ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Child Care

UNPAID COPAYMENT WORKSHEET

TO:

Child Care Specialist's Name: _____ Fax No. *(Include area code)*: _____

Address *(No., Street, City, State, ZIP)*: _____

FROM:

Provider's Name: _____ Provider P #: _____

Provider Contact Person's Name: _____ Phone No. *(Include area code)*: _____

Parent/Guardian's Name: _____ ID No.: _____

Child(ren)'s Name(s): _____

I have attempted to collect copayment fees and have not received the total amount owed for the time period of *(date)* _____ to *(date)* _____. For this period of time, I estimate that the total amount of additional charges owed is *(amount)* $ _____ and the amount of outstanding copayment owed is $ _____.

I have made the following attempts to collect the outstanding copayment amount:

☐ Oral ☐ Written ☐ Small Claims Court ☐ Other: _____

I understand any payment made by the parent/guardian will first be applied to the outstanding copayment balance.

Provider Contact Person's Signature: _____ Date: _____

COPAYMENT: A fixed daily fee that DES assigns to families based on the eligible family's size and income. The copayment is not to be considered the difference (dollar amount) between the amount that DES reimburses the provider and the provider's actual charges.

ADDITIONAL CHARGES: Any fee charged by a provider that exceeds the DES reimbursement rate, minus any DES-established copayment, is considered an additional charge. This is the daily amount of the provider rate not subsidized by DES, and is the responsibility of the parent/guardian to reimburse the provider. Additional charges are not to be referred to as copayments.

FOR DES USE ONLY BELOW THIS LINE

Parent or Guardian's Name *(Last, First)*: _____

1. 1st Child's Name: _____ ID No.: _____

   1A. Total Amount of Copayment Owed for Child 1: $ _____

2. 2nd Child's Name: _____ ID No.: _____

   2A. Total Amount of Copayment Owed for Child 2: $ _____

3. 3rd Child's Name: _____ ID No.: _____

   3A. Total Amount of Copayment Owed for Child 3: $ _____

For families receiving Transitional Child Care (TCC) there is no copayment assigned beyond the 3rd child in the family.

4. 4th Child's Name: _____ ID No.: _____

   4A. Total Amount of Copayment Owed for Child 4: $ _____

5. 5th Child's Name: _____ ID No.: _____

   5A. Total Amount of Copayment Owed for Child 5: $ _____

See page 2 for EOE/ADA disclosures

6. 6th Child's Name: _____ ID No.: _____

6A. Total Amount of Copayment Owed for Child 6: $ _____

7. Total Copayment Amount Owed *(Add 1A, 2A and 3A)*: $ _____

8. Total Amount Paid by Parent or Guardian During the Above-Stated Period: $ _____

9. Copayment Amount Owed by Parent or Guardian *(if the amount entered on line 7 is greater than the amount on line 8, subtract line 8 from line 7 and enter the remainder here.)*: $ _____

10. No Copayment Owed by Parent or Guardian *(If the amount entered on line 7 is equal to or greater than the amount on line 8, enter 0 here)*: $ _____

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1. Provider Contact Person's Name: _____ Date Provider Contacted: _____

2. Copayment Status: ☐ Resolved ☐ Unresolved *(If unresolved complete #3 below)*

3. Date 30-Day Notice of Action (CC-502) Sent To Client *(Complete #4 and #5 by 30th day)*: _____

4. Provider Contact Person's Name: _____ Date Provider Contacted: _____

5. Copayment Status: ☐ Paid in full ☐ Satisfactory arrangements made ☐ Case closed Date: _____

Verified By: _____ Title: _____ Date: _____