



**COUNTY OF YORK - CITY OF POQUOSON  
DEPARTMENT OF SOCIAL SERVICES**



**Parental Co-Payment Screening Form**

**CSA Client:** \_\_\_\_\_

**Screening Date:** \_\_\_\_\_

**CSA Number:** \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Income: \$ \_\_\_\_\_

Income: \$ \_\_\_\_\_

Source: W-2 Pay-Stub Other

Source: W-2 Pay-Stub Other

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

**Please list all household members**

| Name | Age | Relationship |
|------|-----|--------------|
|      |     |              |
|      |     |              |
|      |     |              |
|      |     |              |
|      |     |              |
|      |     |              |
|      |     |              |

**Other Income**

|   | Y                        | N                        | Amount |
|---|--------------------------|--------------------------|--------|
| Do you receive child support for the child receiving services?                | <input type="checkbox"/> | <input type="checkbox"/> | \$     |
| Do you receive SSA benefits for you or your spouse?                           | <input type="checkbox"/> | <input type="checkbox"/> | \$     |
| Does the child receiving services receive SSA benefits?                       | <input type="checkbox"/> | <input type="checkbox"/> | \$     |
| Does the child receiving services receive Supplemental Security Income (SSI)? | <input type="checkbox"/> | <input type="checkbox"/> | \$     |
| Do you receive any income through subsidy?                                    | <input type="checkbox"/> | <input type="checkbox"/> | \$     |
| Do you receive insurance payments as income?                                  | <input type="checkbox"/> | <input type="checkbox"/> | \$     |

**Total Household Income \$**

**Collection Agreement**

I/We, the undersigned, do hereby agree to honor the terms of this parental co-payment agreement. I/We agree to report any changes in income, family size or treatment expenses to the CSA Office. I/We understand that within 30 days of notification of my/our assessed co-payment, I/we may request a reduction or waiver of the co-payment. All requests must be submitted in writing to the CSA office with accompanying evidence of hardship. If the parental co-pay is not paid, there will be additional collection fees and interest charges added to the account and York/Poquoson Social Services will take any necessary actions in order to collect the debt.

|                                 |        |                                 |      |
|---------------------------------|--------|---------------------------------|------|
| Parent/Legal Guardian Signature | Date   | Parent/Legal Guardian Signature | Date |
|                                 |        |                                 |      |
| Name of CSA Screener            | Agency | Signature of CSA Screener       | Date |

| CSA office use only                                   |  |
|---|--|
| <input type="checkbox"/> Fee Assessed \$ _____ /month | <input type="checkbox"/> Fee reduced \$ _____ /month             |
| <input type="checkbox"/> Fee waived, under income     | <input type="checkbox"/> No co-pay, IEP                          |
| <input type="checkbox"/> Fee waived for expenses      | <input type="checkbox"/> No co-pay, support enforcement referral |