



Fee Determination Form  
Instructions  
**Utah Department of Health**  
 Baby Watch Early Intervention Program

**Header Information**

● **Insert** your own logo or other means of identifying your program in the space provided. The Baby Watch/ Department of Health logo must remain on the document.



Logo Here

**Family Fee Determination Form**  
 Utah Department of Health Baby Watch Early Intervention Program

**Family Information:**

**Please type or print legibly.** The billing office needs accurate, easy to read data to properly process family billing information. Please make sure all information is complete, accurate and easy to read.

- **Complete the family information field.**
- **Child's Name field:** If more than one family member is receiving E.I., enter the name of the oldest child. Upon the exit of this child, the family's fee determination form must be updated if there is another child in the family receiving E.I. services.
  - **Gender field:** Check the box which shows the child's gender, male or female.
  - **Address field:** Refers to the primary residence of the household.
  - **Parent/Guardian field:** Enter the name of the person who is providing family information and signing the form.
  - **Phone fields:** Enter the telephone numbers for the parent/guardian.
  - **Additional children enrolled in Early Intervention field:** Enter the name(s) and birth date(s) of other children in the family who are receiving E.I. services.

Child's Name:
Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address:
City & Zip
Parent/Guardian:
Home Phone:
Daytime Phone:
If more than one child is enrolled in EI, please list names and date of birth each child:




**Decline Participation**

● **Declining participation in the fee process:** Families may elect to forego the fee determination process if they feel that they will not be eligible for reduced fees. If they choose to forego this process, they will be charged the maximum level of the fee schedule. For the current fiscal year this amount is \$100.

<b>Decline Participation</b>
<input type="checkbox"/> Parent declines to participate in the Family Fee Determination process, and will be billed for the full amount of \$100 per month.

**Income Verification**

<p>● Check the box indicating which documents were used to verify income.</p>	<p>Income verified by:</p> <p><input type="checkbox"/> Most recent tax return</p> <p><input type="checkbox"/> Last 3 consecutive pay stubs</p> <p><input type="checkbox"/> Other/program ID _____</p>	
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**Extenuating Circumstances**

<p>● <b>Extenuating Circumstances</b> are almost always already covered by the financial information worksheet in the allowable deductions and expenses fields. If a family's income changes substantially they should be advised to submit a new fee determination form. If extenuating circumstances exist, the situation should be explained to the program coordinator, whose signature is required.</p>	<p>Extenuating circumstances are unexpected events that affect your family's financial situation and should be taken into consideration when determining the family's monthly fee:</p>    <p>_____</p> <p>Program Coordinator Signature _____ Date _____</p>
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**EI Staff Verification**

<p>● <b>Staff verification:</b> The EI staff member who assists the family in filling out the form must explain the families rights and responsibilities related to cost participation (family fees) and certify that information provided by the family was used by signing and dating in this block.</p>	<p>I verify that I have informed the parent(s) regarding their rights and responsibilities related to cost participation through family fees, and that I have utilized all the information provided to me by the family in calculating their fee:</p>   <p>_____</p> <p>Staff member signature _____ Date _____</p>
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**Financial Information**

<p>● <b>Medicaid/ CHIP Number:</b> Optional field. Enter the child's Medicaid and/or CHIP enrollment number. Inform the family that if the child is found to be Medicaid eligible that BWEI will bill Medicaid for services.</p>	<p align="center"><b>Medicaid/CHIP Number</b></p> <p align="center">(Child Medicaid/CHIP # _____ )</p> <p align="center">Optional</p>
<p>● No fee will be charged if a family or child is eligible, and has documentation for any of the</p>	<p align="center"><b>Automatic Eligibility for Zero Financial Responsibility.</b></p>

<p>following programs:</p> <ul style="list-style-type: none"> <li>• Medicaid</li> <li>• Children’s Health Insurance Program (CHIP) Temporary Assistance to Needy Families (TANF); Family Employment Plan-Cash Assistance (FEP)</li> <li>• Women Infants and Young Children (WIC)</li> <li>• Child/family participates in PCN</li> <li>• Child is a ward of the State</li> <li>• Family meets Early Head Start income eligibility guidelines</li> <li>• Families of children receiving <b>only</b> USDB services based on IFSP team decision will not be charged a fee.</li> <li>• The family then marks the service received and signs at the bottom. The form is complete.</li> </ul>	<p>Mark all services currently received by family. (If the family receives any of these services, stop here, mark the service, and sign below.)</p> <p><input type="checkbox"/> FEP/TANF <input type="checkbox"/> WIC <input type="checkbox"/> PCN <input type="checkbox"/> Early Head Start <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP</p>
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**Annual Income for Family**

<p><b>1. - 5. Identification of Gross Income:</b> Income information/documentation needs to be reviewed and verified by the EI staff member, and should be referenced by the family when determining gross income.</p> <ul style="list-style-type: none"> <li>• Recently filed Internal Revenue Service tax forms</li> <li>• Last 3 months check stubs may be averaged and multiplied by 12</li> </ul>	<p><b>Annual Family Income</b></p>									
	<table border="1"> <tr> <td>1. Gross Monthly Salary (1<sup>st</sup> wage earner) (gross before taxes, social security, insurance, union dues)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>2. Gross Monthly Salary (2<sup>nd</sup> wage earner) (gross before taxes, social security, insurance, union dues)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>3. Other Monthly Income (pensions, rentals, interest, dividends, alimony, child support)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td>4. Total Monthly Income (Add 1 + 2 + 3)</td> <td style="text-align: right;">\$ _____</td> </tr> <tr> <td><b>5. Annual Income (Line 4 x 12)</b></td> <td style="text-align: right;"><b>\$ _____</b></td> </tr> </table>	1. Gross Monthly Salary (1 <sup>st</sup> wage earner) (gross before taxes, social security, insurance, union dues)	\$ _____	2. Gross Monthly Salary (2 <sup>nd</sup> wage earner) (gross before taxes, social security, insurance, union dues)	\$ _____	3. Other Monthly Income (pensions, rentals, interest, dividends, alimony, child support)	\$ _____	4. Total Monthly Income (Add 1 + 2 + 3)	\$ _____	<b>5. Annual Income (Line 4 x 12)</b>
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4. Total Monthly Income (Add 1 + 2 + 3)	\$ _____									
<b>5. Annual Income (Line 4 x 12)</b>	<b>\$ _____</b>									

- Countable Income Sources:** All income sources listed below must be included on Lines 2, 3, and 4.
- Wages or Salary: total money earnings received for work performed before deductions are made for taxes, bonds, pensions, union dues, etc. Includes, but is not limited to, wages, salary, commissions, tips, piece rate payments, cash bonuses, etc.
  - Non-farm self-employment income: the gross receipt minus expenses from a business, professional enterprise or partnership. Utilization of the last year’s IRS form is most appropriate for these income earnings.
  - Farm self-employment: the gross receipts minus operating expenses from the operation of a farm by a person on his or her own account, as an owner, renter or sharecropper. Utilization of the last year’s IRS form is most appropriate for these income earnings.
  - Social Security: includes Social Security pensions and survivor’s benefits, and permanent disability insurance payments made by the Social Security Administration prior to deductions for medical insurance, and railroad retirement insurance checks from the U.S. Government.

- e. Workers' Compensation: compensation received periodically from private or public insurance companies for injuries incurred at work. The cost of this insurance must have been paid by the employer and not by the employee.
- f. Pensions and Annuities: includes pensions or retirement benefits paid to a retired person or his survivors by a former employer or by a union, either directly or through an insurance company; periodic receipts from annuities or insurance.
- g. Unemployment Compensation: compensation received from government unemployment insurance agencies or private companies during the period of unemployment and any strike benefits received from union funds.
- h. Alimony: allowance paid to one spouse by the other for support pending or after legal separation.
- i. Child Support: money paid by an absent parent for the benefits of his/her child
- j. Veteran's Pensions: monies paid by the Veteran's Administration to disabled members of the Armed Forces or to survivors of deceased veterans.
- k. Miscellaneous: includes interest on saving and checking accounts; income room rental or a house, double or apartment, store, or other property minus the cost of doing business; royalties; dividends from stock holdings or membership in associations; receipts from boarders or lodgers; other government benefits, etc.

**● Non-Countable Income Sources:**

- a. Payments or allowances received pursuant to the Home Energy Assistance Act of 1980.
- b. The value of assistance to children or their families under the National School Lunch Act of 1966 and Food Stamp Act of 1977.
- c. Reimbursements from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
- d. Any payment to volunteers under Title I (VISTA and others), Title II (RSVP-foster grandparents, and others) of the Domestic Volunteer Service Act of 1973.
- e. Payments received under the Job Training Partnership Act.
- f. Payment to volunteers under Section 8 of the Small Business Act.
- g. Education grants, student loans, stipends and scholarships for education and training.
- h. Earnings or stipends received from participation in any type of work study program.
- i. Earnings of a dependent child under the age of twenty-two (22) years of age.
- j. Veteran's educational benefits.
- k. College or university assistantships.
- l. Subsidized housing.
- m. Food allowance or subsidized housing for military housing allowances received by families living off a military base.

- n. If the child or family is temporarily living within another household, only the income of the child or family participating in Early Intervention services shall be used for determining financial eligibility.

**Calculating Total Annual Income:** If income information other than annual is provided, convert the income for each family member to a yearly amount as shown in the examples below and use the results to complete Line 5:

<b>Weekly (\$1244)</b> \$1244/Week $\times 52$ \$64,688 Annually	<b>Every Other Week (\$1580)</b> \$1580/ 2 Week Period $\times 26$ \$41,080 Annually	<b>Semi-Monthly (Twice per Month) (\$1333)</b> \$1333 $\times 24$ \$32,000 Annually	<b>Monthly (\$3100)</b> \$3100/Month $\times 12$ \$37,200 Annually
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### Allowable Monthly Deductions for Family & Modified Family Income

**6-8. Allowable deductions** for determining modified annual income are

- Medical/Dental expenses
- Child Day care costs
- Child support or alimony payments

The expenses should reflect nonreimbursed costs accumulated over the last twelve (12) month period. Medical/dental expenses are determined from the worksheet on the back of the form. Child support *payments* (Line 8) made for the benefit of children not living in the household are not to be confused with child support *income*, which should be reported on Line 3. The family may refer to recent IRS tax forms or canceled checks, receipts, etc. Complete each line by converting monthly expenses to an annual amount by multiplying by 12.

Allowable Deductions from Income	
6. Medical/Dental expenses >5% of income (Worksheet on reverse side)	-- _____
7. Child Care Costs \$ _____/month X 12 months =	-- _____
8. Child Support or Alimony payments \$ _____/month x 12 months =	-- _____

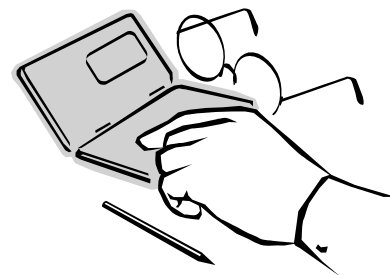


### Modified Family Income

**9. Annual Income for determining fee** is calculated by finding the family's total annual income (Line 5) and subtracting allowable deductions (Lines 6, 7 and 8) from this number. Enter the total on Line 9.

Example: Modified Annual Income	
Line 5 (annual income) = \$50,000.00:	\$50,000.00
Line 6 (total allowable medical expenses)	-\$500.00
Line 7 (total allowable deductions for daycare)	<u>-\$3800.00</u>
Line 9 (modified annual income)	\$45,700.00

**9. Modified Family Income** Line 5 minus Lines 6, 7, and 8 \$ \_\_\_\_\_



### Family Size

**10 – 12. Determining Family Size:** Family is defined as a group of two or more persons living together as one financial group and includes the number of children and the number of adults living in a household (including parent(s), spouse, and other dependents living in the household).

Family Size	
10. Number of Adults in family	_____
11. Number of children in family	_____
12. Total family size (add 10 + 11)	_____

**Monthly Sliding Fee**

**13. Determine the Sliding fee** by taking the number of family members and modified annual income and locating the fee amount on the sliding scale. Inform the family and write the amount on Line 13.

Monthly Family Sliding Fee	
<b>13. Using line 9 (income) and line 12 (family size), find fee on Sliding Fee Schedule</b>	\$ _____ <b>Per month</b>

**Signatures**

**Signature** and date of the parent or guardian providing the financial information, denoting payment arrangements and receipt of parent rights and responsibilities, is needed. Ensure that the parent reads the paragraph in the signature field.

I understand that my financial responsibility is calculated based on the information I have provided. I also understand that non-payment of fees may result in the discontinuation of services and that a minimum penalty fee of \$20 will be charged for returned checks. I certify to the best of my knowledge the information provided above is true and correct. I have received a copy of my parent rights and responsibilities related to cost participation through family fees and understand that I may ask for a review of my family fee if my financial situation changes.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Form Review Dates**

**Periodic review** of the Family Fee Determination Form is required. Programs must review the form with the family at regular intervals, and at each annual IFSP. More frequent reviews may be needed as family circumstances change, i.e. family request, gain/loss of income, addition of a family member, moving, etc. A circumstance which results in a change to the monthly fee, or if the family moves requires a new form. Initial and date this field at each review on the original form which is kept in the child's file.

Form review dates: \_\_\_\_\_  
 Staff    EI staff    Date    EI Staff    Date    EI Staff    Date    EI Staff    Date    EI

**Note: Change in circumstances requires a new form.**



## Back of Form

### Medical Deductions Worksheet

● **Qualifying** medical and dental expenses must be directly related to the health or medical condition of a family member. Expenses must be out of pocket for the previous 12 months and for which the family will not be reimbursed.


**19 – 30. How to complete the Medical/ Dental Deductions Worksheet:** Using information from all sources such as medical statements, pay stubs (for insurance premiums), most recent tax return, cancelled checks, or other documentation, complete Lines 19 through 30 of the worksheet. If the family believes this amount will not be significant, i.e. over 5% of annual income, (for a family grossing \$50,000/year the amount would need to be more than \$2,500/year) this field may be skipped.



#### **Medical/Dental Deductions Worksheet**

- |  |                 |
|--|-----------------|
| 14. Health Insurance Premiums<br>\$ _____ per month x 12 months =                          | \$ _____        |
| 15. Insurance Co-payments<br>\$ _____ per month x 12 months =                              | \$ _____        |
| 16. Dental and Vision Expenses<br>\$ _____ per month x 12 months =                         | \$ _____        |
| 17. Hospital Expenses<br>\$ _____ per month x 12 months =                                  | \$ _____        |
| 18. Prescriptions<br>\$ _____ per month x 12 months =                                      | \$ _____        |
| 19. Nutritional supplements ordered by physician<br>\$ _____ per month x 12 months =       | \$ _____        |
| 20. Medical equipment, Assistive Technology, or Adaptations expenses for the year          | \$ _____        |
| 21. Specialized clothing required by medical condition<br>\$ _____ per month x 12 months = | \$ _____        |
| 22. Specialized respite care or child care above typical costs not listed on front, line 7 | \$ _____        |
| 23. Medical transportation cost<br>\$ _____ per month x 12 months =                        | \$ _____        |
| 24. Other related medical costs (specify):<br>\$ _____ per month x 12 months =             | \$ _____        |
| <b>25. Total Medical Deductions (Add lines 13 – 24)</b>                                    | <b>\$ _____</b> |



<p><b>Conversion of Expenses to an annual amount:</b></p> <p>a. <b>Weekly</b> expenses are multiplied by 52 to arrive at the total annual amount.</p> <p>b. <b>Biweekly</b> expenses should be multiplied by 26.</p> <p>c. <b>Semi-monthly</b> amounts should be multiplied by 24.</p> <p>d. <b>Monthly</b> amounts should be multiplied by 12.</p> 	<p><b>Example:</b> Jose's family health insurance premium is \$47.50 deducted biweekly from each paycheck:</p> $\begin{array}{r} \$47.50 \\ \times 26 \\ \hline \$1235.00 \end{array}$ <p>per year.</p> <p>Enter \$1,235.00 on Line 13.</p>	<p style="text-align: center;"><b><u>What can be included:</u></b></p> <ul style="list-style-type: none"> <li>• Capital expenses for equipment or improvements to your home needed for medical care</li> <li>• Cost and care of guide animals aiding the blind, deaf, and disabled</li> <li>• Cost of lead based paint removal</li> <li>• Expenses of an organ donor</li> <li>• Hospital services fees (lab work, therapy, etc.)</li> <li>• Birth control pills, legal abortion, legal operations to prevent having children</li> <li>• Life-care fee paid to retirement home designated for medical care</li> <li>• Meals and lodging provided by a hospital during medical treatment</li> <li>• Medical and hospital insurance premiums</li> <li>• Medical services fees (from doctors, dentists, surgeons, specialists and other medical practitioners)</li> <li>• Oxygen equipment and oxygen</li> <li>• Prescriptions, medicines, and insulin</li> <li>• Psychiatric care at a specialty equipped medical center (includes meals and lodging)</li> <li>• Social security tax, Medicare tax, FUTA and state employment tax for worker providing medical care</li> <li>• Special items (hearing aids, wheelchairs, etc.)</li> <li>• Special school or home for mentally or physically disabled person</li> <li>• Travel and related expenses</li> <li>• Treatment at a drug or alcohol center</li> <li>• Wages for nursing services</li> <li>• Diaper costs related to medical problem</li> </ul>
<p>● <b>Allowable Medical/Dental Deductions</b> listed on the form as “<u>What can/cannot be included</u>” are taken from Internal Revenue Service Publication 502, Medical and Dental Expenses. Expenses include amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, and for treatments affecting any part or function of the body for any member of the family considered a member of the household. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness.</p>	<p style="text-align: center;"><b><u>What cannot be included</u></b></p> <ul style="list-style-type: none"> <li>• Diaper services</li> <li>• Health club dues</li> <li>• Household help</li> <li>• Stop smoking program</li> <li>• Weight loss program</li> <li>• Life insurance or income protection policies</li> <li>• Maternity clothes</li> <li>• Medicine bought without a prescription</li> <li>• Nursing care for a healthy baby</li> <li>• Surgery for purely cosmetic reasons</li> </ul>	

## Calculating Medical Deductions

**A . Calculating Medical Deductions:** Take the total annual income from Line 5 and multiply this number by .05 to determine what 5% of that amount is. Don't forget the two decimal places! If the amount is greater than Line 25, medical expenses are not significant enough to deduct. If the amount on Line A is less than Line 25, medical deductions are allowed.

### Calculate Allowed Medical/Dental Deduction

A. Multiply front line 5 (annual income) -- \_\_\_\_\_  
x .05 = \_\_\_\_\_

If Line A is GREATER than Line 25:

- You may not deduct medical/dental expenses from income as they are less than 5% of your income. Write "0" on Line 6 on front page.

If Line A is LESS THAN Line 25:

Line 25– Line A = \$ \_\_\_\_\_  
Write this amount on Line 6 on front page.

## Procedural Safeguards and Parent Rights:

- A copy of the **Procedural Safeguards and Parent Rights** handout should be given to the parent at the time the fee determination form is completed. Review with the family their rights and procedural safeguards as to services under the IFSP and their family fee. Assure the family that services will not be denied because of an inability to pay. Inform the family that if they experience a significant change of income or extenuating circumstances they should request a reevaluation, at anytime.



### Utah Department of Health Baby Watch Early Intervention Program

#### Procedural Safeguards and Parent Rights

Fees will not be charged for services that a child is otherwise entitled to receive at no cost: child find, evaluation and assessment, service coordination, development and review of IFSP, provisions of procedural safeguards, and services provided by the Utah Schools for the Deaf and Blind. Parent rights guarantee that:

1. Services will not be denied because of an inability to pay.
2. Early intervention programs will provide consideration of extenuating circumstances that affect a family's financial situation.
3. Families will receive an annual review of their family fee.
4. Families have the right to appeal the amount of their family fee through their program's complaint and conflict resolution procedure.
5. Families are entitled to receive uninterrupted services during the appeal process.

- **Explain When Fees are due.** The collection of fees will begin the first month that a child is receiving services and will be evaluated at the annual IFSP review for appropriateness. Statements will be sent monthly from the Department of Health with a return envelope. Payments are due the 15<sup>th</sup> day of each month. Families determined by the schedule to pay a fee must do so unless extenuating circumstances are identified. Collection of fees will be done in strict accordance with the Fee Collection and Accounting Procedures for Family Fees developed by the Department of Health
- **Consequences of Non-Payment:** Once the contractor has implemented a valid means for determining that a family has the ability to pay the amount required by the Baby Watch Sliding Fee Schedule, nothing in Part C prohibits withholding fee eligible Early Intervention service(s) should the family choose not to make the payment. The contractor should contact the family to determine the reasons for non-payment of fees (e.g., extenuating circumstances). If a family's situation has changed, a new Family Fee Determination Form must be completed. The family must also be made aware of the appeals process.