GILES COUNTY CPMT CSA SERVICES

PARENTAL CONTRIBUTION REFERRAL NOTICE

CASE MANAGER COMPLETES THE FOLLOWING INFORMATION:
(Please Print)

Name of Child:_____ SS#_____

Name of Parent: _____ SS#_____

Address: _____ City: _____ Zip Code_____

Telephone Number: ( ) _____-_____ Home/Cell
( ) _____-_____ Work

If parents are contributing to the cost of CSA for sibling(s) of above child, please give names(s):

Case Manager:_____ Eligibility Category: _____

Agency:_____ Telephone:_____

I (We) verify that_____, Case Manager for our child(ren) _____, has explained to me (us) the expectations of my (our) active involvement in the treatment aspect of services and my (our) financial responsibility for services. I (We) understand that I (We) may be assessed a fee, based on my (our) gross annual income, that will be my (our) contribution to the cost of services for my (our) child(ren).

Parent Signature:_____ Date:_____

Parent Signature:_____ Date:_____

GILES COUNTY CPMT CSA SERVICES

PARENTAL CONTRIBUTIONS FINANCIAL WORKSHEET

(Please Print)
Name of Child:_____
Medicaid Number (if eligible):_____
Parent Name:_____
Address:_____City:_____State:_____ Zip Code:_____
Employer Name and Address:_____
Private Insurance Carrier:_____
Name of Insured:_____Policy#:_____Group#:_____

Parent Name:_____
Address:_____City:_____State:_____Zip Code:_____
Employer Name and Address:_____
Private Insurance Carrier:_____
Name of Insured:_____Policy#:_____Group#:_____

Please complete the following with information from the three most recent pay stubs and attach supporting documents. If self-employed, please complete using information from your most recent quarterly tax report and attach a copy:

GROSS INCOME:	MOTHER	FATHER	MONTHLY
1. Salary, tips, bonuses, professional fees	_____ +	_____ =	_____
2. Net income from rental property	_____ +	_____ =	_____
3. Social Security, pensions, annuities, Trust funds	_____ +	_____ =	_____
4. Alimony	_____ +	_____ =	_____
5. Child Support	_____ +	_____ =	_____
6. Other Income	_____ +	_____ =	_____
SUBTOTAL =			_____
TOTAL			_____

Monthly Contribution will be: _____
I (we) certify that the above information is a true and accurate statement of the financial status and composition of my household.
I (we) understand the payments must be made in cash or money orders. No personal checks will be accepted.

Parent Signature:_____ Date:_____

Parent Signature: _____Date: _____

GILES COUNTY CPMT CSA SERVICES

PARENTAL REQUEST FOR ADDITIONAL SUSIDY/WAIVER

(Please Print)

To be completed by case manager:

Name of Child:_____ DOB:_____

Name of Parents:_____

_____

Day Phone:_____ Work Phone:_____

Case Manager:_____ Eligibility Category:_____

Agency:_____ Telephone Number:_____

To be completed by the parent:
Please provide a statement outlining the circumstances of your family's hardship, which prevents you from paying the monthly parental contribution as determined by the CSA Fee Scale. You may attach copies of any documentation, which supports your request for additional subsidy/waiver.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Attach additional sheets if necessary)

Signature:_____ Date:_____

Co-Pay Chart

Gross Monthly Income	Home Based Services	Out of Home Services
$0 - $1,000	$0	$0
$1,001 - $2,000	$20	$25
$2,001 - $3,000	$30	$50
$3,001 - $4,000	$40	$75
$4,001 - $5,000	$50	$100
$5,001 - $6,000	$60	$125
$6,001 - $7,000	$70	$150
$7,001 - $8,000	$80	$175
$8,001 - $9,000	$90	$200
$9,001 - $10,000	$100	$225

Parental Co-Pay Agreement for Non-Residential Services
Children's Services Act

Child Name:_____ Case Number:_____

This Agreement made and entered into this_____ day of _____, 20___ between Giles County Department of Social Services and (1)_____ Social Security number_____, and (2)_____Social Security number_____, as legally responsible parents or guardians of the above referenced child.

I (we), _____ and _____ hereby acknowledge that I/we owe _____ per month for co-payment of the costs of services listed in the service plan presented at the FAPT meeting held on _____ for the above referenced child for the expected term of the service plan. I understand this amount is assessed based on policies of the Giles County CPMT as required by the Virginia Office of Children's Services. The monthly co-payment amount is based on implementation of the service plan referenced above and should the service plan be interrupted, changed, or terminated prior to the dates shown in the plan, the obligation stated on this document shall be adjusted or prorated based on the length of time of the service plan and services provided under the plan.
I/we agree to make payments of _____ per month beginning_____ with the total paid equal to our obligation of derived from our co-pay for the above referenced service plan. Each payment must be made by the _____ day of each month.

I understand that in the event I fail to fulfill the above agreement that the Department of Social Services may bring action necessary to collect the full amount which remains unpaid. I also acknowledge that I have received a copy of this agreement and it has been explained to me. Payments are to be made to:_____

Signature:_____ Date:_____

Address:_____

State of Virginia, County of Giles, to wit:
I, _____, a notary public in and for the County and State aforesaid, do hereby certify that _____
whose name is signed to the foregoing statement, has acknowledged the same before me in my County and State aforesaid.
Given under my hand this _____day of_____. 20___.
My Commission expires_____. Signature:_____