This is an image of an up and down arrow key.  **Only use arrow down/up keys to navigate. Do not use tab key.**

**MDHHS-6194, 2025 Infant Car Seat Distribution Program Self-Declaration of Low-Income and/or Public Benefits**

Michigan Department of Health and Human Services (MDHHS)

(Revised 5-25)

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| This form allows for beneficiaries of the Maternal Infant Health Program (MIHP) to self-declare their income eligibility and request an infant car seat(s). It must be completed in its entirety. See Instructions for eligibility information.  The completed and signed declaration should be sent by encrypted email or encrypted fax to the beneficiary’s Medicaid Health Plan to request a car seat(s). |

**section 1 – requester information**

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| MIHP Agency Name |

|  |  |  |
| --- | --- | --- |
| MIHP Coordinator’s Name | Email | Phone |

**SECTION 2 – APPLICANT INFORMATION**

|  |  |  |
| --- | --- | --- |
| We are requesting a car seat(s) from |  | for the following |
| beneficiary/caregiver: | (Health Plan Name) |  |

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| --- |
| Maternal  Infant(s) |

|  |  |  |
| --- | --- | --- |
| Maternal Beneficiary Name | Medicaid ID Number | Date of Birth |

|  |  |  |
| --- | --- | --- |
| Infant Beneficiary Name(s) | Medicaid ID Number(s) | Date of Birth(s) |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Legal Representative Name of Infant Beneficiary | Legal Representative Relationship to Infant Beneficiary |

|  |
| --- |
| Beneficiary/Legal Representative Address |

|  |  |  |  |
| --- | --- | --- | --- |
| City | County | State | Zip Code |

|  |
| --- |
| Select the following option(s) that best describes your eligibility.  Current (within past 12 months) recipient of: |

|  |
| --- |
| Food Assistance Program (Supplemental Nutrition Assistance Program) |
| Family Independence Program (Cash assistance) |
| State Emergency Relief |
| Weatherization |
| Community Services Block Grant Assistance |
| Low- Income Household Assistance Program |
| Supplemental Security Income |

|  |
| --- |
| **OR** |

|  |  |
| --- | --- |
| Gross Monthly Income | Number of Household Members |

|  |
| --- |
| The family attests that the following number of car seats are needed. |

|  |  |
| --- | --- |
| Number of standard car seats | Number of car seats appropriate for special needs\* |

|  |
| --- |
| Brief description of special needs\* |

**section 3 – certification and form submission information**

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| I declare under penalties of perjury that the foregoing representations of the income for my household are true, correct, accurate, and complete in all respects.  I understand that providing false, incomplete, or inaccurate information on application forms may result in termination of participation in the Maternal Infant Health Program and possible criminal liability. |

|  |  |
| --- | --- |
| Signature of Beneficiary or Legal Representative (electronic signature accepted)  → | Date |

**Income must be at or below the following to qualify for Temporary Assistance for Needy Families (TANF) funding.**

|  |  |
| --- | --- |
| **Household/Family Size** | **200%** |
| **1** | **$31,300.00** |
| **2** | **$42,300.00** |
| **3** | **$53,300.00** |
| **4** | **$64,300.00** |
| **5** | **$75,300.00** |
| **6** | **$86,300.00** |
| **7** | **$97,300.00** |
| **8** | **$108,300.00** |
| **9** | **$119,300.00** |
| **10** | **$130,300.00** |
| **11** | **$141,300.00** |
| **12** | **$152,300.00** |
| **13** | **$163,300.00** |
| **14** | **$174,300.00** |

**Temporary Assistance for Needy Families**

Households with children aged 17 years or younger and at or below 200% Federal Poverty Limit (FPL).

**State General Funds**

Households with recipients 18 years and older and/or greater than, or equal to, 200% FPL.

|  |  |  |  |
| --- | --- | --- | --- |
| Car seat(s) to be delivered to | Beneficiary | Health Plan | MIHP Provider |

|  |
| --- |
| Deliver to: |

|  |
| --- |
| Name of Beneficiary, Legal Representative, Health Plan or MIHP Provider |

|  |  |  |  |
| --- | --- | --- | --- |
| Address | City | State | Zip Code |

|  |
| --- |
| Date this form sent to Health Plan |

|  |  |
| --- | --- |
| MIHP Coordinator Signature  → | Date |

**section 4 – agency use only**

|  |
| --- |
| Date MIHP agency confirmed the beneficiary received the car seat(s) |

**(Do not type beyond this point)**

|  |
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| The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group on the basis of race, national origin, color, sex, disability, religion, age, height, weight, familial status, partisan considerations, or genetic information. Sex-based discrimination includes, but is not limited to, discrimination based on sexual orientation, gender identity, gender expression, sex characteristics, and pregnancy. |

**INSTRUCTIONS**

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**Only one form is needed for all eligible infants under 18 months of age.**

TANF-eligible families may be eligible for more than one car seat in these circumstances:

* Multiples (twins, triplets, etc.)
* Infants under 18 months of age that were previously enrolled in the MIHP are also eligible to receive a car seat if there is a currently enrolled beneficiary (younger infant or pregnant person) in the family.
* To accommodate the pending arrival of the newborn as well as any currently enrolled infant in a family.

Infants in these situations may receive a car seat:

* An enrolled infant who is nearing 18 months of age so will be discharged soon from the program is eligible for a car seat if the form was submitted on a date before the infant turns 18 months old.
* An enrolled infant 18 months or older who remains enrolled in the program due to an approved exception is eligible for a car seat.

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**Section 1 – Requester Information**

Insert the MIHP Agency name and the MIHP Coordinator’s Name, Email and Phone Number.

**Section 2 – Applicant Information**

Insert the name of the beneficiary’s Medicaid Health Plan in the space provided. Check the appropriate box for whom you are requesting a car seat(s) for.

Insert the name, Medicaid ID Number and date of birth of the maternal beneficiary, if applicable.

If the beneficiary is an infant, add their name(s), Medicaid ID(s) and date(s) of birth.

If applicable, add the name of the legal representative of the infant. Insert the legal representative’s relationship to the infant beneficiary by inserting “mother,” “father,” “foster parent,” “guardian” or other relative (and specify).

Add the beneficiary’s or legal representative’s address including city, state and zip code.

Beneficiary or legal representative must fill out the “Select the following option(s) that best describes your eligibility” section by checking which they have been a recipient of in the past 12 months **OR** their Gross Monthly Income and Number of Household Members. See the additional information about income requirements on the second page.

Enter the number of standard car seats that is being requested. One seat is allowed per infant, but two or more seats can be requested if the beneficiaries are twins or triplets, or if the family has more than one eligible infant younger than 18 months. Insert the names, Medicaid ID numbers and dates of birth of current or previously enrolled beneficiaries in need of car seats. If the infant(s) has any special needs that need to be noted, enter that information.

\*If an infant(s) requires a car seat(s) appropriate for a special need, submit medical documentation from a provider such as a physician, occupational or physical therapist, or certified car seat technician with the Car Seat Eligibility Form to the Health Plan.

**Section 3 – Certification and Form Submission Information**

Complete by having the beneficiary or legal representative sign and date this attestation.

Insert the date this form was sent to the Health Plan. Check the box where the car seat will be delivered to (Beneficiary, Health Plan or MIHP Provider). Insert the address where the car seat(s) should be delivered to.

Insert coordinator signature and date. This could be the same date the form was sent to the Health Plan.

**Section 4 – Agency Use Only**

Insert the date the MIHP agency confirmed the beneficiary received the car seat(s).

Return this form via encrypted fax or encrypted email to the Michigan Department of Health and Human Services Maternal Infant Health Program after the agency has received confirmation that the family has received the car seat(s).

Fax: (517) 763-0366

Email: [MDHHS-MIHP-CAR-SEAT-PROGRAM@michigan.gov](mailto:MDHHS-MIHP-CAR-SEAT-PROGRAM@michigan.gov)

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**End of form**