Reset Form

INDIANA FIRST STEPS COST PARTICIPATION AND COPAYMENT DETERMINATION

State Form 51361 (R4 / 2-21)
FAMILY AND SOCIAL SERVICES ADMINISTRATION

first steps

COST PARTICIPATION

Child Information

Name of child	Identification number of child	Date of birth *(month, day, year)*

Is the child in foster care or relative placement through DCS?
☐ Foster Care ☐ Relative Placement ☐ N/A

Is the child cared for by a relative or guardian outside of DCS?
☐ Relative Care ☐ Guardianship ☐ N/A

Presumptive Income Verification for Families at or below 250% Federal Poverty Level

*If the family has one or more of the following services, skip to the **Cost Participation Copayment Determination** section.*
*If the family does NOT have one or more of the above services, complete the remainder of the **Cost Participation** section.*

Does the family currently access any of the following services? *(Select all that appply.)*
☐ SNAP ☐ TANF ☐ CCDF Vouchers ☐ WIC ☐ N/A

Actual Income Verification for Families above 250% Federal Poverty Level

*If the family does **not** access SNAP, TANF, CCDF, or WIC as listed above, complete the remainder of the Cost Participation Worksheet.*

Household and Insurance

List members of the family living in the home (including child) and provide the requested information. Insurance information must be collected for the child. Only collect insurance information for family members if the family does not access the above service(s).

Name of Family Member	Relationship to Child	Type of Insurance *(Select all that apply.)*	Type of Public Insurance *(Select all that apply.)*
	Self	☐ Private ☐ Public ☐ None	☐ Medicaid ☐ Medicaid Waiver ☐ Other ☐ Unknown
		☐ Private ☐ Public ☐ None	☐ Medicaid ☐ Medicaid Waiver ☐ Other ☐ Unknown
		☐ Private ☐ Public ☐ None	☐ Medicaid ☐ Medicaid Waiver ☐ Other ☐ Unknown
		☐ Private ☐ Public ☐ None	☐ Medicaid ☐ Medicaid Waiver ☐ Other ☐ Unknown
		☐ Private ☐ Public ☐ None	☐ Medicaid ☐ Medicaid Waiver ☐ Other ☐ Unknown
		☐ Private ☐ Public ☐ None	☐ Medicaid ☐ Medicaid Waiver ☐ Other ☐ Unknown

Income

All members of the family (except the child) must provide three (3) recent consecutive paystubs, most recent tax document (W-2, 1040), and a signed statement from the employer or a signed statement from the family. If collecting a signed statement, it must include income amount, frequency of income amount, and reason paystubs or tax documents are not collected. Income should only be collected for families that do not meet requirements of presumptive income verification.

Name of family member	Name of employer

Pay period 1 end date *(month, day, year)*	Gross income	Pay period 2 end date *(month, day, year)*	Gross income	Pay period 3 end date *(month, day, year)*	Gross income

Pay interval ☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____

Total gross income

Explain any variation in documentation

	Amount of deduction	Deduction interval	
Health insurance			☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____
Dental insurance			☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____
Vision insurance			☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____

Notes

Income *(continued)*					
Name of family member		Name of employer			
Pay period 1 end date *(month, day, year)*	Gross income	Pay period 2 end date *(month, day, year)*	Gross income	Pay period 3 end date *(month, day, year)*	Gross income
Pay interval ☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____			Total gross income		
Explain any variation in documentation					

Health insurance	Amount of deduction	Deduction interval	☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____
Dental insurance	Amount of deduction	Deduction interval	☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____
Vision insurance	Amount of deduction	Deduction interval	☐ Weekly (x52) ☐ Biweekly (x26) ☐ Twice monthly (x24) ☐ Monthly (x12) ☐ Other: _____
Notes			

Other Medical and Personal Care Needs Expense Deductions	
Expense *(medical bills, supplies, etc.)*	**Amount *(Receipts are required.)***

COPAYMENT DETERMINATION

Determination of Adjusted Income and Copay		
Total gross income	☐ Presumptive income verification ($0)	☐ Declined to provide information (n/a)
Total deductions *(from insurance and other medical and personal care needs expenses)*	☐ Presumptive income verification ($0)	☐ Declined to provide information (n/a)
Adjusted income *(gross income minus deductions)*	☐ Presumptive income verification ($0)	☐ Declined to provide information (n/a)
Copayment per fifteen (15) minutes of service	☐ Presumptive income verification ($0)	☐ Declined to provide information (n/a)
Monthly family maximum	☐ Presumptive income verification ($0)	☐ Declined to provide information (full fee)
Percent of poverty	☐ Presumptive income verification (at or below 250%)	☐ Declined to provide information (full fee)

Parent Acknowledgement and Agreement

Check one.

☐ **Presumptive Income:** I have supplied accurate information to First Steps about my family's use of SNAP, TANF, CCDF, and/or WIC benefits, as indicated under the "Presumptive Income Verification" section on page one (1) of this form. I understand that First Steps is using my family's participation in these services as verification that my family's income is at or below 250% of the federal poverty level. I also understand that if the information provided is not correct, I may be assessed cost participation fees for services provided.

☐ **Actual Income:** I have supplied accurate income and deduction information to First Steps for the calculation of my family's cost participation copay and agree to pay the copay amount listed above. I understand I am responsible to meet my financial obligations to First Steps.

☐ **Full Fee Option:** I am declining to provide income information to First Steps. I understand that by withholding this information, I will be charged the maximum copay for services. I understand the maximum copay for services is $30 per fifteen (15) minutes of service up to $960 monthly. I understand I am responsible to meet my financial obligations to First Steps. **I understand that if I decide to provide income information at a later date, First Steps will not retroactively adjust my billing statements**.

☐ **My service coordinator has explained my cost participation rights and responsibilities under Part C of the Individuals with Disabilities Education Act (IDEA).** I understand if I believe my rights have been violated, I should e-mail FirstStepsWeb@fssa.in.gov, call 800-545-7763, or send my complaint via mail to 402 West Washington Street, room W453, Indianapolis, Indiana 46204.

☐ By signing, I consent to the above selection and copayment calculation.

Signature of parent / guardian	Date *(month, day, year)*