APPLICATION FOR REVIEW OF ASSESSED FEE AND COMMITTEE FINDINGS

To be completed by child or person requesting review on behalf of the child

Client/Requester information

Date of Application: Click or tap to enter a date. Date Initial 285D filed with Court: Click or tap to enter a date.

Child Name: _____ Date Entered Licensed Care: Click or tap to enter a date.

FSFN Person ID: _____ Date of Birth: Click or tap to enter a date.

Case Plan Goal: _____

Name of Requester (if different than child): _____

Relationship to Child: _____

Phone Number: _____ Email Address: _____

Type of Request (choose one)

☐ Reduce Cost of Care (amount requesting) $ _____ Period of Time: _____

☐ Change in Allowance to $ _____ Period of Time: _____

Account Balance(s)

Current Needs Account	$	As of Date:	Click or tap to enter a date.
Disabled Special Needs Trust aka "Dedicated Account"	$	As of Date:	Click or tap to enter a date.
Long Term Needs Account	$	As of Date:	Click or tap to enter a date.
PASS Account	$	As of Date:	Click or tap to enter a date.
ABLE Account	$	As of Date:	Click or tap to enter a date.

Financial Information

Monthly		**Source of Income**			
Total Income/Benefit Received	$	☐ SSI	$	☐ Wages	$
Monthly Cost of Care	$	☐ SSA	$	☐ Trust	$
		☐ VA	$	☐ Child Support	$
		☐ Other	$		

Criteria – This section includes the required components, per 65C-17.004, to be considered in the assessment of requests to reduce fees. *Attach documentation to substantiate request, i.e. Master Trust Expenditure Plan, an itemized budget, vendor quotes or estimates, bills, or certified statements.*

Reason for request –

Expressed Preferences of the Client – *If age and developmentally appropriate, explain the client's preferences in relation to their short-term and long-term goals. For example, a client may have interests that require specialized training, classes, or equipment to meet a specific goal.*

Needs of the Child – *Explain how the requested services, equipment, or items being purchased can potentially improve the client's quality-of-life.*

Status of the Case – *Explain how the requested funds will be utilized to promote a successful outcome in achieving the goal. For example, if the goal is reunification, will the account balances make the client or family ineligible for benefits upon returning home? If the goal is APPLA, will the funds assist the client in achieving their educational and vocational goals*

APPLICATION FOR REVIEW OF ASSESSED FEE AND COMMITTEE FINDINGS

Amount and Duration – *Explain the amounts of money currently available to the client including master trust subaccounts and other income or assets the client may have outside of master trust. If the client receives SSI benefits, the Master Trust Expenditure Plan must reflect that the funds that would accumulate upon approval will not exceed the maximum countable $2,000 resource limit.*

Other Reasonable Resources Available – *Explain what efforts were made prior to making this request to utilize other family or community resources to meet the needs of the client.*

REQUESTER'S SIGNATURE: **DATE:** Click or tap to enter a date.

Fee Waiver Committee Notes and Recommendation *(To be filled out by Committee Chair):*

Date Fee Waiver request received: Click or tap to enter a date.

Date of Fee Waiver Committee Meeting: Click or tap to enter a date.

COMMITTEE MEMBERS:

Name	Title

ATTENDEES (other than committee members):

COMMITTEE FINDINGS:

COMMITTEE RECOMMENDATION:

☐ APPROVED ☐ NOT APPROVED

Request for reduced fee is approved for the amount of: $

Effective Date: Click or tap to enter a date. Duration *(not to exceed 6 months):*

COMMITTEE MEMBER SIGNATURES:

DECISION OF FAMILY WELL-BEING DIRECTOR or DEPARTMENT DESIGNEE *(Not Permitted to be from Lead Agency):*

☐ APPROVED ☐ DENIED

Name: Title:

Signature: Date: Click or tap to enter a date.

If the request for fee waiver or change in allowance is denied, the client or requester has the right to request a Chapter 120, F.S., administrative hearing within 30 days of the decision. Requests for a 120 hearing may be directed to the Department.