

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
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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.

From: _____ To _____ \$ _____ per month X _____ months = \$ _____
From: _____ To _____ \$ _____ per month X _____ months = \$ _____
Total New Obligation = \$ _____
<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.