ANNUAL FAMILY PROGRAM FEE - PAYMENT FORM (SECOND NOTICE)

Consumer's Name	RC#	# UCI # Fiscal Year of Assessment		Amount Paid
(Please provide information on	the back for other sib	olings receiving region	al center services.)	
Program Fee of \$ Institutions Code Section 47	for services provions (785). One fee is ass The annual income a	ded to your child. Tl essed per family reg mount used to set y	am Fee. You have been assessed an his fee is authorized by state law (Wardless of the number of children rour fee depends on your family size amount.	elfare and eceiving
	your regional cente	r in order to reduce	r for further information. Docume your fee. **DO NOT send your final global center.	
disagree with your fee asses complete a Fair Hearing Rec	ssment. If you wish quest form within 30	to have your fee ass days of the assessr	a an opportunity to request a fair he sessment reviewed under this statu nent date. You may access this for v.dds.ca.gov), form number DS 180	te, you must m through the
order, payable to "DDS-Ann	ual Family Program	Fee." Please includ	om of this form when you mail your le the UCI and RC numbers shown a MasterCard by calling 800-862-000	bove on your
If you have any questions r	egarding your fee, p	olease contact your	regional center.	
IMPORTANT: DETACH AND RETU	RN THE BOTTOM PORTI	ON OF THIS STATEMEN	T WITH YOUR PAYMENT TO ENSURE PROP	ER CREDIT
ANNUAL FAN	ЛILY PROGRA	M FEE - PAYN	IENT FORM (SECOND NO	OTICE)
Indicate Regional Center and	d UCI # on all inquiri	es and payments.		
Consumer's Name	RC#	UCI#	Fiscal Year of Assessment	Amount Paid
(Please provide information on	the back for other sib	lings receiving region	al center services.)	

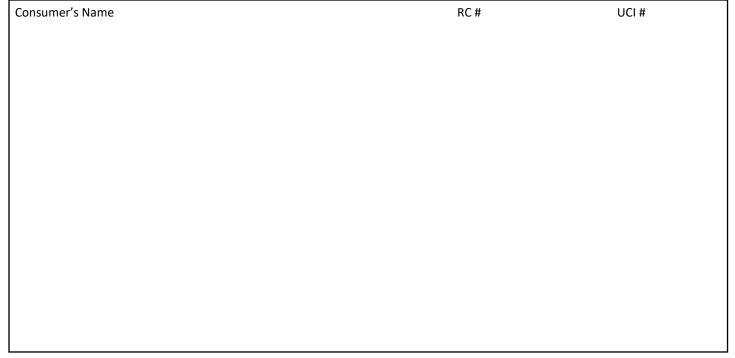
(Confidential Consumer Information - California Welfare and Institutions Code 4514)

Mail to: California Department of Developmental Services

Client Financial Services 1215 O Street MS 10-30 Sacramento, CA 95814

ANNUAL FAMILY PROGRAM FEE - PAYMENT FORM (SECOND NOTICE)

Each family with an AFPF eligible child or children receiving services through the regional center are assessed a single annual fee. Please provide information below on other siblings receiving regional center services.



Families with annual incomes at or above 800 percent of the Federal Poverty Level (FPL) are assessed an annual fee of \$200.00. Families with incomes between 400 and 799 percent of the FPL are assessed an annual fee of \$150.00. Families with incomes below 400 percent of the FPL are not assessed a fee. Please use the chart below to estimate your fee amount based on family size and parents' annual income.

If you think your income qualifies you for lower fee, please contact the regional center.

SIZE	ANNUAL INCOME	FEE	ANNUAL INCOME	FEE	ANNUAL INCOME	FEE
2	\$0 - \$67,639	\$0	\$67,640 - \$135,279	\$150	\$135,280 - Over	\$200
3	\$0 - \$85,319	\$0	\$85,320 - \$170,639	\$150	\$170,640 - Over	\$200
4	\$0 - \$102,999	\$0	\$103,000 - \$205,999	\$150	\$206,000 - Over	\$200
5	\$0 - \$120,679	\$0	\$120,680 - \$241,359	\$150	\$241,360 - Over	\$200
6	\$0 - \$138,359	\$0	\$138,360 - \$276,719	\$150	\$276,720 - Over	\$200

For family size larger than above visit the DDS website (https://www.dds.ca.gov)