# Form EI-17

| Today's Date | Child's Name | Child's DOB | ETID Number |
|---|---|---|---|
| | | | |

## Extraordinary Medical Expenses Worksheet

Parent Name(s): _____

Parent Income: ☐ Weekly (52) ☐ Bi-weekly (26) ☐ Monthly (12) ☐ Bi-monthly (24) Family Size: _____

Pay Stub Date(s) _____

Gross Amount(s) _____

Parent Income: ☐ Weekly (52) ☐ Bi-weekly (26) ☐ Monthly (12) ☐ Bi-monthly (24) Family Size: _____

Pay Stub Date(s) _____

Gross Amount(s) _____

Total Annual Income: _____

Calculations for family income at 210-401% or greater Federal Poverty Level (FPL) may be found at https://ohioearlyintervention.org/system-of-payments.

| Total Annual Income | x | EME | = | Out-of-Pocket Medical Expense |
|---|---|---|---|---|
| | | | | |

I have calculated the anticipated out-of-pocket medical expenses based on the most recent federal poverty level as determined by the US Department of Health and Human Services and published in the Federal register, and have shared this information with the parent. DCY will use this information to make the final determination of the family's extraordinary medical expenses.

EI Service Coordinator Name _____ Date _____

EI Service Coordinator Signature _____

Department of Children & Youth

Help Me Grow Early Intervention