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 family size from your current **federal tax return**
   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 **federal tax return**
   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		

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.**