

Each year, the Family Support Subsidy must be renewed during your child's birth month. Enclosed you will find the paperwork that needs to be completed and returned to me **ASAP**.

**Parent's responsibility:**

- Complete and sign application (required)
- Send copy of your current year or most recent Michigan 1040 Individual tax return (sample enclosed) (required)
- Take School information into school for completing (must be on school letterhead) (required)
- If you are guardian to the individual, submit a copy of current guardianship papers

*\*Application cannot be processed until ALL required items listed have been received.*

**Proof of Income:**

**If you file TAXES**, please provide proof of your income by submitting a copy of your current MI 1040 tax return (sample attached)

**If you DO NOT FILE TAXES**, please contact me as soon as possible and request that I send you the "Request and Consent for Disclosure of Michigan Tax Return Information" document.

***If you are MARRIED or DIVORCED:***

1. If married, you must submit proof of both parent's incomes
2. If not married, but live together, you must submit proof of both parent's incomes
3. If divorced, you must submit a copy of the divorce decree

*\*If you have submitted a copy of the divorce decree previously, do not resubmit*

**Tax information:** You have until April 30<sup>th</sup> to report that your taxable income for the year has exceeded \$60,000 by faxing a copy of your MI-1040 tax return immediately.

The school information **MUST** come from the school. **School information will not be accepted from the parent.**

Please note that you have a **60-day grace period** to turn in your renewal information. In addition, checks are mailed directly from the State of Michigan. **Family Support Subsidy checks should arrive around the 21<sup>st</sup> of every month.** The State of Michigan will not investigate any lost checks unless it has been late for at least 14 days (from the 21<sup>st</sup> or whenever the check was mailed).

**IN OAKLAND COUNTY, MAIL APPLICATIONS AND OTHER REQUIRED DOCUMENTS TO:**

OAKLAND COMMUNITY HEALTH NETWORK  
ATTN: STEPHANIE GLENNIE  
5505 CORPORATE DR.  
TROY, MI 48098

Thank you,  
Stephanie Glennie  
FSS Coordinator  
Phone: 248.464.6379 / fax: 947.218.3836 / email: glennies@oaklandchn.org



STUDENT'S NAME \_\_\_\_\_

TO WHOM IT MAY CONCERN:

Attached is the newest Educational Eligibility Checklist (eff 7/17/17) for the FSS program for the Director of Special Education, RESA, Teacher or ISD Authority to complete. Please discard old educational eligibility checklist and begin to use the current one. If you would like this form sent electronically, please email me.

Make sure school documentation is copied or typed (if typed, must use the exact verbiage from original form) on the school's letterhead.

Never give the documentation to the parents to submit; it has to come directly from the school or it will not be considered valid.

**Please note:**

1. Date – **required**
2. From – **required**
  - a. **Signature** (person completing form) and **name of the school** (Public, ISD, RESA, or Charter) providing the information is **required**
3. **Per requirement of the State of Michigan**, this information **MUST BE COPIED** onto school letterhead
4. If student is ASD, you **must** identify if the student is enrolled/attending public school

**Please send the eligibility checklist to me through one of the three ways provided:**

**Mail:** OCHN, ATTN: Stephanie Glennie, 5505 Corporate Dr., Troy, MI 48085

**Fax:** 947.218.3836, ATTN: Stephanie Glennie

**Email:** [glennies@oaklandchn.org](mailto:glennies@oaklandchn.org)

Please do not hesitate to contact me if you have any questions regarding this form.

Thank you,

Stephanie Glennie  
FSS Coordinator  
Oakland Community Health Network  
Phone: 248.464.6379  
Fax: 947.218.3836

Rev. 7/17/17

**Suggested Language to Report a Student's Educational Eligibility Category  
& Programming for Michigan's Family Support Subsidy Program**

**Must be printed on school stationery and include a school authority signature at bottom of page.**

DATE:

TO: **Stephanie Glennie, OCHN, Fax: 947.218.3836 / Email: glennies@oaklandchn.org**

FROM: (Insert school authority name along with the name of the Public School, Intermediate School District, Local Educational Agency or Public School Academy providing this information)

SUBJECT: **Identification of Special Education Eligibility Category\* & classroom or program placement if ASD (R 340.1715)**

Student's Name: \_\_\_\_\_

This student is eligible for special education under the eligibility category of:

Cognitive Impairment (CI) R 340.1705

If the eligibility category is cognitive impairment, does the latest intellectual assessment show development at a rate of 4.5 or more standard deviations below the mean?

Yes  No

Severe Multiple Impairment (SXI) R 340.1714

Autism Spectrum Disorder (ASD) R 340.1715

If the student's educational eligibility category is ASD, please verify programming by checking one of the following options:

R 340.1738 Programs for Students with Severe Cognitive Impairment

R 340.1748 Programs for Students with Severe Multiple Impairments

R 340.1758(a) or (b) Programs for Students with Autism Spectrum Disorder

Student's Resource Room program (Elementary R 340.1749a, Secondary R 340.1749b) meets the requirements of R 340.1758(b)

Student's Early Childhood Special Education program (R 340.1754) meets the requirements of R 340.1758(b)

Student's Early Childhood Special Education Services (R 340.1755) meets the requirements of R 340.1758(b)

Student's Individualized Family Service Plan (R 340.1862) meets the requirements of R 340.1758(b)

Student's mild (R 340.1740) or moderate (R 340.1739) Cognitive Impairment program meets the requirements of R 340.1758(b)

ISD Plan Content Areas (R 340.1832) This student is receiving special education services through an approved ISD plan. This plan meets the requirements of R 340.1758(b)

Student's educational programming does not meet any of the above criteria

For **ASD students only** - Student is enrolled/attending public school

Signature: \_\_\_\_\_

**\*Please note this only identifies the special education category for the student listed above, The school does NOT determine educational eligibility for the Family Support Subsidy Program.**

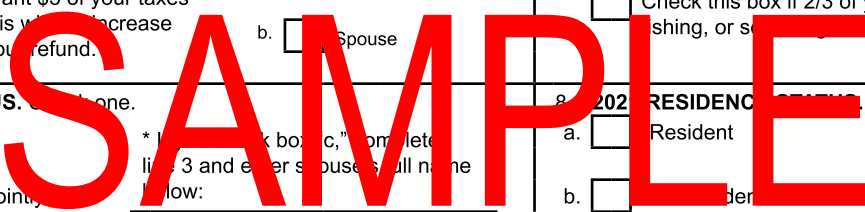
# 2021 MICHIGAN Individual Income Tax Return MI-1040

Amended Return   
(Include Schedule AMD)

Return is due April 18, 2022. Type or print in blue or black ink.

1. Filer's First Name	M.I.	Last Name	2. Filer's Full Social Security No. (Example: 123-45-6789)
If a Joint Return, Spouse's First Name	M.I.	Last Name	3. Spouse's Full Social Security No. (Example: 123-45-6789)
Home Address (Number, Street, or P.O. Box)			4. School District Code (5 digits – see page 60)
City or Town		State	ZIP Code

<b>5. STATE CAMPAIGN FUND</b> Check if you (and/or your spouse, if filing a joint return) want \$3 of your taxes to go to this fund. This will increase your tax or reduce your refund. a. <input type="checkbox"/> Filer b. <input type="checkbox"/> Spouse	<b>6. FARMERS, FISHERMEN, OR SEAFARERS</b> <input type="checkbox"/> Check this box if 2/3 of your income is from farming, fishing, or seafaring.
<b>7. 2021 FILING STATUS.</b> Check all that apply. a. <input type="checkbox"/> Single b. <input type="checkbox"/> Married filing jointly c. <input type="checkbox"/> Married filing separately*	<b>8. 2021 RESIDENCE STATUS.</b> Check all that apply. a. <input type="checkbox"/> Resident b. <input type="checkbox"/> Part-Year Resident c. <input type="checkbox"/> Part-Year Resident *



**9. EXEMPTIONS. NOTE:** If someone else can claim you as a dependent, check box 9e, enter 0 on line 9a and enter \$1,500 on line 9e (see instr.).

a. Number of exemptions (see instructions).....	9a.		x \$4,900	9a.		00
b. Number of individuals who qualify for one of the following special exemptions: deaf, blind, hemiplegic, paraplegic, quadriplegic, or totally and permanently disabled.....	9b.		x \$2,800	9b.		00
c. Number of qualified disabled veterans.....	9c.		x \$400	9c.		00
d. Number of Certificates of Stillbirth from MDHHS (see instructions).....	9d.		x \$4,900	9d.		00
e. Claimed as dependent, see line 9 NOTE above.....	9e.	<input type="checkbox"/>		9e.		00
f. Add lines 9a, 9b, 9c, 9d and 9e. Enter here and on line 15.....	9f.			9f.		00

10. <b>Adjusted Gross Income</b> from your U.S. Form 1040 (see instructions).....	10.		00
11. Additions from Schedule 1, line 9. <b>Include Schedule 1</b> .....	11.		00
12. <b>Total.</b> Add lines 10 and 11.....	12.		00
13. Subtractions from Schedule 1, line 29. <b>Include Schedule 1</b> .....	13.		00
14. <b>Income subject to tax.</b> Subtract line 13 from line 12. If line 13 is greater than line 12, enter "0".....	14.		00
15. <b>Exemption allowance.</b> Enter amount from line 9f or Schedule NR, line 19.....	15.		00
16. <b>Taxable income.</b> Subtract line 15 from line 14. If line 15 is greater than line 14, enter "0".....	16.		00
17. <b>Tax.</b> Multiply line 16 by 4.25% (0.0425).....	17.		00

**NON-REFUNDABLE CREDITS**

	AMOUNT	CREDIT
18. Income Tax Imposed by government units outside Michigan. Include a copy of the return (see instructions).....	18a.	00
19. Michigan Historic Preservation Tax Credit carryforward (see instructions).....	19a.	00
20. <b>Income Tax.</b> Subtract the sum of lines 18b and 19b from line 17. If the sum of lines 18b and 19b is greater than line 17, enter "0".....	20.	00

Filer's Full Social Security Number

—	—
---	---

21. Enter amount of Income Tax from line 20.....	21.		00
22. Voluntary Contributions from Form 4642, line 6. <b>Include Form 4642</b> .....	22.		00
23. <b>USE TAX.</b> Use tax due on Internet, mail order or other out-of-state purchases from Worksheet 1 (see instructions).....	23.		00
24. <b>Total Tax Liability.</b> Add lines 21, 22 and 23 .....	24.		00

**REFUNDABLE CREDITS AND PAYMENTS**

25. <b>Property Tax Credit. Include MI-1040CR or MI-1040CR-2</b> .....	25.		00
26. <b>Farmland Preservation Tax Credit. Include MI-1040CR-5</b> .....	26.		00
27. Earned Income Tax Credit. Multiply line 27a by 6% (0.06) and enter result on line 27b. ....	27a.	FEDERAL	MICHIGAN
		00	00
28. Michigan Historic Preservation Tax Credit (refundable). <b>Include Form 3581</b> .....	28.		00
29. Credit for allocated share of tax paid by an electing flow-through entity (see instructions).....	29.		00
30. Michigan tax withheld from Schedule W, line 6. <b>Include Schedule W (do not submit W-2s)</b> .....	30.		00
31. Estimated tax, extension payments and 2020 credit forward.....	31.		00
32. <b>2021 AMENDED RETURNS ONLY.</b> Taxpayers completing an original 2021 return should skip to line 33. Amended returns must <b>include Schedule AMD (see instructions)</b> .			
32a. <input type="checkbox"/> If you had a refund and/or credit forward on the original return, check box 32a and enter this amount as a negative number on line 32c.			
32b. <input type="checkbox"/> If you paid with the original return, check box 32b and enter the amount paid with the original return, plus any additional tax paid after filing, as a positive number on line 32c. Do not include interest or penalty.			
32c.			00
33. Total refundable credits and payments. Add lines 25, 26, 27b, 28, 29, 30, 31 and 32c .....	33.		00

**REFUND OR TAX DUE**

34. If line 33 is less than line 24, subtract line 33 from line 24. If applicable, see instructions.	34.		00
Include interest <input style="width: 50px;" type="text"/> 00 and penalty <input style="width: 50px;" type="text"/> 00 .....		<b>YOU OWE</b>	
35. <b>Overpayment.</b> If line 33 is greater than line 24, subtract line 24 from line 33 .....	35.		00
36. <b>Credit Forward.</b> Amount of line 35 to be credited to your 2022 estimated tax for your 2022 tax return ...	36.		00
37. Subtract line 36 from line 35.....	37.	<b>REFUND</b>	00

**DIRECT DEPOSIT**

Deposit your refund directly to your financial institution! See instructions and complete a, b and c.

<b>a. Routing Transit Number</b>	<b>b. Account Number</b>	<b>c. Type of Account</b>
		1. <input type="checkbox"/> Checking    2. <input type="checkbox"/> Savings

**Deceased Taxpayer.** If Filer and/or Spouse died after December 31, 2020, enter dates below. **ENTER DATE OF DEATH ONLY.** Example: 04-15-2021 (MM-DD-YYYY)

Filer	— —	Spouse	— —
-------	-----	--------	-----

**Preparer Certification.** I declare under penalty of perjury that this return is based on all information of which I have any knowledge.

<b>Taxpayer Certification.</b> I declare under penalty of perjury that the information in this return and attachments is true and complete to the best of my knowledge.	Preparer's PTIN, FEIN or SSN
Filer's Signature	Date
Spouse's Signature	Date
Preparer's Name (print or type)	
Preparer's Signature	
Preparer's Business Name, Address and Telephone Number	
<input type="checkbox"/> By checking this box, I authorize Treasury to discuss my return with my preparer.	

**Refund, credit, or zero returns.** Mail your return to: **Michigan Department of Treasury, Lansing, MI 48956**  
**Pay amount on line 34 (see instructions).** Mail your check and return to: **Michigan Department of Treasury, Lansing, MI 48929**

EXECUTIVE DIRECTOR & CEO  
Annette Downey

BOARD OFFICERS  
Judith Summers, Chair  
Dr. Steffan Taub, Vice Chair  
Jonathan Landsman, Secretary

BOARD MEMBERS  
Adam Fuhrman  
Dr. Bijaya Avastny Hans  
Robert Klotz  
Mary Kucharek  
Malkia Newman  
Sidney Rubin  
John Paul Torres  
Sarah Guadalupe  
Hadas Bernard

RE: Request & Consent for Disclosure of Michigan Tax Return

This letter is in follow-up to your application for Family Support Subsidy benefits. In order to process the application, we are required to obtain verification of your income. If you have reported that state income tax was not filed, it is necessary to verify your income through the Michigan Department of Treasury. The attached form will provide the required authorization for income verification. Please sign/date the form and return it as soon as possible to:

**Oakland Community Health Network  
ATTN: Stephanie Glennie  
5505 Corporate Dr.  
Troy, MI 48098**

Sincerely,

Stephanie Glennie  
Administrative and Special Projects Coordinator  
Oakland Community Health Network  
Phone: (248) 464-6379  
Fax: (947) 218-3836  
[glennies@oaklandchn.org](mailto:glennies@oaklandchn.org)

# Request and Consent for Disclosure of Michigan Tax Return Information

Issued under authority of Public Act 122 of 1941, MCL 205.1.

The Revenue Act, Public Act 122 of 1941, MCL 205.28(1)(f), makes all information acquired in administering taxes confidential. The Michigan Department of Treasury recoups cost for preparing copies of tax returns or tax return information requested by local units of government or other third parties. Taxpayers may receive copies of their personal tax returns at no charge. The current fee schedule is listed below (see Part 3).

PART 1: TAXPAYER INFORMATION				
Enter the name of the individual or business, address and account number for which the tax information is being requested.				
Taxpayer Last Name	First Name	MI	Social Security Number or FEIN	Telephone Number
Secondary Taxpayer Last Name	First Name	MI	Social Security Number or FEIN	Telephone Number
Address (Street)		City		State      ZIP Code
Tax Type <input type="checkbox"/> Income Tax <input type="checkbox"/> SBT <input type="checkbox"/> MBT <input type="checkbox"/> CIT <input type="checkbox"/> SUW <input type="checkbox"/> Other _____				
Tax Year(s)		Tax Forms		
PART 2: AUTHORIZATION				
I authorize the State of Michigan, Department of Treasury to furnish tax returns and/or tax return information specified in Part 1 to the appointee listed below. <b>This authorization expires in six months and is not a substitute for a formal Form 151, Authorized Representative Declaration.</b>				
Appointee Name		E-mail Address		Telephone Number
Address (Street)		City		State      ZIP Code
Signature of Taxpayer <b>OR</b> Legal Representative				Date
Signature of Taxpayer <b>OR</b> Legal Representative				Date
PART 3: FEE SCHEDULE				
Local units of government or other third parties must pay the fee described here. Taxpayers may receive copies of their personal tax returns at no charge. Payment for tax return information must accompany the request. Make checks payable to the State of Michigan and write index code # 19182 on the check. * Large requests will be assessed differently.				
<b>First Year</b>	\$ 5.00	\$5.00		
<b>Additional Year(s)</b>	\$ 3.00 X _____			
<b>FEE TOTAL</b>				
<b>Please allow 60 days for processing your request.</b>				
Submit your request with payment to the following address: Michigan Department of Treasury Office of Privacy and Security, Disclosure Unit 430 W. Allegan Street Lansing, MI 48922 Telephone: (517) 636-4239				
Treasury Use Only				
1. <input type="checkbox"/> The attached information is furnished for tax year(s) _____				
2. <input type="checkbox"/> No record of filing a return for tax year(s) _____				
3. <input type="checkbox"/> The account number submitted needs to be verified for accuracy.				
4. <input type="checkbox"/> The account number provided is being used by another taxpayer.				
5. <input type="checkbox"/> Other _____				
Disclosure Office Approval			Fee Received	Date Completed



**MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES**  
**FAMILY SUPPORT SUBSIDY PROGRAM**  
**ANNUAL FAMILY SURVEY**  
**INFORMATION SHEET**  
(Updated January 2018)

EXECUTIVE DIRECTOR & CEO  
Annette Downey

BOARD OFFICERS  
Judith Summers, Chair  
Dr. Steffan Taub, Vice Chair  
Jonathan Landsman, Secretary

BOARD MEMBERS  
Adam Fuhrman  
Dr. Bijaya Avastny Hans  
Robert Klotz  
Mary Kucharek  
Malkia Newman  
Sidney Rubin  
John Paul Torres  
Sarah Guadalupe  
Hadas Bernard

The Michigan Department of Health and Human Services, Family Support Subsidy (FSS) program is required by statute to send an annual report to the Governor and Legislature outlining efforts undertaken by the FSS program in providing monetary assistance to eligible families caring for children with severe developmental disabilities. A large part of the report communicated what you think of the program and reports other types of assistance you would welcome. This information comes from your completing of the FSS annual family survey which is done during your child's annual renewal for FSS. Although completing of this brief survey is optional, your assistance in completing this survey provides valuable feedback.

The survey can be taken online or by using the traditional mail-in paper form. To access the online survey, please visit: <https://survey.mphi.org/surveys/?s=celjUgcyo3>. Although online completing is highly encouraged, print materials (survey and postage paid envelope) are available by contacting Stephanie Murray, OCHN Family Supports Subsidy Coordinator, at 248.464.6379.

Data entered on this survey online is secure and cannot be viewed by others. If you encounter problems using the on-line survey, you may contact Wendy Walser at 517.241.5774 or by email at [walserw1@michigan.gov](mailto:walserw1@michigan.gov). As an alternative, you can simply contact your local FSS coordinator for a paper copy and postage paid envelope.

Family Support Subsidy Program  
Annual Family Survey  
Form Number: MDHHS-1180



# Family Support Subsidy Annual Survey



Greetings! This survey is available to parents or guardians of children enrolled in the family support subsidy program. It should take between five and ten minutes to complete.

On an annual basis, the Michigan Department of Health and Human Services sends a family support subsidy program report to the Governor and Legislature. Data collected from this survey makes up much of the report. Completing the survey is optional, but we highly encourage you to take a few minutes to respond. The annual report is also made available on the MDHHS website. To locate the most recently published report, go to [www.michigan.gov/mdhhs](http://www.michigan.gov/mdhhs) and type "family support subsidy program" in the search box.

Thank you for your willingness to share your thoughts regarding the administration of the family support subsidy program.

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

- 1. When did your family receive a subsidy check for the FIRST time?
  - 1-12 months ago
  - 13-24 months ago
  - More than 24 months ago
  
- 2. How often is the monthly amount of the subsidy adequate to help you meet your child's needs?

	Never	Seldom	Sometimes	Usually	Always
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
  
- 3. What is your child's educational eligibility category?
  - Cognitive Impairment (CI)
  - Severe Multiple Impairment (SXI)
  - Autism Spectrum Disorder (ASD)
  
- 4. Did your child return to your home from an out-of-home placement during the last year?
  - Yes
  - No (*please skip to question 7*)
  
- 5. How much did the subsidy influence your decision to bring your child home?

	Not at all	A little	Some	A lot
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please describe how the subsidy helped bring your child home: \_\_\_\_\_

7. Here is a list of services and items you may have purchased with the subsidy. Please check all the ways you have used the subsidy in the last year.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Adaptive equipment for your child          | <input type="checkbox"/> Depends/Pull-ups/Diapers        | <input type="checkbox"/> Occupational, physical or speech therapy |
| <input type="checkbox"/> Behavioral aides                           | <input type="checkbox"/> Educational aids or toys        | <input type="checkbox"/> Respite services                         |
| <input type="checkbox"/> Camp or recreation for your child          | <input type="checkbox"/> General household expenses      | <input type="checkbox"/> Special foods                            |
| <input type="checkbox"/> Changes to make your house more accessible | <input type="checkbox"/> Individual or family counseling | <input type="checkbox"/> Transportation expenses                  |
| <input type="checkbox"/> Clothing for your child                    | <input type="checkbox"/> In-home nursing care            | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> Day care for your child with disabilities  | <input type="checkbox"/> Medical expenses                | _____   |

<i>How satisfied are you with....</i>	Very Dissatisfied	Somewhat Dissatisfied	Neutral	Somewhat Satisfied	Very Satisfied
8. The amount of the subsidy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. How your application was handled at the community mental health services agency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. The information you received about the program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Your overall experience with the subsidy program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>How much has the subsidy...</i>	Not at all	A little	Some	A lot
12. Helped meet the special needs of your family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Helped meet the special needs of your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Improved your family's life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Improved your ability to care for your child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Helped your family do more things together?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Eased your financial worries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Reduced stress in your family's life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. You are invited to share an example or story describing how the subsidy has helped your child in the past year.

---

---

---

---

---

---

20. We would like to know about other services your family might be receiving from your county community mental health agency.

*Please check the services you have received in the past 12 months to support your child with disabilities.*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Adaptive equipment                        | <input type="checkbox"/> In-home behavioral aides                          | <input type="checkbox"/> Respite services                                 |
| <input type="checkbox"/> Camp or recreational activities           | <input type="checkbox"/> In-home nursing                                   | <input type="checkbox"/> Services coordination                            |
| <input type="checkbox"/> Changes to make your house accessible     | <input type="checkbox"/> Occupational, physical, or speech therapy         | <input type="checkbox"/> Sibling support groups                           |
| <input type="checkbox"/> Children's Waiver Program                 | <input type="checkbox"/> Parent support groups                             | <input type="checkbox"/> Specialized medical services                     |
| <input type="checkbox"/> Day care for your child with disabilities | <input type="checkbox"/> Person-centered planning/family centered practice | <input type="checkbox"/> Training on how to teach your child basic skills |
| <input type="checkbox"/> Individual or family counseling           | <input type="checkbox"/> Planning for child's transition to adult services | <input type="checkbox"/> Training on managing behavior problems           |

21. Consider the services you DID NOT report receiving in the past year from question #20 above. From this list, please tell us the top three services you would be most interested in receiving by listing them in order of importance.

1<sup>st</sup> most important: \_\_\_\_\_

2<sup>nd</sup> most important: \_\_\_\_\_

3<sup>rd</sup> most important: \_\_\_\_\_

***The following information is used to track the demographics of enrolled families.***

22. Your child's birth date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

23. Your child's gender:  Male  
 Female

24. What race/ethnic group best describes your child?

- American Indian or Alaskan Native
- Asian or Pacific Islander
- Black, not of Hispanic origin
- Hispanic
- White, not of Hispanic origin
- Multi-racial or another race

25. Your most recently filed Michigan income tax form shows a taxable income of:

- Below \$20,000
- \$20,000 to \$44,999
- \$45,000 to \$60,000
- Above \$60,000

26. Which county do you live in? \_\_\_\_\_

---

Your assistance in providing this information is appreciated. Your county community mental health agency may also offer other programs and services of value to your family. To find your county community mental health agency's contact information, go to [www.macmhb.org](http://www.macmhb.org) and click on CMHSP Directory.

You may also be interested in another State of Michigan on-line tool called "Helping Hand". It is useful for researching government services available to Michigan citizens facing economic challenges. To access this tool, go to [www.michigan.gov/helpinghand](http://www.michigan.gov/helpinghand).

---