Oakland Community Health Network

Developmental Disabilities • Mental Health • Substance Recovery

Important FAMILY SUPPORT SUBSIDY PROGRAM information for New Families

Michigan has a program to provide financial support to families who care for their children with severe handicaps at home. The subsidy program is intended to pay for special expenses the family incurs while caring for their child with severe disabilities.

Supporting families of children with severe disabilities in this way enables the families to stay together; allows them flexibility in purchasing special services at a local level; and saves money for the taxpayer by avoiding and/or reducing the need for more costly out-of-home placement.

WHO IS ELIGIBLE:
Families may be eligible for this program if they have a child under the age of 18 who has been recommended by a public school district's multidisciplinary team through the following categories:

- Severe Cognitive Impairment (SCI) (must be within the severe range)
- Severe Multiple Impairment (SXI)
- Autism Spectrum Disorder (ASD) with specific programming

WHO IS NOT ELIGIBLE?

- Families with a Michigan taxable income that exceeds $60,000.00 (line 16 of the Ml-1040)
- A child with a diagnostic category other than SCI, SXI, ASD with appropriate programming
- Children living in out-of-home placements (foster care, institutionalization)
- Children over the age of 18
- Families that receive a medical subsidy from the Adoption Subsidy Program

PAYMENTS
Payments are uniform for all families ($300.36 per month at the present time) and there are no provisions under the law for smaller payments.

The Family Support Subsidy payments are disbursements by a governmental unit in the interest of general welfare and are not includible in the gross income of the family member or the gross income of the parents or legal guardians. This subsidy is not taxable and is to be reported only for Michigan Property Tax Credit.

HOW TO APPLY FOR FAMILY SUPPORT SUBSIDY:
Applications for the family support subsidy program may be obtained from and submitted to offices of Michigan's community mental health boards. **To obtain an application in Oakland County or any questions, please contact Debra Monroe at 947-345-1576.**

Required documents to submit along with your FSS application:

- A copy of the child's birth certificate
- A copy of the child's social security card
- A copy of the parent(s) social security card
- A copy of the parent(s) driver's license
- A copy of the family's Michigan 1040 Tax Return for the preceding year
- If divorced, I will need copy of the divorce decree
- Custody Papers (if divorced, must know who has custody of the child)

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Educational Eligibility form

A written verification from the school district, which certifies that the child has been recommended for an eligible diagnostic category, is required. If the child is currently placed in a program specifically for Autism Spectrum Disorder (ASD), it must be identified what type of classroom setting the child is currently in and if the child is enrolled/attending public school to meet the requirements for the program.

TO ASSURE THE VALIDITY OF SCHOOL DOCUMENTATION AND PREVENT FRAUD, PAPERWORK USED TO VERIFY EDUCATIONAL ELIGIBILTY FOR FAMILY SUPPORT SUBSIDY MUST COME DIRECTLY FROM THE PUBLIC SCHOOL OR INTERMEDIATE SCHOOL DISTRICT.

Applications may be obtained and submitted at any time. There is no waiting list for the program. Coverage will begin the month following the month of the application submission. If you expect that the school documentation of eligibility will be delayed, please contact Debra Monroe at 947-345- 1576 regarding a pending application. Actual payment for the first covered month may be delayed during the processing of the application.

Questions?

Please contact me directly via email at FSS@Oaklandchn.org or by phone 947.345.1576.

Submit your application and other required documents:

- Via email: FSS@OaklandCHN.org
- FAX: 248.906.8411
- US Mail: OAKLAND COMMUNITY HEALTH NETWORK
  ATTN: Debra Monroe
  5505 CORPORATE DR.
  Troy, Michigan 48098

DCH-1181 COMPLETION INSTRUCTIONS

Collect the following documents (copies are acceptable):

- Your child's legal birth certificate. (Your child must be under age 18.)
- Your most recently filed Michigan income tax return (MI-1040), or if a MI-1040 income tax form was not filed, you may submit a copy of your most recently filed United States (US-1040) income tax return. For new applicants only, other evidence of current year income may be used if neither a Michigan nor a U.S. income tax form was filed. Your family's taxable income must not exceed $60,000. In situations where there is joint physical custody, both parents must submit a copy of their individual tax return.
- Your child's social security card (optional). If your child does not currently have a social security number, you may apply online for one through the Social Security Administration http://www.ssa.gov or telephone 800-772-1213. You may apply for this subsidy while you are waiting to receive a social security number.

Note: This information will be used to complete the application and will serve as proof of eligibility. Make sure to submit copies as any documents you provide will not be returned to you.

You must also contact your child's local public school, intermediate school district or regional educational services agency and provide authorization to send or fax written verification of your child's educational eligibility category and, if necessary, evidence of educational programming to your local county community mental health services program (CMHSP). This is the agency that provided you with this form. Please note that the only special education eligibility categories that meet FSS criteria are **Severe Cognitive Impairment, Severe Multiple Impairment or Autism Spectrum Disorder AND in a program that qualifies under FSS law.** Your CMHSP representative will provide you with a fax number and/or mailing address for the educational institution to use in transferring required documentation.

Other information:

- If your child is currently living in a nursing home, center for persons with developmental disabilities, foster family care home or residential school, you may apply for FSS if the child is returning to your home in a very short period of time.
- If your child is adopted and enrolled in the Michigan Department of Health and Human Services, Adoption Subsidy Program, you may continue to receive the monthly adoption subsidy even if your child becomes eligible for FSS payments. Your child may NOT, however, also have an open medical subsidy within the Adoption Subsidy Program. If you are unsure if your child has an open **medical** subsidy, you can verify this information by calling (517) 335-6443. If there is an open medical subsidy, you may wish to request closure of it as a means to meeting FSS eligibility requirements.

Line-by-line completion instructions:

1. Purpose:
   - Check **New Applicant** if this is the first time you have applied for the subsidy.
   - Check **Annual Renewal** if you are renewing eligibility.
   - Check **Restore** if there has been a gap in eligibility/payments.
   - Check **Change of Status** and write in the corresponding block number(s) to report changes in information previously provided. When reporting a change in status, you need to complete ONLY blocks 1, 2, 3 and 4 as well as the block(s) containing the information that has changed.
2. Child's Name – First, Middle Initial, Last.
3. Child's Date of Birth – Month/Day/Year.
4. Child's Social Security Number. Note: You may apply for FSS at the same time that you are completing social security number registration for your child.
5. Child's Gender – Male or Female.
6. Telephone Number – Your primary telephone number including area code.
7. Race (optional)
   a) **White** – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
   b) **Black or African American** - A person having origins in any of the Black racial groups of Africa.
   c) **American Indian and Alaska Native** - A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

d) **Asian** - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

e) **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

f) Some other race.

g) Unknown.

8. Name of public school that signed the Multi-Disciplinary Evaluation Team (MET) report.

9. Parent/Guardian Name (First, Middle Initial, Last) **THE PERSON LISTED IN THIS BOX WILL BE THE SOLE PAYEE FOR FSS PAYMENTS. If you desire both parents'/guardians' names on the check then select "Another Payee" and the other parent/guardian must complete block 20.**

10. Parent/Guardian Social Security Number – Enter the SSN of the person listed in block 9.

11. Print the address where the child resides (must be same as parent/guardian- only one address may be listed).

12. Has the child's residence changed in the last year? If yes, enter previous city name.

13. Is your child adopted? Check **yes** or **no**.

14. If your child is adopted, check **yes** or **no** indicating if the child is receiving a medical subsidy through the Michigan Department of Health and Human Services Adoption Subsidy Program.

15. Check the bracket corresponding to the **taxable** income amount displayed **on line** 16 on your most recently filed Michigan income tax form (MI-1040). If a Michigan income tax form was not filed, you will be required to complete a Michigan Department of Treasury 4095 form to prove that you did not file a Michigan income tax form. Your CMHSP will guide you in this process. (Note: if joint physical custody, both parents' incomes must be reported.

16. Confirm **yes** or **no** that the child lives in Michigan with one or both of the persons listed in blocks 9 and 20. If no, fill in the month and year the child left the family home.

17. If **no** is marked in block 16, indicate whether the child is temporarily living with another relative.

18. It is important to read and understand all the items listed. **Your signature in block 19 (and 20 if another payee is listed) indicates that you understand and agree to all bulleted items.** Questions about the information displayed in this block can be directed to the agency representative providing you with this form.

19. Signature of the person named in block 9. Be sure to include the date of signature.

20. If "another payee" was selected in block 9, the other parent/guardian must complete block 20.

The bottom portion of the application is for CMHSP use.

NEXT STEPS: Take or send this completed application along with a copy of your most recently filed Michigan income tax form, a copy of your child's legal birth certificate and a copy of your child's social security card to the CMHSP representative that gave this paperwork to you. You must also contact your child's public school, intermediate school district or regional services educational agency to give them permission for the sharing of documentation with the CMHSP. The CMHSP representative will give you a fax number or mailing address that the school can use to send the required educational information.

FAMILY SUPPORT SUBSIDY PROGRAM

Michigan Department of
Health and Human Services

1. Purpose ☐ New Applicant ☐ Annual Renewal ☐ Restore ☐ Change of Status (Enter block #s that have changed):_____

2. Child's name (first, middle initial, last)	3. Date of Birth (m/dd/yy)	4. Child's SSN

5. Gender ☐ Male ☐ Female	6. Primary Telephone No.	7. Race (see instructions for codes)	8. Name of public school signing MET report

9. Parent/Guardian name (first, middle initial, last)	Another payee (If yes fill in block 20) ☐ Yes ☐ No	10. Parent/Guardian SSN

IMPORTANT: If found eligible, Family Support Subsidy checks will be mailed to this address.

11. Parent/Guardian Address (number & street)	City	State	Zip Code

12. Has your family moved in the last year? ☐ No ☐ Yes → Previous city:

13. Is your child **adopted?** ☐ No ☐ Yes →

14. If **yes**, is your child receiving a **medical subsidy** through the Adoption Subsidy Program? ☐ No ☐ Yes

15. What is your **taxable** income as listed (line 16) on your most recently filed Michigan income tax form? (If joint physical custody, both parent's incomes must be reported.)
☐ $19,999 or **Less** ☐ $20,000 - $44,999 ☐ $45,000 - $60,000 ☐ **Over** $60,000

16. Does your child currently live in Michigan with one or both of the parents/guardians listed? ☐ Yes ☐ No → If no, date child left the family home: Month:_____ Year_____

17. Does your child **temporarily** live with a **relative**? ☐ Yes ☐ No

18. **PARENT/GUARDIAN CERTIFICATION:**

- I agree to notify my county Family Support Subsidy coordinator within **two weeks** of **any** changes in information reported on this form.
- I understand that a change in status can include name, address, living arrangement, an open medical subsidy, a more recent tax return with a taxable income of more than $60,000, or a change in the child's educational eligibility category and/or programming.
- I understand that this program requires a **yearly renewal** near or during my child's birth month and that I must contact my community mental health services program to start the renewal process. There is a two-month grace period following my child's birth month in which I may renew the subsidy without penalty.
- If I fail to reapply within the renewal period or grace period, I will **not** receive compensation for any payments I may have missed if my child is later found eligible. The new eligibility period will start and payments will resume the month following receipt of a complete packet of renewal information.
- I agree that subsidy dollars received will be used to meet the special needs of my child/family.
- I declare that this information is complete and true to the best of my knowledge.
- I understand that providing false information or failing to provide notice of a change in required information may result in denial of eligibility, repayment of any amount inappropriately received and perjury penalties as provided by law.

19. Parent/Guardian signature	Date

20. **Other Payee** (Parent/Guardian signature)	**Other Payee** (printed name)	**Other Payee** SSN	Date

THIS SECTION IS FOR CMHSP USE ONLY – DO NOT WRITE BELOW THIS LINE

Child's current education eligibility category:

☐ **A. Severe Cognitive Impairment:** If Severe Cognitive Impairment, does the documentation include written verification from the public school that the child's latest intellectual assessment shows development at a rate of 4.5 or more standard deviations **below** the mean? ☐ Yes ☐ No

☐ **B. Autism Spectrum Disorder:** If Autism Spectrum Disorder, does the child's special education programming fall under any of the following options?

1) Severe Cognitive Impairment Program (**R340.1738**)..... ☐ Yes ☐ No
2) Severe Multiple Impairments Program (**R340.1748**)..... ☐ Yes ☐ No
3) Autism Spectrum Disorder Program (**R340.1758**) ..... ☐ Yes ☐ No

☐ **C. Severe Multiple Impairment**

Is this family eligible for the one-time double subsidy payment to prepare for the child's return to home? ☐ Yes ☐ No

Has this child been in an out-of-home placement during the past 12 months? ☐ Yes ☐ No
If yes, enter the date child returned home: Month:_____ Year:_____

Type of out-of-home placement: ☐ **Group Home** ☐ **Foster Care** ☐ **Other (explain):**_____

Complete application packet received date (M/DD/YYY)	Effective Date (M/DD/YY)	Expiration Date (M/DD/YY)

Eligible ☐ Yes ☐ No (Due to block #):_____	CMHSP authorized signature	Date	CMHSP Board No.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Sections 155-161 of PA 258 of 1974, as amended.
COMPLETION: Is voluntary for a new application, but is required for annual renewal, change of status or restore to active status.

School logo or letterhead

Form for reporting a Student's Educational Eligibility Category Programming for Michigan's Family Support Subsidy Program

Today's date:	
TO:	**Debra Monroe, Oakland Community Health Network**
Subject:	**Identification of Special Education Eligibility Category & classroom or program placement if ASD (R 340.1715)**
Name of the Public School & District, ISD, LEA or PSA providing information	
Student's name & date of birth:	

*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.

☐ **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 {bl 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. l 758(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)
- ☐ ISO Plan Content Areas (R 340.1832) This student is receiving special education services through an approved ISO 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 of staff completing the form: _____

Return form to: Debra Monroe, Oakland Community Health Network **Email:** Fss@oaklandchn.org / **Fax:** 248.906.8411

Never give the documentation to the parents to submit.
Form must come directly from the school, or it will not be considered valid.

Issued under authority of Public Act 281 of 1967, as amended.

2025 MICHIGAN Individual Income Tax Return MI-1040

Amended Return ☐
(Include Schedule AMD)

Return is due April 15, 2026. 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)			
City or Town	State	ZIP/Postal Code / Country Code	4. School District Code (5 digits)

5. **STATE CAMPAIGN FUND**
Check if you (and/or your spouse, if filing a joint return) want $3 of your taxes to go to this fund. This will not increase your tax or reduce your refund.
a. ☐ Filer
b. ☐ Spouse

6. **FARMERS, FISHERMEN, OR SEAFARERS**
☐ Check this box if 2/3 of your income is from farming, fishing, or seafaring.

7. **2025 FILING STATUS.** Check one.
a. ☐ Single
b. ☐ Married filing jointly
c. ☐ Married filing separately*
* If you check box "c," complete line 3 and enter spouse's full name below:

8. **2025 RESIDENCY STATUS.** Check all that apply.
a. ☐ Resident
b. ☐ Nonresident *
c. ☐ Part-Year Resident *
* If you check box "b" or "c" you must complete and **include Schedule NR**.

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	$5,800	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	$3,400	9b.	00
c. Number of qualified disabled veterans	9c.		x	$500	9c.	00
d. Number of Certificates of Stillbirth from MDHHS (see instructions)	9d.		x	$5,800	9d.	00
e. Claimed as dependent, see line 9 **NOTE** above	9e.	☐			9e.	00
f. Add lines 9a, 9b, 9c, 9d and 9e. Enter here and on line 15					9f.	00

10. **Adjusted Gross Income** from your U.S. Form *1040* (see instructions)	10.		00
11. Additions from Schedule 1, line 9. **Include Schedule 1**	11.		00
12. **Total.** Add lines 10 and 11	12.		00
13. Subtractions from Schedule 1, line 31. **Include Schedule 1**	13.		00
14. **Income subject to tax.** Subtract line 13 from line 12. If line 13 is greater than line 12, enter "0"	14.		00
15. **Exemption allowance.** Enter amount from line 9f or Schedule NR, line 19	15.		00
16. **Taxable income.** Subtract line 15 from line 14. If line 15 is greater than line 14, enter "0"	16.		00
17. **Tax.** Multiply line 16 by 4.25% (0.0425)	17.		00

Continue on page 2. This form cannot be processed if pages 2 and 3 are not completed and included.

Michigan Department of Treasury
4095 (Rev. 06-23)

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

Request and Consent for Disclosure of Michigan Tax Return Information

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 authorized 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	Email Address

Tax Type

☒ Income Tax ☐ SBT ☐ MBT ☐ CIT ☐ SUW ☐ Other _____

Tax Year(s)	Tax Forms
	Michigan 1040

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. I understand that once the tax returns are furnished, the appointee is solely responsible for the privacy and security of the tax return information. **This authorization expires in six months and is not a substitute for a formal Form 151, *Authorized Representative Declaration*.**

Appointee Name	Email Address	Telephone Number
Debra Monroe, Oakland Community Health Network	monroed2@Oaklandchn.org	(947) 245-1576

Address (Street)	City	State	ZIP Code
5505 Corporate Drive	Troy	MI	48098

Signature of Taxpayer **OR** Legal Representative	Date

☒ Check this box if you prefer to have your request emailed back.

PART 3: FEE SCHEDULE

Authorized third parties must pay the fee described here. 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.

First Year ☒ N/A	$ 5.00	$5.00
Additional Year(s)	$ 3.00 X _____	
	FEE TOTAL	

Please allow 60 days for processing your request.
The Disclosure Unit will only provide records once. Records will not be resent without submitting a new 4095 form and fee.
You must submit your request with payment to the following address, "Michigan Department of Treasury, Disclosure Unit does not issue invoices. Please wait 30 days from mailing to check the status of request.

Send this form to:
Michigan Department of Treasury
Privacy and Security, Disclosure Unit
P.O. Box 30832
Lansing, MI 48909
Email: **Treas_Disclosure@michigan.gov**
Allow 60 days to process your request.

Treasury Use Only

1. ☐ The attached information is furnished for tax year(s) _____
2. ☐ No record of filing a return for tax year(s) _____
3. ☐ Other _____
4. ☐ See attached 4374 form for additional information needed

Disclosure Unit Approval Certification	Date Completed