Family Fee Determination Form

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Program Name

Family and Child Contact Information			
Parent/Legal Guardian Last Name: First Name:		**Parent/Legal Guardian** Last Name: First Name:	
Street Address:	City:	Zip Code:	Home Phone: ( ) Daytime Phone: ( )

Please list all children enrolled in early intervention by name and date of birth.

Last Name	First Name	Date of Birth	Gender	Public Insurance Number*
1.			☐ Male ☐ Female	☐ Medicaid ☐ CHIP #
2.			☐ Male ☐ Female	☐ Medicaid ☐ CHIP #
3.			☐ Male ☐ Female	☐ Medicaid ☐ 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 of No-Cost Protections. STOP HERE.

Family Services Information

☐ FEP/TANF	☐ WIC	☐ Early Head Start	☐ PCN	☐ Medicaid	☐ CHIP

If any family member receives any 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. STOP HERE.

Option to Decline Disclosure of Family Financial Information

☐ 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 of $200 on Line E. Parent/legal guardian and program staff member must both sign below. STOP HERE.

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

Monthly Family Fee	
A. **Modified Family Income** (From page 2, Line 25.)	$
B. Number of adults in family	
C. Number of children in family	
D. **Total family size** (Add Line B + Line C.)	
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.	$
This monthly family fee amount will become effective:	
Month:	Year: 20______

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:

______________________________ __________
Program Coordinator or Designee Signature Date

Parent/Legal Guardian Certification

☐ The No-Cost Protections for families when billing a child's public insurance have been reviewed with me and I have received a copy of the Procedural Safeguards and No-Cost Protections.

☐ 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.

______________________________ __________
Parent/Legal Guardian Signature Date

Program Staff Member Certification

I verify that I have informed the parent/legal guardian 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.

______________________________ __________
Program Staff Member Signature Date

NOTE: A new form is required at each annual review or any time there is a change in family size, income, address, or phone number.

UTAH DEPARTMENT OF
HEALTH
Baby Watch Early Intervention
Birth to Three Development

Family Fee Calculation Worksheet

Annual Family Income	
Income verified by (check all that apply): □ Most recent tax return □ Last three consecutive pay stubs □ Other ________________________	
1. Gross Monthly Salary (1st wage earner) (Before taxes, social security, insurance, etc.)	$
2. Gross Monthly Salary (2nd wage earner) (Before taxes, social security, insurance, etc.)	$
3. Other Monthly Income (pensions, rentals, interest, dividends, alimony, child support)	$
4. Total Monthly Income (Add Lines 1+2+3.)	$
5. **Annual Family Income** (Multiply Line 4 x 12 and enter on Line 23.)	$
Medical/Dental Expenses	
6. Health Insurance Premiums $______ per month x 12	$
7. Dental and Vision Expenses $______ per month x 12	$
8. Insurance Copayments $______ 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	$
17. **Total Medical/Dental Expenses** (Add Lines 6 through 16.)	$
Calculate Deductions from Income	
18. Minimum Medical/Dental Deduction (Multiply Line 5 [Annual Income] x .075.)	$
19. Deductible Medical/Dental Expenses (Subtract Line 18 from Line 17. If the result is greater than 0, enter it here. Otherwise enter $0.)	$
20. Child Care Costs $______ per month x 12	$
21. Child Support or Alimony Payments $________ per month x 12	$
22. **Total Deductions** (Add Lines 19+20+21 and enter on Line 24.)	$
Calculate Modified Family Income	
23. Amount from Line 5.	$
24. Amount from Line 22.	-$
25. Modified Family Income (Subtract Line 24 from Line 23 and enter it here and on page 1, Line A.)	**$**

Allowable Medical Expenses

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 you will not be reimbursed. You may deduct qualifying medical/dental expenses that are *greater than 7.5%* of your adjusted gross income. Please refer to "IRS Publication 502, Medical and Dental Expenses" for additional details or www.IRS.gov.

- 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

UTAH DEPARTMENT OF HEALTH
Baby Watch Early Intervention
Birth to Three Development

No-Cost Protections

The Baby Watch Early Intervention Program (BWEIP) is required by the Individuals with Disabilities Education Act (IDEA) to inform parents of the following procedural safeguards and no-cost protections regarding payment for early intervention services.

Medicaid and CHIP

NOTICE TO FAMILY: Medicaid or CHIP will be billed for your child's early intervention services if they are covered by either program.

- BWEIP must provide parents with written notice prior to billing public insurance (Medicaid/CHIP) for their child's early intervention services.
- Parents cannot be required to enroll in a public insurance or benefits program (Medicaid/CHIP) if they are not already enrolled in such a program to receive early intervention services from the BWEIP.
- Early intervention services, as specified in the child's Individualized Family Service Plan (IFSP) and to which the parent has consented, cannot be denied due to a parent's refusal to allow their public insurance to be billed for such services.
- BWEIP does not require a parent to pay any costs as a result of the BWEIP using a child's or parent's public insurance or public benefits to pay for early intervention services.
- BWEIP, Medicaid, and CHIP are programs within the Utah Department of Health, therefore parental consent is not required prior to a child's personally identifiable information (name, date of birth, policy number, and address) being submitted for billing purposes.
- Parents have the right to withdraw their consent to disclose their child's personally identifiable information at any time without affecting the BWEIP services their child is receiving as specified in their child's IFSP.
- Parents must be informed that billing their public insurance in Utah (Medicaid/CHIP) will not result in a decrease in lifetime benefits, result in the child's parents paying for services that would otherwise be covered, result in an increase in premiums or discontinuation of public benefits or insurance, or will risk loss of eligibility for home and community-based waivers based on aggregated health-related expenditures for the child or the child's parents.
- BWEIP must obtain written consent from parents if billing their public insurance would result in a decrease in lifetime benefits, result in the child's parents paying for services that would otherwise be covered, result in an increase in premiums or discontinuation of public benefits or insurance, or will risk loss of eligibility for home and community-based waivers based on aggregated health-related expenditures for the child or the child's parents.

Family Fees

The BWEIP will not charge a fee for services that a child is entitled to receive at no cost under IDEA: child find, evaluation and assessment, service coordination, development and review of IFSP, provisions of procedural safeguards, and services provided by the Utah Schools for the Deaf and the Blind. Parent's Rights guarantee that:

- All early intervention services on the IFSP will be provided at no cost without delay if the family meets the state's definition of inability to pay.
- Families will receive an annual review of their family fee or may request a review at any time.
- Families have the right to appeal the amount of their family fee through their program's conflict resolution procedure.
- Families are entitled to receive uninterrupted services during the appeal process.

PLEASE NOTE:

- **A service will be considered rendered and the family will be subject to a fee for a no show or untimely cancellation.**
- **Please cancel prior to 9am on the day of the scheduled service.**
- **Fee-eligible services may be suspended if unpaid charges exceed 90 days past due.**