CHILD AND FAMILY CONNECTIONS
FAMILY PARTICIPATION FEE EXEMPTION REQUEST

Child's Last Name, First Name & Middle Initial _____

Child's Date of Birth (Month/Day/Year) _____ CBO/EI # _____

Parent/Guardian's First & Last Name _____

You may request exemption from participation fees if your out-of-pocket extraordinary medical expenses or losses due to disaster such as fire, flood or tornado which meet or exceed 15% of your gross income. A decision will be made within ten (10) business days of the Bureau of Early Intervention receiving your request from Child and Family Connections.

Check type of exemption requested:

_____ 1) Exemption due to out of pocket medical expenses, which meet or exceed of 15% of gross income, paid during past 12 months and/or currently owed.

_____ 2) Exemption due to out of pocket expenses, which meet or exceed of 15% of gross income, due to disaster such as fire, flood or tornado, paid during past 12 months and/or currently owed.

Attach documentation:

A. REQUIRED--Copy of computer generated Cornerstone Family Fee Report showing the family's annual fee amount.

B. REQUIRED--Itemized list of medical expenses or disaster losses paid by the family during past 12 months or currently owed, which total, which meet or exceed 15% of the family's annual gross income, AND, for each item listed, copies of paid receipts or invoices showing patient portion currently owed. TIP: Start with largest expenses and stop itemizing when you meet 15%.

C. OPTIONAL—In addition to A and B, other documentation the family believes necessary to prove they should receive exemption from fees, including statement of why they want the additional information considered.

PARENT/GUARDIAN CERTIFICATION:

I certify this information is correct to the best of my knowledge.

PARENT OR GUARDIAN SIGNATURE _____

MAILING ADDRESS _____

CITY, STATE & ZIP CODE _____

DATE SIGNED _____

**CFC MUST SUBMIT FORM AND ATTACHMENTS
TO FAMILY FEE COORDINATOR AT THE DEPARTMENT OF HUMAN SERVICES, BUREAU OF EARLY INTERVENTION FOR DECISION**

Sign below to certify documentation has been reviewed for completeness and accuracy. CFC #: _____

_____ _____

Program Manager Signature *Date* *Service Coordinator Signature* *Date*

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.