**Arlington County Children’s Services Act (CSA)**

**Annual Parental Copayment Assessment**

**PART I**

**Instructions:** CSA case managers must discuss the copayment assessment requirements and process with parents or guardians, explain how to complete the copay form properly, and obtain verification of household income information

(2 consecutive paystubs, recent tax return or statement of earnings).

|  |  |  |
| --- | --- | --- |
| Child’s Name | Date of Birth | Client ID (DMC) # |
| Address | Parent/Guardian Email |
| Parent/Guardian #1 | Parent/Guardian #2 |
| Relationship to Child | Relationship to Child |
| Phone | Phone |
| Annual **Gross** Income $ | Annual **Gross** Income $ |
| Social Security Number  | Social Security Number  |
| Other Sources of Income (Ex: child support, alimony, Social Security, unemployment and other forms of income) $ |
| Family/Household size # | Annual Total of Household **Gross** Income  Yearly $ |

\*Household is synonymous with family and is defined as a group of related or unrelated individuals who are not residents of an institution or boarding house, but who are living as one economic unit sharing housing and all significant income and expenses.

|  |
| --- |
| *Circle which applies:*Community Based Services (CBS) OR Residential or Group home placements (RTC/GH)  |
| Exemption from paying COPAY (Reason): | Exemption timeframe: FROM (Date) TO (Date)  |

This is to acknowledge that all of the income information provided is accurate to the best of my knowledge, that the fee assessment process has been explained to me.

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Parent/Guardian#1 Name – PRINT Parent/Guardian#1 Name – SIGN Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian#2 Name – PRINT Parent/Guardian#2 Name – SIGN Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Name-PRINT Date

**Case Manager and System of Care please fill out supplemental questions on next page. Thank you.**

**Case Manager and System of Care please fill out supplemental questions below. Thank you.**

**Supplemental Questions:**

1. Is this a CPS case? [ ] Yes [ ] No
2. Is this a Kinship placement case? [ ] Yes [ ] No
3. Is Social Security family’s only income? [ ] Yes [ ] No
4. Is Medicaid/Private Insurance paying for Residential/Group home placements? [ ] Yes [ ] No
5. Is client approved for both Community Based Services AND Group home placements? If yes, please specify estimate time frame of each service.

[ ] Yes [ ] No

Community Based Services time frame: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group home placements time frame: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does family receive any form of public assistance? [ ] Yes [ ] No
2. Does client receive an IEP (Individualized Education Program)? If yes, please specify effective dates.

 [ ] Yes [ ] No

IEP effective dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does client receive additional services outside IEP? [ ] Yes [ ] No

PART II to be completed and signed only **after** Application and supporting documentation is reviewed and COPAY amount is assessed by the Management and Budget Specialist.

**PART II**

I agree to pay assessed monthly fee of $\_\_\_\_\_\_\_\_\_ for all services received within 30 days after receipt of the billing statement.\*Monthly copay will be prorated for partial month of placement/services. I understand that any delinquent balance for services received is subject to the collection procedures including wage garnishment and tax refund interception. I will discuss any problems that arise about making payments as agreed to above with my Case Worker.

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Parent/Guardian#1 Parent/Guardian#2 Date

**OFFICE USE ONLY**:

|  |  |
| --- | --- |
| Co-payment Amount – Residential or Group home placements (RTC/GH)$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Co-payment Amount – Community Based Services (CSB)$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

CSA Staff/Designee Title/Position Date