Clarke County CSA Household Income Form

If your FAPT meeting results in the funding of services through CSA then we are required through State and Local policy to assess your family's income and expenses to determine a parental copayment. This form is an assessment tool for that purpose. The co-payment is based on your family's income and is paid only during the length of service. There are procedures in place to file for relief of the co-payment if you feel that the amount requested is more than you can pay. At that time we will factor in your monthly expenses and other extenuating circumstances. Any questions regarding this process can be directed to the CSA Coordinator at 540-955-5198. Co-payments will not be required for special education services listed in your child's IEP. Co-payments are effective the second month of service delivery and are paid directly to the provider.

Child's Name:					DOB:			Date:		
Parent:					Parent:					
				-						
Number of Fam	ily Memb	ers in the	home :							
				0			D D		30	41-1
Salary/Wages		Employ	Employer		Gross Income Per Pay Period		Pay Per Freque		Mon Inco	
Parent 1:										
Parent 2:										
Other Family:										
Other Family:										
Other Income (include children's income)										
General Relief:		\$	\$		Social Security:			\$		
Supplemental Security Insurance (SSI):		\$	\$		Alimony/Child Support:			\$		
Aid to Dependent Children:		\$	\$		Interest/Dividends:			\$		
Unemployment Comp:		\$	\$		Disability/Worker's Comp:		\$			
Retirement/Pension from Whom:		n \$	\$		Other Income:		\$			
Total Monthly In	come:	·		·						
Family		2	4			_	7		0	
Members	2	3	4	5		6	7		8	
Percent	5%	4.5%	4%	3.5	%	3%	2.5%		2%	
	0/ V	,								
# family member	_ % X 's		nonthly income	=		monthly c	o-payment amo	ount		

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Parental Co-Pay Responsibility Agreement

Today's Date:	_ Child's N	Child's Name: Mother's Name: Father's Name:				
FAPT Date and Time:	_ Mother's					
CSA Case Manager's Name:	Father's					
We have requested services for our child a and Planning Team (FAPT). These service Plan that we have signed or will sign at the necessary, and that their success, and the continuing and consistent involvement. We child's treatment in the following manner:	es are described on E FAPT meeting. W refore the ultimate	the FAPT Individual Family Service e agree that these services are success of our child, will require our				
 with our responsibilities as outlined 3. Communicate on a regular, ongoin 4. Provide information needed to determinediately notify the case manag 5. We agree that the total number of p 	r in the development in the treatment plug basis with our chiermine and maintainer of any mailings recepte living in our better the provider (see Determination Wo	ild's case manager. In eligibility for Medicaid. Also, received from these programs. Industrial household is and our monthly Industrial household is and our monthly Industrial household is toward the cost of each month of solutions is the amount orksheet.)				
Parent Signature	date	Parent Social Security Number				
Parent Signature	date	Parent Social Security Number				
Parent Billing Address		Parent Telephone Number				
Case Manager Signature	date	Case Manager Phone Number				
List the service(s) and estimated costs CSA Office; COPY MUST BE PROVIDED		this form must be returned to the				
Service		\$				
Service		\$ Estimated Total Cost per Month				

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