



Parent's responsibility:

- Complete and sign application (required)
- Send copy of your current year or most recent Michigan 1040 Individual tax return (sample enclosed) or Request and Consent for Disclosure form if taxes are not filed (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

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

Tax information: You have until April 30th 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.**

GRACE PERIOD

Families must renew their child's eligibility (form DCH-1181) for FSS payments each year near or during their child's birth month. Families are notified that their eligibility period is running out three times prior to expiration. Notification is in the form of messages on the check stubs or by email if payments are electronically directed to a financial institution.

Subsidy payments continue up to and including the birth month of the child. After that there are no further payments until eligibility is re-determined. There is a two-month grace period following the child's birth month in which families can renew the subsidy without penalty. If the renewal process is completed during the first or second month following the birth month of the child and meets FSS eligibility criteria, the subsidy will be reinstated retroactively. Families renewing their child's FSS after the grace period ends will be treated as new applicants. In this situation, payments will resume the month following the date that the community mental health services program has in its possession a completed, signed application and all other required supporting documentation.

Checks are mailed directly from the State of Michigan. **Family Support Subsidy checks should arrive around the 21st 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 21st or whenever the check was mailed).

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

**OAKLAND COMMUNITY HEALTH NETWORK
ATTN: Debra Monroe, fss@oaklandchn.org**

5505 CORPORATE DR. TROY, MI 48098

Debra Monroe
FSS Coordinator
Fax: 248.906.8411 / email: fss@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: Debra Monroe, 5505 Corporate Dr., Troy, MI 48098

Fax: **ATTN: Debra Monroe** 248.906.8411,

Email: ATTN: **Debra Monroe** fss@oaklandchn.org

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

Thank you,

Debra Monroe
FSS Coordinator
Oakland Community Health Network
Email: fss@oaklandchn.org
Fax: 248.906.8411

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: **Debra Monroe, OCHN, Fax: 248.906.8411 / Email: Fss@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.

2024 MICHIGAN Individual Income Tax Return MI-1040

Amended Return
(Include Schedule AM3)

Return is due April 15, 2025. 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 (8 digits)	
City or Town		State		ZIP Code	
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. <input type="checkbox"/> Filer b. <input type="checkbox"/> Spouse			6. FARMERS, FISHERMEN, OR SEAFARERS <input type="checkbox"/> Check this box if 2/3 of your income is from farming, fishing, or seafaring.		
7. 2024 FILING STATUS. Check one. a. <input type="checkbox"/> Single b. <input type="checkbox"/> Married filing jointly c. <input type="checkbox"/> Married filing separately * * If you check box "c," complete line 3 and enter spouse's full name below: <input type="text"/>			8. 2024 RESIDENCY STATUS. Check all that apply. a. <input type="checkbox"/> Resident b. <input type="checkbox"/> Nonresident * c. <input type="checkbox"/> 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.	<input type="text"/>	x \$5,000	9a.	<input type="text"/>	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.	<input type="text"/>	x \$3,300	9b.	<input type="text"/>	00
c. Number of qualified disabled veterans	9c.	<input type="text"/>	x \$600	9c.	<input type="text"/>	00
d. Number of Certificates of Stillbirth from MDHHS (see instructions)	9d.	<input type="text"/>	x \$5,000	9d.	<input type="text"/>	00
e. Claimed as dependent, see line 9 NOTE above	9e.	<input type="checkbox"/>		9e.	<input type="text"/>	00
f. Add lines 9a, 9b, 9c, 9d and 9e. Enter here and on line 15	9f.	<input type="text"/>		9f.	<input type="text"/>	00

10. Adjusted Gross Income from your U.S. Form 1040 (see instructions)	10.	<input type="text"/>	00
11. Additions from Schedule 1, line 9. Include Schedule 1	11.	<input type="text"/>	00
Total. Add lines 10 and 11	12.	<input type="text"/>	00
13. Subtractions from line 12. Include Schedule 1	13.	<input type="text"/>	00
14. Income tax. Subtract from line 13 is greater than line 12, enter "0"	14.	<input type="text"/>	00
15. Exemption allocation. Subtract from line 14. Include NRL line 15	15.	<input type="text"/>	00
16. Taxable income. Subtract line 15 from line 14. If result is greater than 0, enter "0"	16.	<input type="text"/>	00
17. Tax. Multiply line 16 by 4.25%	17.	<input type="text"/>	00

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

Sample



EXECUTIVE DIRECTOR & CEO
Annette Downey

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Dr. Steffan Taub, Vice Chair
Jonathan Landsman, Secretary

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John Paul Torres
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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: Debra Monroe
5505 Corporate Dr.
Troy, MI 48098

Sincerely,

Debra Monroe
FSS Coordinator
Oakland Community Health Network
Fax: (248) 906-8411
fss@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 checked="" 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	
The most recent completed tax year within the last 5 years			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. This authorization expires in six months and is not a substitute for a formal Form 151, Authorized Representative Declaration.				
Appointee Name		E-mail Address		Telephone Number
Debra Monroe (Oakland Community Health Network)		fss@oaklandchn.org		947-345-1576
Address (Street)		City		State ZIP Code
5505 Corporate Drive		Troy		MI 48098
Signature of Taxpayer OR Legal Representative				Date
Signature of Taxpayer OR 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.				
First Year	\$ 5.00	\$5.00		
Additional Year(s)	\$ 3.00 X _____			
FEE TOTAL			\$0.00	
<p>Please allow 60 days for processing your request. 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</p>				
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

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Dr. Steffan Taub, Vice Chair
Jonathan Landsman, Secretary

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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. 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 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"/> |

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"/>				
9. How your application was handled at the community mental health services agency?	<input type="checkbox"/>				
10. The information you received about the program?	<input type="checkbox"/>				
11. Your overall experience with the subsidy program?	<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.

1st most important: _____

2nd most important: _____

3rd 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 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.
