Washington State Department of CHILDREN, YOUTH & FAMILIES

ESIT System of Payments and Fees (SOPAF)

Ability to Pay/Monthly Participation Fee/Hardship Exemption

Date _____ ESIT Provider Agency _____

FRC/ESIT Staff Name _____ Phone Number _____

Section A: Identifying Information

Child's Legal Name _____ Date of Birth _____

Parent/Guardian Name 1 _____ Phone _____

Parent/Guardian Name 2 _____ Phone _____

Section B: Reason for Ability to Pay Determination *(Check one)*

☐ Family denied access to Apple Health for Kids CHIP, TRICARE, or Private Insurance
☐ Family has No Insurance
☐ Family requested Ability to Pay Determination.
☐ Family allowed access to TRICARE or Private Insurance (Check one)
- ☐ No Benefit for **ALL** services on the IFSP subject to Family Cost Participation (FCP).
- ☐ Reimbursement denied for **ALL** services on the IFSP subject to FCP.

Section C: Declined to Provide Income and Expense Information

☐ Family declined to provide income and expense information and will be placed on the monthly fee schedule at the highest level for their family size and are not eligible for a hardship exemption.

Section D: Annual Income

Provide proof of income during the past twelve months or previous tax year. One document type will be needed to demonstrate proof of income and proof will not be retained in the child's file.

✓	**Document Type *(Select one)***	**Annual Income**
☐	Most recent IRS Tax Return	
☐	Lasty pay stub *(gross income)*	
☐	Most recent W2(s)	
☐	A written statement of salary or wages attached *(Must include company or employer's name, address, phone number, and supervisor or human resource staff signature.)*	
☐	A written or verbal statement of income from the family. *(Allowed if the family does not have access to the other documentation listed above).*	
	Total Allowable Annual Income	

Section E: Allowable Annual Expenses

Provide documentation for non-reimbursed expenses incurred for the child and/or other family members during the past twelve months and this documentation will not be retained in the child's file.

Allowable Non-Reimbursed Annual Expense Categories	**Expense Amount**
Medical, dental, and mental health expenses including premiums, co-pays, co-insurance, deductibles and non-covered medical services	
Home Health Care provided by a licensed Home Health agency	
Child Support/Alimony Payments	
Childcare Costs *(occurred during work or school)*	
Total Allowable Annual Expenses	

Section F: Adjusted Annual Income, Family Size, and FPL

Document Type *(Select one)*	**Annual Income**
1. Total Annual Income *(as documented in Section D):*	
2. Allowable Annual Expenses *(as documented in Section E*):	
3. Adjusted Income *(Line 1 minus Line 2):*	
4. Family Size: All family members living in the child's home:	
5. Family's Percentage of FPL using Monthly Fee Schedule *(Line 3 and 4):*	
Total Allowable Annual Income	

Section F: Ability to Pay Determination *(check one)*

☐ Family Meets Inability to Pay Criteria if Line 5 is below 200% of the Federal Poverty Level for family size and will receive all services at no cost.

☐ Family Meets Ability to Pay Criteria if Line 5 is above 200% of the Federal Poverty Level for family size. The family is responsible for any copays, coinsurance, deductibles, or Monthly Participation fee (which is determined below). **If the family is still unable to pay complete Section I: Hardship Exemption.**

Section G: Reason for Monthly Participation Fee *(Check One)*

☐ Family denied access to Apple Health for Kids CHIP, TRICARE, or Private Insurance.
☐ Family has No Insurance.
☐ Family allowed access to TRICARE or Private Insurance (Check one)
- ☐ No Benefit for **ALL** services on the IFSP subject to FCP.
- ☐ Reimbursement denied for **ALL** services on the IFSP subject to FCP.

Section H: Monthly Participation Fee

The Monthly Participation Fee will not be more than the actual cost of services, is a flat fee for **all** services on the child's IFSP subject to FCP, and is the maximum amount charged regardless of the number of children enrolled in services.

Adjusted Income *(from above)*	
Family Size: All family members living in the child's home	
Monthly Participation Fee based off Monthly Fee Schedule	
The family would like to request a hardship exemption *(Check yes or no)*	☐ Yes ☐ No

Section I: Reason for Hardship Exemption

The family has been determined to have the ability to pay, and are unable to meet their family cost participation obligation due to a circumstance, **including but not limited to the following:** **(Check all that apply)**

- ☐ A change in income or expenditures.
- ☐ Any significant and/or ongoing medical expense(s).
- ☐ A change in employment status (e.g. loss of job or reduced hours).
- ☐ A significant life event (e.g. divorce, relationship breakdown, injury, illness, or death in the family).
- ☐ An emergency or natural disaster.
- ☐ Rent or mortgage payments, with monthly costs, including utilities other than telephone, that exceed 30% of a household's monthly income.

By signing, I hereby affirm that:

- I provided information on this form that is accurate and complete.
- I agree to notify my FRC or ESIT Provider of any changes in my situation.
- My FRC has explained SOPAF to me and has given me a copy of the SOPAF policy.
- I understand that my ability to pay determination and/or hardship exemption will be reviewed annually unless my situation changes prior to the review date.

Parent / Guardian's Signature(s)

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

By signing, I affirm that the information provided, reviewed, and documented on this form is accurate and complete to the best of my knowledge.

FRC/ESIT Staff Signature

FRC or ESIT Staff Signature _____ Date _____