ATTACHMENT A FORM

Family Support Service Application

Enrollee Name: _____

Enrollee Date of Birth: _____ Enrollee Social Security Number: _____

Name of Parent(s)/Guardian: _____

Home Phone Number: _____ Email Address _____

Street Address: _____

City:_____ State:_____ Zip:_____

THE PERCENTAGE OF EACH REIMBURSABLE FAMILY SUPPORT SERVICE THAT THE FAMILY SHALL PAY WILL BE DETERMINED ACCORDING TO YOUR _____ INDIVIDUAL FEDERAL INCOME TAX RETURNS:

TAXABLE INCOME	PERCENTAGE OF FAMILY CONTRIBUTION
$27, 258 or Less	0%
$27, 259 to $37,759	10%
$37,760 to $48,260	30%
$48, 261 to $62,261	50%
$62,262 to $79,762	75%
$79,763 and Over	100%

THE ABOVE CIRCLED TAXABLE INCOME WAS MY FAMILY'S TOTAL INCOME FOR THE PREVIOUS YEAR, WHICH PLACES MY FAMILY IN THE _____ % CO-PAYMENT RANGE.

Pro-rated funding for new enrollees is effective July 1, 2014. The Annual reimbursement amount will be allocated quarterly, for the current year, based on the date of the application; according to the table:

Application Date	Percentage of Annual Reimbursement
After September 30	75%
After December 31	50%
After March 31	25%

Parent/Guardian Signature:_____ Date: _____

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FOR OFFICE USE ONLY

APPROVED _____ **NEW** _____

NOT APPROVED _____ **REDETERMINATION** _____

FSS COORDINATOR: _____ **Date:** _____

Revised 5/15/2019