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
Monroe Co.	**Mike Jones**

Regarding

Client Name	Client ID Number
Minnie Smith	**0000000033**
Period of Coverage	Adult Client or Legally Responsible Party
From: 12/1/2022 To: 11/30/2023	**Alice Smith**

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 _____)** effective date: ..... _____

☒ Change in family **income (new income amount $ 51,000)**, effective date: **2/11/2023**

☐ 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:**	**1/31/2023**	**$ 31**	**Per month X**	**2**	**Months =**	**$ 62**
From:	**2/1/2023**	**To:**	**11/30/2023**	**$ 10**	**Per month X**	**10**	**Months =**	**$ 100**
							Total New Obligation =	**$ 162**

- 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.