Apt/Lot Number, City, State, Zip)		5. Client Date of Birth		
		/ /	Region	
6. List other immediate family members in household with CSHCS coverage (atta	ch additional pages if ne			
Name (Last, First, Middle)		Client ID Number Birth D	ate	
		/	/	
7. Does the <b>client</b> have any of the following?  Active Full Medicaid		IMPORTANT:		
Active MIChildYes Is the <b>client</b> a foster child or living in a private placement agency? (attach documentation)Yes		If you checked any box in #7, a payment for this client may not be required <b>once</b>		
		documentation is verified.		
Does the <b>client</b> live with a court-appointed legal guardian? (attach documentation)		<b>GO</b> to Line #10, enter \$0.00, and		
		continue to Section 3. (See inst.	continue to Section 3. (See instructions.)	
SECTION 2 – Income Information				
8. Enter the total family size from your current <b>federal tax return</b>				
This includes you, your spouse if filing jointly, and all dependents lis your Federal 1040, including qualifying relatives.	ted on			
9. Enter the total Adjusted Gross Income on your current <b>federal tax re</b>	turn	_		
If using Financial Worksheet (MSA-0742) enter amount from line #8		_\$		
<ol> <li>Enter the yearly Payment Agreement enrollment fee amount according Agreement Guide (MSA-0738-B)</li> </ol>	ng to the Payment	\$		
Agreement duide (MOA-0730-b)		Ψ		
SECTION 3 – Payment Agreement (One agreement per family	1			
I agree to pay the State of Michigan the entire yearly payment agreer		nount on line #10 for Children's S	Special	
Health Care Services (CSHCS) coverage.	none ornominone roo di	induit on mie n to for ormatorio o	opo olal	
I understand that I am responsible for the entire yearly payment agre			ot of my	
<ul> <li>payment notification. Payment shall be made in full or according to the</li> <li>If my circumstances change I will contact a CSHCS representative at</li> </ul>				
I understand that when the Michigan Department of Health and Human			cover	
monies from a third person or public or private contractor (except Me	dicare) is transferred to			
under such right is to be made directly to the State of Michigan, MDH				
<ul> <li>I certify under the penalty of perjury that the information on this form understand that any misrepresentation of this information may result</li> </ul>			edge. I	
I authorize the State of Michigan to verify any information on this form		soverage.		
• I understand that if the amount due to the State of Michigan is not pa	d in full, it may result i		verage. If	
unpaid, my account may also be sent to the Michigan Department of				
<ul> <li>I understand that payments are non-refundable and required even if ended, the client ages out of the program, or the client moves out of t</li> </ul>		of used, CSHCS coverage is vol	untarily	
11. Signature D	ate Signed	14. The person signing Box 11 is t	he:	
		☐ PARENT of Minor Client		
12. Print Name Signed Above Area Code a	nd Telephone Number	☐ COURT-APPOINTED L	LEGAL	
	,	GUARDIAN of Client		
40 Octob Octob New York Provide All In Oliver		☐ FOSTER PARENT of Clie	ent	
13. Social Security Number for Parent of Minor Client or Adult Client		☐ ADULT Client		

Mail or fax the signed and dated copy, with any additional page(s) to:

Michigan Department of Health and Human Services CSHCS Division PO Box 30734 Lansing, MI 48909-8234 Fax: 517-335-9491

If you have any questions, contact a CSHCS representative at your local health department or call 1-800-359-3722.

# Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available. Call 800-359-3722 (TTY users call 711).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia		
Amahia	lingüística. Llame al 800-359-3722 (TTY: 711).  800-359-3722 أذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 3722-359-359		
Arabic	منحوطة: إذا كلت للخدف الحر اللغة، قبل خلمات المساعدة اللغوية للواقر لك بالمجال. الصل برقم 7/2 -359-300 (رقم هاتف الصم و البكم: 711:TTY).		
Chinese	注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 800-359-		
	5		
Syriac (Assyrian)	ر ی ی ی ی ی ی ی ی ی ی ی ی ی ی ی ی ی ی ی		
	ر با الم الم الم الم الم الم الم الم الم ال		
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-359-3722 (TTY:711).		
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-359-3722 (TTY:711).		
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수		
	있습니다. 800-359-3722 (TTY:711)번으로 전화해 주십시오.		
Bengali	ল�� ক�নঃ যিদ আপিন বাংলা, কথা বলেত পােরন, তাহেল িনঃখরচায় ভাষা		
	সহায়তা প <b>ির</b> েষবা উপল <b>৵</b> আেছ। েফান ক <b>৵১</b> -800-359-3722 <b>(</b> TTY		
	<b>5-711)</b>		
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-359-3722 (TTY:711).		
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 800-359-3722 (TTY:711).		
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-359-3722 (TTY:711).		
Japanese	注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。800- 359-3722 (TTY:711) まで、お電話にてご連絡ください		
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-359-3722 (телетайп 711).		
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-359-3722 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 711).		
m 1	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng		
Tagalog	tulong sa wika nang walang bayad. Tumawag sa 800-359-3722 (TTY: 711).		

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - o Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator Compliance Office, 4<sup>th</sup> Floor P.O. Box 30195 Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax), MDHHS-ComplianceOffice@michigan.gov

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://bit.ly/2IKsHMS.

If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by:

Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all of the information requested in the form.

To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410

Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.