MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 07-24

Distribution: Local Health Departments

Issued: June 1, 2007

Subject: Changes to CSHCS Application and Payment Agreement Policy

Effective: July 1, 2007

Programs Affected: Children's Special Health Care Services

Change to CSHCS Application

Effective July 1, 2007, foster parents are considered legally responsible to sign the Children's Special Health Care Services (CSHCS) application on behalf of their foster child.

Change to CSHCS Payment Agreement Policy

For CSHCS clients/families who enter into a new or renewal payment agreement effective on or after July 1, 2007:

- The total amount of the financial obligation is due upon receipt of the payment agreement notification.
- Adoption with a pre-existing CSHCS eligible medical condition is no longer an exemption from a payment agreement.

The payment agreement changes are reflected in the attached form MSA-0738. CSHCS payment agreements with an effective date prior to July 1, 2007 remain intact as agreed upon until their end date. The policy changes described above will impact the client's next annual payment agreement.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

Sample Only

Michigan Department of Community Health - Children's Special Health Care Services

INCOME REVIEW / PAYMENT AGREEMENT

SECTION 1 – Client Information (Adult Client or Minor Child) and Household Information

1. Client Name (Last, First, Middle)	2. County	3a. Client ID #	
		3b. Client Social Security #	Suffix
4. Client's Home Address (Street, Apt/Lot Number, City, State, Zip)		5. Client Date of Birth	Region

6. List other immediate family members in household with CSHCS coverage (attach additional pages if needed)

Name (Last, First, Middle)	**Client ID Number**	**Birth Date**

7. Does the **CLIENT** have any of the following?

- Full Medicaid ..... ☐ Yes
- W.I.C. ..... 9-digit W.I.C. Family #_____ ..... ☐ Yes
- MIChild…..(Not mihealth) ..... ☐ Yes

Does the **CLIENT** live in a foster home or private placement agency? ..... ☐ Yes

Is the **CLIENT** a ward of the county/state or under 18 years of age with a legal guardian? ..... ☐ Yes

Is the **CLIENT** deceased? (If Yes, date of death) _____ ..... ☐ Yes

IMPORTANT:

If you checked any box in #7, **NO PAYMENT IS REQUIRED FOR THIS CLIENT.**

GO to Line #10, enter $0.00, and continue completing the form. (*See instructions.)*

SECTION 2 – Income Information

8. Enter the total number of exemptions from your current **Federal Tax Form** (line 6d of the 1040 or 1040A, or line 5 of the 1040EZ) .....

Check box if step-parent is excluded in total number of exemptions..... ☐

9. Enter the responsible party's income from your current **Federal Tax Form**. (Line 22 of the 1040; Line 15 of the 1040A; or Line 4 of the 1040EZ) If using Financial Worksheet (MSA-0742) enter amount from line #8. ..... **$**

Check box if step-parent income is excluded..... ☐

10. Enter the **YEARLY** amount of the required Payment Agreement according to the Payment Agreement Guide (MSA-0738-B). ..... **$**

SECTION 3 – Payment Agreement (One agreement per family.)

- I understand if I did **not** check **ANY** box in **#7**, I agree to pay the State of Michigan the required amount on Line #**10** for Children's Special Health Care Services coverage.
- I understand that I am responsible for the entire payment agreement amount which is due upon receipt of my payment notification. Payment shall be made in full or according to the instructions I will get with my notification. Payments are non-refundable.
- If my circumstances change and I am unable to continue paying, I will contact the local health department CSHCS immediately for a possible amendment to this agreement.
- I understand that when the Michigan Department of Community Health (MDCH) pays for services, any right to recover monies from a third person or public or private contractor (except Medicare) is transferred to the MDCH. Payment of any recovery under such right is to be made directly to the State of Michigan, MDCH, or agent.
- I certify under the penalty of perjury that the information on this form is true, complete and accurate to the best of my knowledge. I understand that any misrepresentation of this information may result in the loss of CSHCS coverage.
- I authorize the State of Michigan to verify any information on this form.
- I understand that if the amount due to the State is not paid in full, it may result in non-renewal of my CSHCS coverage. If unpaid, my account may also be sent to the Michigan Department of Treasury for collection.

11. Signature of Legally Responsible Party **or** Adult Client	Date Signed	13. The person signing Box 11 is the:
		☐ PARENT of Minor Client
12. Print Name Signed Above	Area Code and Telephone Number	☐ GUARDIAN of Client
		☐ FOSTER PARENT of Client
		☐ ADULT Client

Retain **PINK** copy. Mail the signed **WHITE** and **YELLOW** copies, with any additional page(s) to:

Michigan Department of Community Health
CSHCS Division
PO Box 30734
Lansing, MI 48909-8234

For assistance or questions call 1-800-359-3722

Sample Only

Michigan Department of Community Health
Children's Special Health Care Services

INCOME REVIEW /PAYMENT AGREEMENT

Instructions for Completion (MSA-0738)

The Income Review/Payment Agreement (MSA-0738) is used to determine if a payment agreement is required of the family to receive coverage by the Children's Special Health Care Services (CSHCS) program.

General Instructions:

- Please **PRINT** clearly in ink.
- This form must be completed for the client.
- Do not write in the gray/shaded areas (official use only).
- Upon completion, keep PINK copy for your records.
- Mail **WHITE** and **YELLOW** copies, and additional page(s) (if applicable) to:

  MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
  CSHCS DIVISION
  PO BOX 30734
  LANSING, MI 48909-8234

- If you need assistance, call **1-800-359-3722 or your local health department CSHCS office.**

SECTION 1 – Client Information (Adult Client or Minor Child) and Household Information

1. Enter the name of the client applying for CSHCS services.
2. Enter the client's county of residence.
3. a. Enter the client's ID number (CSHCS or Medicaid). b. Enter the client's social security number.
4. Enter the client's home address.
5. Enter the client's date of birth.
6. List other immediate family members in the household with CSHCS coverage (attach additional pages if needed).
7. Check all that apply to the **client**. **Note:** If you check **any** box in # 7, NO PAYMENT IS REQUIRED FOR THIS CLIENT. Skip #8 and #9, and then go to #10 and enter the amount $0.00. Continue to Section 3.

SECTION 2 – Income Information

(**Note:** Contact your local health department's CSHCS office to complete this section due to no federal tax form, change in family size, loss of income, or other similar circumstance.)

8. Enter the total number of exemptions on your current federal tax form (see line 6 d. on the Federal 1040 or the 1040A, or line 5 of the Federal 1040EZ).
9. Enter the responsible party's income from your current Federal Tax Form (line 22 of the Federal 1040, line 15 of the Federal 1040A, or line 4 of the Federal 1040EZ) **or** line 8 from Financial Worksheet (MSA 0742). If no Federal Tax Form is available, call 1-800-359-3722 for assistance. **Note:** Clients age 18 or older are legal adults; therefore, only their income is considered and not that of the family or guardian. Step-parent income and exemptions may be excluded. Contact your local health department for assistance.
10. Enter the **Yearly Payment Agreement Amount** according to the enclosed Payment Agreement Guide (MSA-0738-B), even if the amount is $0.00.

SECTION 3 – Payment Agreement

Read each statement carefully. This is your yearly Payment Agreement for the CSHCS program. Contact your local health department for assistance.

11. Signature of legally responsible party **or** adult client and date signed.
12. Print name of person signing #11. Phone number including area code.
13. Check box which identifies the person signing #11.

Payment Instructions

When your payment agreement notification comes in the mail, the total amount will be due at that time. If you cannot pay the total amount right away, you can make payments according to the instructions you receive with your notification. Contact your local health department if you do not receive the payment instructions after submission of this form. Payments are non-refundable.

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is Voluntary, but required if CSHCS program services are desired.