Payment Agreement

Date: _____

Child Name: _____ Date of Birth: _____

Parent Name: _____ Phone Number: _____

Address: _____

City: _____State: _____Zip: _____

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1. Infant Learning Programs are required to charge a fee for some early intervention services, including Occupational, Physical and Speech therapy.
2. Fees are based on rates set by the Department of Health and Social Services. The family's fee amount will be determined according to a sliding fee scale, based on family size and income. No family will be denied services due to inability to pay.
3. This payment agreement may be reviewed and adjusted at any time if there are changes in the family financial situation, such as a change in income or unexpected expenses related to:
   - the child's disability
   - a family medical/health care expense
   - catastrophic life event

I certify that the income and family size I have indicated is accurate. I agree to report any income changes in the next 12 months to this agency.

I agree to pay _____% or $_____ per session for the cost of:

☐ Physical therapy

☐ Occupational therapy

☐ Speech Language therapy

If the payment rate is less than 100% of actual cost of these services, indicate reason for reduced rate:

☐ Rate determined by Sliding Fee Scale

☐ Other reason (explain) _____

Parent Signature: _____ Date: _____

If "Other reason" is used for fee reduction, authorized agency staff must approve this agreement.

Authorized Staff Name: _____Agency approval: _____ Date: _____

2013 SLIDING FEE SCALE FOR EI/ILP THERAPY SERVICES

STATE OF ALASKA, Department of Health and Social Services

Office of Children's Services

323 E 4th Avenue, Anchorage, AK 99501

INSTRUCTIONS TO PARENT:

1) If you know your gross **annual** income, use **SCALE A**.
2) If you know your gross **monthly** income, use **SCALE B**.
3) Look at the scale you are going to use and find your FAMILY SIZE in the Family Size Column and circle that number.
4) After circling your Family Size, follow that row across to the right until you find your family's income range and then circle those numbers.
5) Complete the certification statement and sign your name.

Scale A: Annual Income

Sliding Fee Rate	***0%***	***10%***	***20%***	***30%***	***40%***	***50%***	***60%***	***70%***	***80%***	***90%***
Family Size	**<115%**	**<130%**	**<145%**	**<160%**	**<175%**	**<190%**	**<205%**	**<220%**	**<235%**	**<250%**
1	16,503	18,655	20,808	22,960	25,113	27,265	29,418	31,570	33,723	35,875
2	22,287	25,194	28,101	31,008	33,915	36,822	39,729	42,636	45,543	48,450
3	28,072	31,733	35,395	39,056	42,718	46,379	50,041	53,702	57,364	61,025
4	33,856	38,272	42,688	47,104	51,520	55,936	60,352	64,768	69,184	73,600
5	39,641	44,811	49,982	55,152	60,323	65,493	70,664	75,834	81,005	86,175
6	45,425	51,350	57,275	63,200	69,125	75,050	80,975	86,900	92,825	98,750
7	51,210	57,889	64,569	71,248	77,928	84,607	91,287	97,966	104,646	111,325
8	56,994	64,428	71,862	79,296	86,730	94,164	101,598	109,032	116,466	123,900
Addl.	5,785	6,539	7,294	8,048	8,803	9,557	10,312	11,066	11,821	12,575

Scale B: Monthly Income

Sliding Fee Rate	***0%***	***10%***	***20%***	***30%***	***40%***	***50%***	***60%***	***70%***	***80%***	***90%***
Family Size	**<115%**	**<130%**	**<145%**	**<160%**	**<175%**	**<190%**	**<205%**	**<220%**	**<235%**	**<250%**
1	1,375	1,555	1,734	1,913	2,093	2,272	2,451	2,631	2,810	2,990
2	1,857	2,100	2,342	2,584	2,826	3,069	3,311	3,553	3,795	4,038
3	2,339	2,644	2,950	3,255	3,560	3,865	4,170	4,475	4,780	5,085
4	2,821	3,189	3,557	3,925	4,293	4,661	5,029	5,397	5,765	6,133
5	3,303	3,734	4,165	4,596	5,027	5,458	5,889	6,320	6,750	7,181
6	3,785	4,279	4,773	5,267	5,760	6,254	6,748	7,242	7,735	8,229
7	4,267	4,824	5,381	5,937	6,494	7,051	7,607	8,164	8,720	9,277
8	4,750	5,369	5,989	6,608	7,228	7,847	8,467	9,086	9,706	10,325
Addl.	482	545	608	671	734	796	859	922	985	1,048

Reference: http://aspe.hhs.gov/poverty/13poverty.cfm