CCA-1021AFORPF (11-11)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Child Care Administration

UNPAID COPAYMENT WORKSHEET

Print | Clear The Form

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/RESPONSIBLE PERSON'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/responsible person 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 RESPONSIBLE PERSON'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 co-payment 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: $
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 RESPONSIBLE PERSON DURING THE ABOVE-STATED TIME PERIOD $

9. COPAYMENT AMOUNT OWED BY PARENT OR RESPONSIBLE PERSON *(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 RESPONSIBLE PERSON *(If the amount entered on line 7 is equal to or greater than the amount on line 8, enter 0 here)* $

1. PROVIDER CONTACT PERSON'S NAME	DATE PROVIDER CONTACTED

2. COPAY MENT 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. COPAY MENT STATUS ☐ Paid in full ☐ Satisfactory arrangements made ☐ Case closed	DATE

VERIFIED BY	TITLE	DATE

See reverse for EOE/ADA/LEP/GINA disclosures.

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UNPAID CO-PAYMENT WORKSHEET

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact 602-542-4248; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Ayuda gratuita con traducciones relacionadas a los servicios del DES está disponible a solicitud del cliente.