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.

  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.
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.**

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

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)

1. Client's Name (Last, First, Middle)	2. County	3a. Client ID Number / 3b. Client Social Security #	Suffix
Last name, Client First Name	Wayne (88)	101010101 / - -	
4. Client's Home Address (Street, Apt/Lot Number, City, State, Zip)		5. Client Date of Birth	Region
100 Your Street ., Detroit, MI 48201		01/01/2007	

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. **If you are 18 years and have no children, then you are a family of 1** — 3

9. Enter the total Adjusted Gross Income on your current **federal tax return**
If using Financial Worksheet (MSA-0742) enter amount from line #8 — **$** 60,299

10. Enter the yearly Payment Agreement enrollment fee amount according to the Payment Agreement Guide (MSA-0738-B) **This is from the payment sheet attached.** — **$** 372.00

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 **Adult client signature if you are over 18**
Parent Signature

Date Signed
Today's date

12. Print Name Signed Above
Parent Name or adult client name

Area Code and Telephone Number
(313) 867-5309 * Your phone number

13. Social Security Number for Parent of Minor Client or Adult Client

14. The person signing Box 11 is the:

- ■ PARENT of Minor Client
- ☐ COURT-APPOINTED LEGAL GUARDIAN of Client
- ☐ FOSTER PARENT of 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.**

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)

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.**

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 lingüística. Llame al 800-359-3722 (TTY: 711).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-359-3722 (رقم هاتف الصم والبكم:-TTY:711).
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 800-359-3722（TTY:711）
Syriac (Assyrian)	ܙܘܗܪ̈ܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܡܣܬܡܫܝܬܘܢ ܡܢ ܚܠܡ̈ܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 800-359-3722 (TTY:711)
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	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-359-3722 (TTY ১-711)
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).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng 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
  - 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, 4th 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.