

***DCH-1181 Completion Instructions***  
***FAMILY SUPPORT SUBSIDY (FSS) PROGRAM MULTI-USE FORM***

Collect the following documents (copies are acceptable):

- ✓ Your child's legal birth certificate. (Your child must be under age 18.)
- ✓ Your most recently filed Michigan income tax return (MI-1040), or if a MI-1040 income tax form was not filed, you may submit a copy of your most recently filed United States (US-1040) income tax return. *For new applicants only*, other evidence of current year income may be used if *neither* a Michigan nor a U.S. income tax form was filed. Your family's **taxable** income must not exceed \$60,000.
- ✓ Your child's social security card (optional). If your child does not currently have a social security number, you may apply online for one through the Social Security Administration <http://www.ssa.gov> or telephone 1-800-772-1213. You may apply for this subsidy while you are waiting to receive a social security number.

NOTE: This information will be used to complete the application and will serve as proof of eligibility. Make sure to submit copies as any documents you provide will not be returned to you.

You must also contact your child's local public school, intermediate school district or regional educational services agency and provide authorization to send or fax written verification of your child's educational eligibility category and, if necessary, evidence of educational programming to your local county community mental health services program (CMHSP). This is the agency that provided you with this form. Please note that the only special education eligibility categories that meet FSS criteria are **Severe Cognitive Impairment, Severe Multiple Impairment or Autism Spectrum Disorder AND in a program that qualifies under FSS law**. Your CMHSP representative will provide you with a fax number and/or mailing address for the educational institution to use in transferring required documentation.

Other information:

- ✓ If your child is currently living in a nursing home, center for persons with developmental disabilities, foster family care home or residential school, you may apply for FSS if the child is returning to your home in a very short period of time.
- ✓ If your child is adopted and enrolled in the Michigan Department of Human Services, Adoption Subsidy Program, you may continue to receive the monthly adoption subsidy even if your child becomes eligible for FSS payments. Your child may NOT, however, also have an open **medical** subsidy within the Adoption Subsidy Program. If you are unsure if your child has an open medical subsidy, you can verify this information by calling (517) 335-6443. If there is an open medical subsidy, you may wish to request closure of it as a means to meeting FSS eligibility requirements.

*Completion instructions begin on next page*

LINE-BY-LINE COMPLETION INSTRUCTIONS:

1) Purpose:

- Check NEW APPLICATION if this is the first time you have applied for the subsidy.
- Check ANNUAL RENEWAL if you are renewing eligibility.
- Check RESTORE if there has been a gap in eligibility/payments.
- Check CHANGE OF STATUS and write in the corresponding block number(s) to report changes in information previously provided. When reporting a change in status, you need to complete ONLY blocks 1, 2, 3 and 4 as well as the block(s) containing the information that has changed.

2) Child's Name – First, Middle Initial, Last.

3) Child's Date of Birth – Month/Day/Year.

4) Child's Social Security Number. Note: You may apply for FSS at the same time that you are completing social security number registration for your child.

5) Child's Gender – Male or Female.

6) Telephone Number – Your primary telephone number including area code.

7) Race (optional)

- White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- Black or African American** - A person having origins in any of the Black racial groups of Africa.
- American Indian and Alaska Native** - A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- Asian** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Some other race.
- Unknown.

8) Name of public school that signed the Multi-disciplinary Evaluation Team (MET) report.

9) Parent/Guardian Name (First, Middle Initial, Last) **THE PERSON LISTED IN THIS BOX WILL BE THE SOLE PAYEE FOR FSS PAYMENTS. If you desire both parents'/guardians' names on the check then select "Another Payee" and the other parent/guardian must complete block 20.**

10) Parent/Guardian Social Security Number – Enter the SSN of the person listed in block 9.

11) Print the address where the child resides (must be same as parent/guardian- **ONLY** one address may be listed).

12) Has the child's residence changed in the last year? If **YES**, enter previous city name.

13) Is your child adopted? Check **YES** or **NO**.

14) If your child is adopted, check **YES** or **NO** indicating if the child is receiving a medical subsidy through the Michigan Department of Human Services Adoption Subsidy Program.

Continued on other side →

Instructions continued:

- 15) Check the bracket corresponding to the **TAXABLE** income amount displayed on your most recently filed Michigan income tax form (MI-1040). If a Michigan income tax form was not filed, check the bracket corresponding to the taxable income amount listed on your most recently filed United States income tax form (US-1040). If neither a state nor federal tax form was filed, other proofs of income can be considered such as W-2 forms or paperwork from other government assistance programs.
- 16) Confirm **YES** or **NO** that the child lives in Michigan with one or both of the persons listed in blocks 9 and 20.
- 17) If **NO** is marked in block 16, indicate whether the child is temporarily living with another relative.
- 18) It is important to read and understand all the items listed. **Your signature in block 19 (and 20 if another payee is listed) indicates that you understand and agree to all bulleted items.** Questions about the information displayed in this block can be directed to the agency representative providing you with this form.
- 19) Signature of the person named in block 9. Be sure to include the date of signature.
- 20) If “another payee” was selected in block 9, the other parent/guardian must complete block 20.

**The bottom portion of the application is for county community mental health agency use.**

**NEXT STEPS: Take or send this completed application along with a copy of your most recently filed Michigan income tax form, a copy of your child’s legal birth certificate and a copy of your child’s social security card to the CMHSP representative that gave this paperwork to you. You must also contact your child’s public school, intermediate school district or regional services educational agency to give them permission for the sharing of documentation with the CMHSP. The CMHSP representative will give you a fax number or mailing address that the school can use to send the required educational information.**

**AUTHORITY:** Sections 155-161 of P.A. 258 of 1974, as amended.

**COMPLETION:** Is voluntary for a new application, but is required for annual renewal, change of status or restore to active status.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

DCH-1181 and INSTRUCTIONS (Rev. 5/13) Previous Editions Obsolete

# FAMILY SUPPORT SUBSIDY PROGRAM

Michigan Department of Community Health

1. Purpose:  New Application  Annual Renewal  Restore  
 Change of Status (Enter block number (s) that have changed): \_\_\_\_\_

2. Child's Name (First, Middle Initial, Last)	3. Date of Birth (Month/Day/Year)	4. Child's Social Security Number
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5. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Primary Telephone Number ( )	7. Race (See instructions for codes)	8. Name of public school signing MET report:
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9. Parent/Guardian Name (First, Middle Initial, Last) Another Payee? (if yes fill in block 20) <input type="checkbox"/> YES <input type="checkbox"/> NO	10. Parent/Guardian Social Security Number
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11. Parent/Guardian Address <u>IMPORTANT</u> : IF FOUND ELIGIBLE, FAMILY SUPPORT SUBSIDY CHECKS WILL BE MAILED TO THIS ADDRESS			
Number & Street	City	State	Zip Code

12. Has your Family Moved in the Last Year?  NO  YES → (previous city): \_\_\_\_\_

13. Is Your Child ADOPTED? <input type="checkbox"/> NO <input type="checkbox"/> YES →	14. IF YES, Is Your Child receiving a <b>medical subsidy</b> through the Adoption Subsidy Program? <input type="checkbox"/> NO <input type="checkbox"/> YES
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15. What is your TAXABLE income as listed on your most recently filed Michigan income tax form?  
 A. \$19,999 or LESS  B. \$20,000 to \$44,999  C. \$45,000 to \$60,000  D. OVER \$60,000

16. Does Your Child Currently Live in Michigan with One or Both of the Parents/Guardians Listed? <input type="checkbox"/> YES <input type="checkbox"/> NO	17. If NO, does Your Child TEMPORARILY Live with a RELATIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO
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**18. PARENT/GUARDIAN CERTIFICATION:**

- I agree to notify my county community mental health services program within **two weeks** of ANY changes in information reported on this form.
- I understand that a change in status can include name, address, living arrangement, an open medical subsidy, a more recent tax return with a taxable income of more than \$60,000, or a change in the child's educational eligibility category and/or programming.
- I understand that this program requires a **YEARLY RENEWAL** near or during my child's birth month and that I must contact my community mental health services program to start the renewal process. There is a two-month grace period following my child's birth month in which I may renew the subsidy without penalty.
- If I fail to reapply within the renewal period or grace period, I will NOT receive compensation for any payments I may have missed if my child is later found eligible. The new eligibility period will start and payments will resume the month following receipt of a complete packet of renewal information.
- I agree that subsidy dollars received will be used to meet the special needs of my child/family.
- I declare that this information is complete and true to the best of my knowledge.
- I understand that providing false information or failing to provide notice of a change in required information may result in denial of eligibility, repayment of any amount inappropriately received and perjury penalties as provided by law.

19. Parent/Guardian Signature	Date
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20. Other Payee (Parent/Guardian) Signature	Other Payee Printed Name	Other Payee Social Security Number	Date
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**THIS SECTION IS FOR CMHSP USE ONLY - DO NOT WRITE BELOW THIS LINE**

Child's Current Educational Eligibility Category:

21.  **A. Severe Cognitive Impairment:**  
 If Severe Cognitive Impairment, does the documentation include written verification from the public school that the child's latest intellectual assessment shows development at a rate of 4.5 or more standard deviations BELOW the mean?  YES  NO

22.  **B. Autism Spectrum Disorder:**  
 If AUTISM SPECTRUM DISORDER, does the child's special education programming fall under any of the following options?

a) Severe Cognitive Impairment Program (R340.1738) .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
b) Severe Multiple Impairments Program (R340.1748) .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
c) Autism Spectrum Disorder Program (R340.1758) .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO

23.  **C. Severe Multiple Impairment**

Is this family eligible for the one-time double subsidy payment to prepare for the child's return to home?  YES  NO

Has this child been in an out-of-home placement during the past 12 months? <input type="checkbox"/> YES <input type="checkbox"/> NO	NOTE: Hospitalization for acute medical illness or exacerbation of chronic medical illness is NOT an out-of-home placement.
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If YES, please enter the date child returned home from placement. If the child is now ineligible for FSS because of a move to an out-of-home placement, indicate the date that the child left the family home. Month: _____ Year: _____	Type of out-of-home placement <input type="checkbox"/> Foster Care <input type="checkbox"/> Group Home <input type="checkbox"/> Other (explain): _____
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COMPLETE Application Packet Received Date (M/D/Y)	Effective Date (M/D/Y)	Expiration Date (M/D/Y)	CMHSP BOARD NO:
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<input type="checkbox"/> ELIGIBLE <input type="checkbox"/> INELIGIBLE (Due to Block #): _____	CMHSP Authorized Signature _____ Date _____
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