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
Wexford Co.	**Judy Johnson**

Regarding

Client Name	Client ID Number
Alice Lookinglass	**0000000011**
Period of Coverage	Adult Client or Legally Responsible Party
From: 12/1/2022 To: 11/30/2023	**Linda Lookinglass**

Original Agreement and Change

Original Agreement Amount: **$ 372**

The original agreement has been changed for the following reason(s):

☐ Change in family **size (new size 5)** effective date: **3/21/2023**

☐ Change in family **income (new income amount $ _____)**, effective date: ..... _____

☐ Death of Client, date: ..... _____

☐ Client has Medicaid or MIChild, effective date:..... _____

New Agreement and Approval: Please adjust the account accordingly.

From:	**12/1/2022**	**To:**	**3/31/2023**	**$ 31**	**Per month X**	**4**	**Months =**	**$ 124**
From:	**4/1/2023**	**To:**	**11/30/2023**	**$ 16**	**Per month X**	**8**	**Months =**	**$ 128**
							Total New Obligation =	**$ 252**

- 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

AUTHORITY: Act 368, P.A. 1978. **COMPLETION:** Is voluntary, but required if CSHCS services are desired.

Distribution: - Original - CSHCS
- Copy - Parent/Guardian
- Copy - LHD