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 **YELLOW** copy for your records.

Fax: 517-335-9491

- Mail **WHITE** 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.
5. 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 the total number of claimed exemptions on your current federal tax return (see line 6d. on the Federal 1040 or the 1040A, or line 5 of the Federal 1040EZ).
9. Enter the income from your current federal tax return (line 22 of the Federal 1040, line 15 of the Federal 1040A, or line 4 of the Federal 1040EZ) **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.**

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is Voluntary, but required if CSHCS program services are desired.

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

INCOME REVIEW / PAYMENT AGREEMENT

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

1. Client's Name (Last, First, Middle)	2. County	3a. Client ID Number 3b. Client Social Security # - -	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 (attach additional pages if needed)

Name (Last, First, Middle)	Client ID Number	Birth Date
		/ /

7. Does the **client** have any of the following?

- Active Full Medicaid ..... ☐ Yes
- Active MIChild ..... ☐ Yes
- Is the **client** a foster child or living in a private placement agency? (attach documentation) ..... ☐ Yes
- Does the **client** live with a court-appointed legal guardian? (attach documentation) ..... ☐ Yes
- Is the **client** deceased? (If Yes, date of death) ___/___/___ ..... ☐ Yes

IMPORTANT:

If you checked any box in #7, a payment for this client may not be required **once documentation is verified.**

GO to Line #10, enter $0.00, and continue to Section 3. (*See instructions.)*

SECTION 2 – Income Information

8. Enter the total number of claimed exemptions from your current **federal tax return** (Line 6d of the 1040 or 1040A, or line 5 of the 1040EZ) .....

9. Enter the income from your current **federal tax return** (Line 22 of the 1040; Line 15 of the 1040A; or Line 4 of the 1040EZ) If using Financial Worksheet (MSA-0742) enter amount from line #8. ..... **$**

10. Enter the yearly Payment Agreement enrollment fee amount according to the Payment Agreement Guide (MSA-0738-B). ..... **$**

SECTION 3 – Payment Agreement (One agreement per family.)

- I agree to pay the State of Michigan the entire yearly payment agreement enrollment fee amount on line #10 for Children's Special Health Care Services (CSHCS) coverage.
- I understand that I am responsible for the entire yearly payment agreement enrollment fee amount which is due upon receipt of my payment notification. Payment shall be made in full or according to the instructions. **Payments are non-refundable.**
- If my circumstances change I will contact a CSHCS representative at my local health department.
- I understand that when the Michigan Department of Health and Human Services (MDHHS) pays for services, any right to recover monies from a third person or public or private contractor (except Medicare) is transferred to the MDHHS. Payment of any recovery under such right is to be made directly to the State of Michigan, MDHHS, or agent.
- I certify under the penalty of perjury that the information on this form is true, complete and accurate to the best of my knowledge. I understand that any misrepresentation of this information may result in the loss of CSHCS coverage.
- I authorize the State of Michigan to verify any information on this form.
- I understand that if the amount due to the State of Michigan is not paid in full, it may result in non-renewal of my CSHCS coverage. If unpaid, my account may also be sent to the Michigan Department of Treasury for collection.
- I understand that 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.

11. Signature	Date Signed	14. The person signing Box 11 is the:
12. Print Name Signed Above	Area Code and Telephone Number	☐ PARENT of Minor Client ☐ COURT-APPOINTED LEGAL GUARDIAN of Client ☐ FOSTER PARENT of Client ☐ ADULT Client
13. Social Security Number for Parent of Minor Client or Adult Client		

Retain **YELLOW** copy. Mail or fax the signed **WHITE** copy, with any additional page(s) to:

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Lansing, MI 48909-8234
Fax: 517-335-9491

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