

Michigan Department of Community Health
 Children's Special Health Care Services
INCOME REVIEW/PAYMENT AGREEMENT AMENDMENT

Purpose: CSHCS representative provides review/amendment to client.

Local Health Department Name	LHD Staff Name and Title
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Regarding:

Client Name	Client Number
Period of Coverage	Local Health Department Name
From:	To:

Original Agreement and Reason(s) for Change in Agreement:

Original Agreement Amount: _____ per month	(_____ months) = \$ _____ total
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The original payment agreement has been changed for the following reason(s):

- Change in family size (new size _____) effective date: _____
- Change in family income (new income amount \$ _____), effective date: _____
- Death of Client, date: _____
Note: No calculation is needed – Results in zero balance to outstanding payment agreement.
- Client has Medicaid, WIC, or MIChild, effective date: _____

New Agreement Computation and Approval: Please adjust the account accordingly.

From _____	To _____,	\$ _____ per month	X _____ (months)	= \$ _____.
From _____	To _____,	\$ _____ per month	X _____ (months)	= \$ _____.
Total New Obligation				= \$ _____.

- The changes shown above are true and complete to the best of my knowledge.
- I approve of the changes in the new payment agreement as shown above.

Signature of person who signed the original agreement	Date Signed
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Mail the completed Amendment request to:

**MDCH/CSHCS
 Customer Support Section
 P.O. Box 30734
 Lansing, MI 48909-8234**

AUTHORITY: Act 368, P.A. 1978.
COMPLETION: Is Voluntary, but required if CSHCS program services are desired.
MSA-0927 (12/06) Previous Edition Obsolete

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