

**Detroit CSHCS direct phone is 313-876-4223 fax number is 313-366-9439**

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

Fax: 517-335-9491

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 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.**

**PAYMENT AGREEMENT GUIDE**  
 Children's Special Health Care Services  
 Michigan Department of Health and Human Services

**This guide does not apply if the client has active full Medicaid, MICHild or Healthy Michigan Plan. If you checked any box in #7 on the MSA-0738, a payment for this client may not be required once documentation is verified.**

This chart will give you the yearly payment agreement enrollment fee amount your family is required to pay to receive coverage by the Children's Special Health Care Services (CSHCS) program. If you have questions or need help, please contact a CSHCS representative at your local health department or call 1-800-359-3722.

**INSTRUCTIONS: Use the information you put on your Income Review/Payment Agreement form MSA-0738:**

- Find the column for the **Family size**. Family size is the number you put on line #8 of the MSA-0738 form.
- Find the **Income range** in this same column that includes the income you put on **line #9** of the MSA-0738.
- Follow the row across to the right to find your **Yearly Payment Agreement Enrollment Fee amount**.
- Put the **Yearly Payment Agreement Enrollment Fee amount** from the chart below on **line #10** of the MSA-0738.
- **Clients 18** or older are legal adults; therefore, only their income is considered for line #9 and #10 of the MSA-0738.

**If your yearly payment agreement enrollment fee is \$120.00 (see chart below), your CSHCS coverage will be for 90 days.** You will be required to also apply for Medicaid, MICHild, Healthy Kids or Healthy Michigan Plan coverage which provide additional comprehensive coverage. You must apply for Medicaid/MICHild/Healthy Kids/Healthy Michigan Plan for your CSHCS coverage to go beyond 90 days. If you do not apply within those 90 days, CSHCS coverage will end.

**You will still be responsible for any CSHCS payment agreement enrollment fee that you sign even if CSHCS coverage is voluntarily ended, services are not used, the client ages out of the program, or the client moves out of the State of Michigan. CSHCS payments are non-refundable.**

FAMILY SIZE / INCOME RANGE														
Family of 0-1	Family of 2	Family of 3	Family of 4	Family of 5	Family of 6	Family of 7	Family of 8	Family of 9	Family of 10	Family of 11	Family of 12	Family of 13	Family of 14	Yearly Payment
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$120.00
\$31,919	\$43,279	\$54,639	\$65,999	\$77,359	\$88,719	\$100,079	\$111,439	\$122,799	\$134,159	\$145,519	\$156,879	\$168,239	\$179,599	\$192.00
\$31,920	\$43,280	\$54,640	\$66,000	\$77,360	\$88,720	\$100,080	\$111,440	\$122,800	\$134,160	\$145,520	\$156,880	\$168,240	\$179,600	\$192.00
\$39,900	\$54,100	\$68,300	\$82,500	\$96,700	\$110,900	\$125,100	\$139,300	\$153,500	\$167,700	\$181,900	\$196,100	\$210,300	\$224,500	\$372.00
\$39,901	\$54,101	\$68,301	\$82,501	\$96,701	\$110,901	\$125,101	\$139,301	\$153,501	\$167,701	\$181,901	\$196,101	\$210,301	\$224,501	\$372.00
\$47,880	\$64,920	\$81,960	\$99,000	\$116,040	\$133,080	\$150,120	\$167,160	\$184,200	\$201,240	\$218,280	\$235,320	\$252,360	\$269,400	\$732.00
\$47,881	\$64,921	\$81,961	\$99,001	\$116,041	\$133,081	\$150,121	\$167,161	\$184,201	\$201,241	\$218,281	\$235,321	\$252,361	\$269,401	\$732.00
\$63,840	\$86,560	\$109,280	\$132,000	\$154,720	\$177,440	\$200,160	\$222,880	\$245,600	\$268,320	\$291,040	\$313,760	\$336,480	\$359,200	\$1,476.00
\$63,841	\$86,561	\$109,281	\$132,001	\$154,721	\$177,441	\$200,161	\$222,881	\$245,601	\$268,321	\$291,041	\$313,761	\$336,481	\$359,201	\$1,476.00
\$79,800	\$108,200	\$136,600	\$165,000	\$193,400	\$221,800	\$250,200	\$278,600	\$307,000	\$335,400	\$363,800	\$392,200	\$420,600	\$449,000	\$2,964.00
\$79,801 no ceiling	\$108,201 no ceiling	\$136,601 no ceiling	\$165,001 no ceiling	\$193,401 no ceiling	\$221,801 no ceiling	\$250,201 no ceiling	\$278,601 no ceiling	\$307,001 no ceiling	\$335,401 no ceiling	\$363,801 no ceiling	\$392,201 no ceiling	\$420,601 no ceiling	\$449,001 no ceiling	\$2,964.00

## INCOME REVIEW /PAYMENT AGREEMENT

This is an example to assist with completion of the form. Please complete the form with your information

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

		3a. Client ID Number <b>101010101</b>	
1. Client's Name (Last, First, Middle) <b>Last name, Client First Name</b>	2. County <b>Wayne (88)</b>	3b. Client Social Security # <b>- -</b>	Suffix
4. Client's Home Address (Street, Apt/Lot Number, City, State, Zip) <b>100 Your Street ., Detroit, MI 48201</b>		5. Client Date of Birth <b>01/01/2007</b>	Region
6. List other immediate family members in household with CSHCS coverage (attach additional pages if needed)			
<b>Name (Last, First, Middle)</b>		<b>Client ID Number</b>	<b>Birth Date</b>
		/ /	/ /
7. Does the <b>client</b> have any of the following?		<b>IMPORTANT:</b>	
Active Full Medicaid..... <input type="checkbox"/> Yes		If you checked any box in #7, a payment for this client may not be required <b>once documentation is verified.</b> <b>GO to Line #10, enter \$0.00, and continue to Section 3. (See instructions.)</b>	
Active MIChild..... <input type="checkbox"/> Yes			
Is the <b>client</b> a foster child or living in a private placement agency? (attach documentation)..... <input type="checkbox"/> Yes			
Does the <b>client</b> live with a court-appointed legal guardian? (attach documentation)..... <input type="checkbox"/> Yes			
Is the <b>client</b> deceased? (If Yes, date of death) <b>/ /</b> ..... <input type="checkbox"/> Yes			

### SECTION 2 – Income Information

8. Enter the <b>total family size</b> from your current <b>federal tax return</b> . This includes you, your spouse if filing jointly, and all dependents listed on your Federal 1040, including qualifying relatives. <b>If you are 18 years and have no children, then you are a family of 1</b>	<b>3</b>
9. Enter the total Adjusted Gross Income on your current <b>federal tax return</b> . If using Financial Worksheet (MSA-0742) enter amount from line #8	<b>\$ 60,299</b>
10. Enter the yearly <b>Payment Agreement</b> enrollment fee amount according to the Payment Agreement Guide (MSA-0738-B) <b>This is from the payment sheet attached.</b>	<b>\$ 372.00</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. <b>Signature</b> <b>Adult client signature if you are over 18</b> <b>Parent Signature</b>	<b>Date Signed</b> <b>Today's date</b>	14. <b>The person signing Box 11 is the:</b>
12. <b>Print Name Signed Above</b> <b>Parent Name or adult client name</b>	<b>Area Code and Telephone Number</b> <b>(313) 867-5309 * Your phone number</b>	<input checked="" type="checkbox"/> PARENT of Minor Client
13. Social Security Number for Parent of Minor Client or Adult Client		<input type="checkbox"/> COURT-APPOINTED LEGAL GUARDIAN of Client
		<input type="checkbox"/> FOSTER PARENT of Client
		<input type="checkbox"/> 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.**

Please continue to scroll down to the Income Review and Payment Agreement Form (**IRPA**) that will be available for completion and submission.

You can fax your documents after completing them and signing them to

**Detroit CSHCS 313-366-9439**

**Thank you**

**Complete and return this form**

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)**

		3a. Client ID Number	
1. Client's Name (Last, First, Middle)	2. County	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)			
<b>Name (Last, First, Middle)</b>		<b>Client ID Number</b>	<b>Birth Date</b>
			/ /
7. Does the <b>client</b> have any of the following?		<b>IMPORTANT:</b>	
Active Full Medicaid..... <input type="checkbox"/> Yes		If you checked any box in #7, a payment for this client may not be required <b>once documentation is verified.</b> <b>GO to Line #10, enter \$0.00, and continue to Section 3. (See instructions.)</b>	
Active MICHild..... <input type="checkbox"/> Yes			
Is the <b>client</b> a foster child or living in a private placement agency? (attach documentation)..... <input type="checkbox"/> Yes			
Does the <b>client</b> live with a court-appointed legal guardian? (attach documentation)..... <input type="checkbox"/> Yes			
Is the <b>client</b> deceased? (If Yes, date of death)    / / ..... <input type="checkbox"/> Yes			

**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 listed on your Federal 1040, including qualifying relatives.	
9. Enter the total Adjusted Gross Income on your current <b>federal tax return</b> 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. <b>Signature</b>	Date Signed	14. The person signing Box 11 is the:
12. <b>Print Name Signed Above</b>	Area Code and Telephone Number	
13. Social Security Number for Parent of Minor Client or Adult Client		
		<input type="checkbox"/> PARENT of Minor Client <input type="checkbox"/> COURT-APPOINTED LEGAL GUARDIAN of Client <input type="checkbox"/> FOSTER PARENT of Client <input type="checkbox"/> 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.**





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
  - 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](mailto:MDHHS-ComplianceOffice@michigan.gov)

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

<p>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 <a href="https://bit.ly/2pBS4YG">https://bit.ly/2pBS4YG</a>, or by mail or phone at:</p> <p>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)</p> <p>Complaint forms are available at <a href="https://bit.ly/2IKsHMS">https://bit.ly/2IKsHMS</a>.</p>	<p>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:</p> <p>Completing a Complaint Form, (AD-3027) found online at: <a href="https://bit.ly/2g9zzpU">https://bit.ly/2g9zzpU</a> 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.</p> <p>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</p> <p>Fax: 202-690-7442; or Email: <a href="mailto:program.intake@usda.gov">program.intake@usda.gov</a></p>
---	--

MDHHS is an equal opportunity provider.