



Family Fee Determination Form Instructions

Utah Department of Health
Baby Watch Early Intervention Program

Header Information



1 Program logo here



2 _____
(Early Intervention Program Name)

1. Insert your own program logo in the space provided. The Baby Watch logo must remain on the document.
2. If the program logo isn't available, write in the name of the early intervention program providing services to the child and family. Program identification is required by the Department of Health Central Billing Office for billing and reimbursement of family fees.

Filling Out the Family Fee Determination Form

Please type or print legibly. Only one form is required per family. If two or more children in a family are enrolled in early intervention, either at the same time or subsequently, the form must contain the information for all children in the family who are enrolled. A program staff person **must** assist the family in filling out the family fee determination form. Please make sure all information is complete, accurate, and legible so that the Department of Health Central Billing Office can process the family billing information. Please avoid scratch outs, write overs, etc.

Family and Child Contact Information

Parent/Legal Guardian 1		Parent/Legal Guardian 2	
Last Name:	First Name:	Last Name:	First Name:
Street Address: 3	City: 4	Zip Code: 5	Home Phone: () 6 Daytime Phone: () 7

1. Enter the first parent's/legal guardian's last name and first name.
2. Enter the second parent's/legal guardian's last name and first name.
3. Enter the street address of the primary residence of the household.
4. Enter the city of the primary residence of the household.
5. Enter the zip code of the primary residence of the household.
6. Enter the home telephone number for the family, including area code.
7. Enter the telephone number where a member of the family can be contacted during the day, including area code.

Children Who are Enrolled in Early Intervention

Please list all children enrolled in EI by their name and their date of birth.

Last Name	First Name	Date of Birth	Gender	Public Insurance Number*
1. 1	2	3	4 <input type="checkbox"/> Male <input type="checkbox"/> Female	5 <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP #
2.			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP #
3.			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP #
4.			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP #

***NOTICE TO FAMILY:** Public insurance (Medicaid/CHIP) will be billed for your child's early intervention services if your child is currently enrolled in a public insurance program. If your child has public insurance, enter a monthly family fee amount of \$0 on Line E. Parent/legal guardian and program staff member must both sign below. Please see the attached statement on no-cost protections. Stop here. 6

1. Enter the last name of the child who will be receiving early intervention services. If other children in the family are receiving early intervention services, enter their information on the following lines. The family will be charged only

one family fee, regardless of the number of children enrolled in early intervention. As each child graduates from early intervention, the fee will continue with the next oldest sibling enrolled in early intervention.

2. Enter the first name of the child who will be receiving early intervention services.
3. Enter the date of birth of the child.
4. Check the box which shows the child’s gender, male or female.
5. Check the box to indicate whether the child has public insurance, i.e., Medicaid or CHIP, and enter their public insurance number if it is available.
6. If the child has public insurance, inform the family that because the child is found to be Medicaid- or CHIP-eligible, public insurance will be billed for billable services. Go to Line E in the “Monthly Family Fee” block, enter 0, and review the no-cost protections statement. The program staff member and the parent/legal guardian sign the form. Do not complete the rest of the form.

Family Services Information					
Mark below all services currently received by family members. ❶					
<input type="checkbox"/> FEP/TANF ❷	<input type="checkbox"/> WIC ❷	<input type="checkbox"/> Early Head Start ❷	<input type="checkbox"/> PCN ❷	<input type="checkbox"/> Medicaid ❷	<input type="checkbox"/> CHIP ❷
If <u>any</u> family member receives <u>any</u> of the services listed above, enter a monthly family fee amount of \$0 on Line E. Parent/legal guardian and program staff member must both sign below. <u>Stop here.</u> ❸					

1. No fee will be charged if any family member is eligible, and has documentation for any of the programs listed on the second line. Additionally, if the child is a ward of the State, or if the child receives only Utah Schools for the Deaf and the Blind Parent Infant Program services, a fee will not be charged.
2. Mark the box(es) to indicate the service(s) received by the family member(s).
3. If any of the boxes are checked, or if the child is a ward of the state, or receives only USDB services, go to Line E in the “Monthly Family Fee” block, enter 0, and review the no-cost protections statement. The program staff member and the parent/legal guardian sign the form. Do not complete the rest of the form.

❶ Option to Decline Disclosure of Family Financial Information
<input type="checkbox"/> Check here if the parent/legal guardian declines to disclose family financial information. The family will be billed for the full fee of \$200 per month. Enter a monthly family fee amount of \$200 on Line E. Parent/legal guardian and program staff member must both sign below. <u>Stop here.</u> ❷

1. Families may elect to forego the fee determination process if they do not wish to disclose their financial information. If they choose to forego this process, they will be charged the maximum level of the fee schedule. For SFY14, the maximum fee level is \$200 per month.
2. If the family declines to disclose their financial information, go to Line E in the “Monthly Family Fee” block, enter \$200, and review the no-cost protections statement. The program staff member and the parent/legal guardian sign the form. Do not complete the rest of the form.

Please fill out the Family Fee Calculation Worksheets on Page 2 unless you were instructed in one of the above sections to stop and sign the form below.

Unless instructed in one of the preceding sections to skip the rest of the form, please go to page two and complete the financial calculations worksheet *before* completing the rest of page one.

Instructions for Page 2, Family Fee Calculation Worksheets.

Check the box indicating which documents were used to verify income. Income information/documentation needs to be reviewed and verified by the EI staff member, and should be referenced by the family when determining gross income. <ul style="list-style-type: none"> • Recently filed Internal Revenue Service tax forms • The check stubs from the last 3 calendar months may be averaged and 	Annual Family Income	
	Income verified by (check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> Most recent tax return <input type="checkbox"/> Last three consecutive pay stubs <input type="checkbox"/> Other 	
	1. Gross Monthly Salary (1 st wage earner) (Before taxes, social security, insurance, etc.)	\$

multiplied by 12. • The “Other” line may include items such as a family affidavit of income. See page 4 of the instructions for the types of income that may or may not be included.	2. Gross Monthly Salary (2 nd wage earner) (Before taxes, social security, insurance, etc.)	\$	
	3. Other Monthly Income (pensions, rentals, interest, dividends, alimony, child support.)	\$	
ADD Lines 1, 2 and 3, and enter the result here.	4. Total Monthly Income (Add Lines 1+2+3.)	\$	
If income information other than annual is provided, convert the income for each family member to a yearly amount and use the results to complete Line 5:	5. Annual Family Income (Multiply Line 4 x 12 and enter on Line 23.)	\$	
<p>Allowable deductions for determining modified annual income are</p> <ul style="list-style-type: none"> • Medical/Dental expenses • Child Day care costs • Child support or alimony payments <p>Qualifying expenses must be directly related to the health or medical condition of a family member. Expenses must be out of pocket for the previous 12 months and for which the family will not be reimbursed. Please refer to “IRS Publication 502, Medical and Dental Expenses” for additional details or www.IRS.gov. The family may refer to recent IRS tax forms or canceled checks, receipts, etc. Complete each line by converting monthly expenses to an annual amount by multiplying by 12.</p> <p>See Page 5 of the instructions for the types of expenses that may or may not be included as medical and dental expenses. Generally allowed and not allowed expenses are also listed on the family fee determination form, Page 2.</p>	Medical/Dental Expenses		
	6. Health Insurance Premiums \$ _____ per month x 12	\$	
	7. Dental and Vision Expenses \$ _____ per month x 12	\$	
	8. Insurance Co-payments \$ _____ per month x 12	\$	
	9. Hospital Expenses \$ _____ per month x 12	\$	
	10. Nutritional supplements ordered by physician \$ _____ per month x 12	\$	
	11. Prescriptions \$ _____ per month x 12	\$	
	12. Durable medical equipment, assistive technology, or adaptations expenses for the year	\$	
	Medical/Dental Expenses Continued		
	13. Specialized clothing required by medical condition \$ _____ per month x 12	\$	
	14. Specialized respite care or child care above typical costs not listed on Line 20	\$	
	15. Medical transportation costs \$ _____ per month x 12	\$	
	16. Other related medical costs (specify): \$ _____ per month x 12	\$	
	ADD Lines 6 through 16 and enter the amount in the box.	17. Total Medical/Dental Expenses (Add Lines 6 through 16.)	\$
	Families may deduct qualifying medical/dental expenses that are greater than 7.5% of their adjusted gross income.	Calculate Deductions from Income	
		18. Minimum Medical/Dental Deduction (Multiply Line 5 [Annual Income] x .075.)	\$
SUBTRACT Line 18 from Line 17 and enter the result here. This result is the amount of medical and dental expenses that may be deducted from the family’s gross income.	19. Deductible Medical/Dental Expenses (Subtract Line 18 from Line 17. If the result is greater than zero, enter it here, otherwise enter \$0.)	\$	
Child care expenses should reflect non-reimbursed costs accumulated over the last twelve (12) month period.	20. Child Care Costs \$ _____ per month x 12	\$	
Child support payments (Line 21) made for the benefit of children not living in the household are not to be confused with child support income , which should be reported on Line 3.	21. Child Support or Alimony Payments \$ _____ per month x 12	\$	
ADD Lines 19, 20 and 21 and enter the result here.	22. Total Deductions (Add Lines 19 + 20 + 21 and enter on Line 24.)	\$	
Reenter the amount from Line 5 in this box.	Calculate Modified Family Income		
	23. Amount from Line 5.	\$	
Reenter the amount from Line 22 in this box.	24. Amount from Line 22.	-\$	
SUBTRACT Line 22 from Line 23. Enter the result in Line 25. This is the family’s Modified Family Income. Return to Page 1 and enter the amount from this box on Line A of the “Monthly Family Fee” block.	25. Modified Family Income (Subtract Line 24 from Line 23 and enter it here and on Page 1, Line A.)	\$	

Income Sources and Expenses

Allowable and not allowable income and expenses generally follow the rules set forth by the Internal Revenue Service (IRS). Please refer to “IRS Publication 502, Medical and Dental Expenses” and other IRS publications for additional details or go to www.IRS.gov.

Countable Income Sources:

- Wages or Salary: total money earnings received for work performed before deductions are made for taxes, bonds, pensions, union dues, etc. Includes, but is not limited to, wages, salary, commissions, tips, piece rate payments, cash bonuses, etc.
- Non-farm self-employment income: the gross receipt minus expenses from a business, professional enterprise or partnership. Utilization of the last year’s IRS form is most appropriate for these income earnings.
- Farm self-employment: the gross receipts minus operating expenses from the operation of a farm by a person on his or her own account, as an owner, renter or sharecropper. Utilization of the last year’s IRS form is most appropriate for these income earnings.
- Social Security: includes Social Security pensions and survivor’s benefits, and permanent disability insurance payments made by the Social Security Administration prior to deductions for medical insurance, and railroad retirement insurance checks from the U.S. Government.
- Workers’ Compensation: compensation received periodically from private or public insurance companies for injuries incurred at work. The cost of this insurance must have been paid by the employer and not by the employee.
- Pensions and Annuities: includes pensions or retirement benefits paid to a retired person or his survivors by a former employer or by a union, either directly or through an insurance company; periodic receipts from annuities or insurance.
- Unemployment Compensation: compensation received from government unemployment insurance agencies or private companies during the period of unemployment and any strike benefits received from union funds.
- Alimony: allowance paid to one spouse by the other for support pending or after legal separation.
- Child Support: money paid by an absent parent for the benefits of his/her child
- Veteran’s Pensions: monies paid by the Veteran’s Administration to disabled members of the Armed Forces or to survivors of deceased veterans.
- Miscellaneous: includes interest on saving and checking accounts; income room rental or a house, double or apartment, store, or other property minus the cost of doing business; royalties; dividends from stock holdings or membership in associations; receipts from boarders or lodgers; other government benefits, etc.

Non-Countable Income Sources:

- Payments or allowances received pursuant to the Home Energy Assistance Act of 1980.
- The value of assistance to children or their families under the National School Lunch Act of 1966 and Food Stamp Act of 1977.
- Reimbursements from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
- Any payment to volunteers under Title I (VISTA and others), Title II (RSVP-foster grandparents, and others) of the Domestic Volunteer Service Act of 1973.
- Payments received under the Job Training Partnership Act.
- Payment to volunteers under Section 8 of the Small Business Act.
- Education grants, student loans, stipends and scholarships for education and training.
- Earnings or stipends received from participation in any type of work study program.
- Earnings of a dependent child under the age of twenty-two (22) years of age.
- Veteran’s educational benefits.
- College or university assistantships.
- Subsidized housing.
- Food allowance or subsidized housing for military housing allowances received by families living off a military base.

- If the child or family is temporarily living within another household, only the income of the child or family participating in Early Intervention services shall be used for determining financial eligibility.

Allowable Medical Expenses

- Capital expenses for equipment or improvements to your home needed for medical care
- Cost and care of guide animals aiding the blind, deaf, and disabled
- Cost of lead based paint removal
- Expenses of an organ transplant
- Hospital services fees (lab work, therapy, etc.)
- Birth control pills, legal abortion, legal operations
- Meals and lodging provided by a hospital during medical treatment
- Medical and hospital insurance premiums
- Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)
- Oxygen equipment and oxygen
- Prescriptions, medicines, and insulin
- Tutoring recommended by a doctor
- Psychiatric care at a specialty equipped medical center (includes meals and lodging)
- Special items (hearing aids, wheelchairs, etc.)
- Special school, tuition, meals and lodging
- Transportation for medical care
- Treatment at a drug or alcohol center
- Wages for nursing services
- Diaper costs related to medical problem
- Other expenses included in IRS Publication 502

What cannot be included as expenses:

- Diaper services
- Health club dues
- Household help
- Stop smoking program
- Weight loss program
- Life insurance or income protection policies
- Maternity clothes
- Medicine bought without a prescription
- Nursing care for a healthy baby
- Surgery for purely cosmetic reasons
- Other expenses not included in IRS Publication 502

Return to Page 1, and Instructions

Monthly Family Fee	
A. Modified Family Income (From page 2, Line 25.)	\$ 1
B. Number of adults in family	2
C. Number of in family	3
D. Total family size (Add Line B + Line C.)	4
E. Enter a monthly family fee amount of \$0 if instructed to do so in one of the above sections OR enter the fee amount from the sliding fee schedule using Line A and Line D.	\$ 5

1. Enter the amount from Page 2, Line 25 “Modified Family Income,” unless instructed to enter 0 by one of the previous sections.
2. Count all adults, persons 18 years of age or older, living in the home and enter the number here.
3. Count all children, persons less than 18 years of age, living in the home and enter the number here.
4. Add the number of adults to the number of children and enter the result here.
5. Refer to the sliding fee scale for the current year. The current sliding fee scales are available on the BWEIP web site, www.utahbabywatch.org. Click on the “For Providers” tab, and then the “BWEIP Forms” sub-tab. Look for “Sliding Fee Scale” in the “General Forms” list. To determine the Monthly Family Fee, find the row for the total family size and move to the right until you find a block that includes the “Modified Family Income,” Line A amount. Follow this column to the top of the scale to find the Monthly Family Fee amount. In the example below a family of 3, with a Modified Family Income of \$55,000, has a Monthly Family Fee of \$30.
6. Enter the Monthly Family Fee on Line E.

Monthly Family Fee:	Exempt	\$10	\$20	\$30	\$40	\$50	\$60
Fee Group:	FX	FH	FG	FF	FE	FD	FC
Family Size:	Modified Income	Modified Income	Modified Income	Modified Income	Modified Income	Modified Income	Modified Income
2	\$0.00 to \$28,848.59	\$28,848.60 to \$31,019.99	\$31,020.00 to \$38,774.99	\$38,775.00 to \$46,529.99	\$46,530.00 to \$62,039.99	\$62,040.00 to \$77,549.99	\$77,550.00 to \$93,059.99
3	\$0.00 to \$36,325.79	\$36,325.80 to \$39,059.99	\$39,060.00 to \$48,824.99	\$48,825.00 to \$58,589.99	\$58,590.00 to \$78,119.99	\$78,120.00 to \$97,649.99	\$97,650.00 to \$117,179.99
4	\$0.00 to \$43,802.99	\$43,803.00 to \$47,099.99	\$47,100.00 to \$58,874.99	\$58,875.00 to \$70,649.99	\$70,650.00 to \$94,199.99	\$94,200.00 to \$117,749.99	\$117,750.00 to \$141,299.99

Effective Date

1 This monthly family fee amount will become effective:

Month: **2** Year: 20 **3**

1. The monthly family fee becomes effective on the same date as the Individualized Family Service Plan (IFSP) whether it is the initial or annual IFSP unless a change is submitted at some other date. The Family Fee Determination Form must be reviewed every six months and a new form is required at each annual review or any time there is a change in family size, income, address, or telephone number. If the fee changes because of a change in family circumstances, the effective date is the date the change was made to the fee and a new Family Fee Determination Form was filled out.
2. Enter the month in which the monthly family fee will become effective.
3. Enter the year in which the monthly family fee will become effective.

Extenuating Circumstances, Certifications and Signatures

Extenuating Circumstances

Extenuating circumstances are unexpected events that affect the family's financial situation and should be taken into consideration when determining the monthly family fee. Enter \$0 on Line E and describe the circumstance:

① _____

② _____

Program Coordinator or Designee Signature

③ _____

Date

Extenuating Circumstances are almost always already covered by the financial information worksheet in the allowable deductions and expenses fields. If extenuating circumstances exist, the situation should be explained to the program coordinator, or authorized designee. A full description of the circumstances (1) and the signature (2) of the program coordinator, or designee are required. Enter the date the program director or designee authorized the extenuating circumstance (3). If a family's income changes substantially they should be advised to submit a new Family Fee Determination Form.

Parent/Legal guardian Certification

- The no-cost protections for families when billing a child's public insurance have been reviewed with me. I have received a copy of the no-cost protections. ①
- I understand that my financial responsibility is calculated based on the information I have provided. I also understand that non-payment of fees may result in the discontinuation of services. A minimum penalty fee of \$20 per check will be charged for returned checks. I certify to the best of my knowledge the information provided above is true and correct. I have received a copy of my parent's rights and responsibilities related to cost participation through family fees and understand that I may ask for a review of my family fee if my financial situation changes. ② _____ ③ _____

④ _____

Parent/Legal guardian Signature

Date

1. The program staff member who is assisting the family fill out the form must review and explain the no-cost protections to the parent/legal guardian of the family.
2. The program staff member who is assisting the family fill out the form must review and explain the family's financial obligations under the family fee program, including the suspension of services for non-payment, to the parent/legal guardian of the family.
3. The parent/legal guardian must sign the Family Fee Determination Form, whether or not the family is being charged a fee. The parent/legal guardian who signs the Family Fee Determination Form is understood to be the guarantor for this child's family fees.
4. Enter the date that the parent/legal guardian signed the Family Fee Determination Form.

Program Staff Member Certification

I verify that I have informed the parent(s)/legal guardian(s) regarding their rights and responsibilities related to cost participation in early intervention through family fees, and that I have utilized all the information provided to me by the family in assisting them to calculate their fee. I have informed the family of the no-cost protections if the child's public insurance is billed. ① _____

② _____

③ _____

Program Staff Member Signature

Date

1. The program staff member certifies that he/she has informed the family of their rights and responsibilities related to the family fee program and has assisted the family in filling out the Family Fee Determination Form. The program staff member further certifies that he/she has informed the family of the cost protections applied to billing public insurance and the procedural safeguards for the family fee cost participation program.
2. The program staff member who assisted the family with the Family Fee Determination Form must sign here.
3. Enter the date the program staff member who assisted the family with the Family Fee Determination Form signed it.

Procedural Safeguards and No Cost Protections

The Utah Baby Watch Early Intervention Program (BWEIP) and its grantees are required by the Individuals with Disabilities Education Act (IDEA) to inform parents of the procedural safeguards and no-cost protections regarding

payment for early intervention services. The program staff member who assists the family in filling out the Family Fee Determination Form must review with the family the procedural safeguards and no-cost protections regarding payment for early intervention services before the parent or legal guardian signs the Family Fee Determination Form. A copy of the procedural safeguards and no-cost protections (page 3 of the Family Fee Determination Form) must be left with the family.

Supervisory Review and Submitting the Family Fee Determination Form to BWEIP

The Family Fee Determination Form must be reviewed by the early intervention program before it is submitted to the Utah Department of Health Central Billing Office. The early intervention program will review the form for legibility, completeness and accuracy of calculations. Any detected errors must be corrected prior to submission. Completed forms may be mailed or faxed to the Central Billing Office.

Attn: Janna Miltenberger (or Natali Rajcevich)
Financial Resources
Family Health and Preparedness
PO Box 142001
Salt Lake City, UT 84114
Fax 801-538-6591

