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.

_____	_____	_____
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: please see next page related to supplemental questions.

SUPPLEMENTAL QUESTIONS (To be completed by Case Manager with support from System of Care)

1. **Is this a Child Protective Services case?** ☐Yes ☐No
2. **Is this a Kinship placement case?** ☐Yes ☐No
3. **Is Social Security the caregiver's only source of income?** ☐Yes ☐No
4. **Does the caregiver receive any form of public assistance?** ☐Yes ☐No
5. **Does the client have an Individual Education Plan (IEP)?** ☐Yes ☐No

   If yes, please specify effective dates: _____
   If yes, are you requesting services not included in the IEP? ☐Yes ☐No

6. **Are you asking for Community-Based Services, a Congregate Care Placement or BOTH?**

   Community-Based Services: ☐Yes ☐No
   Congregate Care Placement: ☐Yes ☐No
   Both: ☐Yes ☐No

   If Congregate Care Placement, is Medicaid/Private Insurance paying for part of the placement? ☐Yes ☐No

   If both, please specify estimate time frame of each service.
   Community Based Services:_____
   Congregate Care Placement: _____

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.

_____ _____ _____
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