

INCOME REVIEW/PAYMENT AGREEMENT AMENDMENT

Children's Special Health Care Services
Michigan Department of Health and Human Services

Purpose: Recalculation of payment agreement.

Local Health Department Name	LHD Staff Name and Title
------------------------------	--------------------------

Regarding

Client Name	Client ID Number
Period of Coverage From: _____ To: _____	Adult Client or Legally Responsible Party

Original Agreement and Change

Original Agreement Amount: \$ _____
The original agreement has been changed for the following reason(s): <input type="checkbox"/> Change in family size (new size _____) effective date: _____ <input type="checkbox"/> Change in family income (new income amount \$ _____), effective date: _____ <input type="checkbox"/> Death of Client, date: _____ <input type="checkbox"/> Client has Medicaid or MICHild, effective date: _____

New Agreement and Approval: Please adjust the account accordingly.

Family Size _____	Family Income \$ _____
New Agreement Amount \$ _____	
<ul style="list-style-type: none">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

FAX the completed Amendment request to:

**MDHHS/CSHCS
517-335-9491**

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: Act 368, P.A. 1978.

COMPLETION: Is voluntary, but required if CSHCS services are desired.