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)

COPAY Exemption Reasons: (1) First 6 months of all CPS cases, (2) Kinship placements, (3) Social Security is the family's only income, (4) Medicaid/Private Insurance paying for RTC/GH, (5) Receiving IEP (Individualized Education Program).

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.

_____	_____	_____
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	

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.* 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.

_____	_____	_____
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

* Monthly copay is a flat rate and does not get pro-rated for partial month placement.