ANNUAL FAMILY PROGRAM FEE - PAYMENT FORM

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.)				
number of children receiving	Ifare and Institution g services. It is a year	ns Code Section 478 arly fee. The annua	for services provided to your of 5). One fee is assessed per family relatives I income amount used to set your for s form for additional information or	regardless of the ee depends on			
center. DO NOT ser	nd financial docume	ents or corresponde	ncome, you must contact your regi ence in the enclosed envelope or to ur regional center for instructions.				
disagree with your fee asses complete a Fair Hearing Rec	sment. If you wish Juest form within 30	to have your fee as: Odays of the assessi	n an opportunity to request a fair he sessment reviewed under this statu ment date. You may access this for w.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 de the UCI and RC numbers shown a MasterCard by calling 800-862-000	bove on your			
If you have any questions re	egarding your fee, p	olease contact your	regional center.				
IMPORTANT: DETACH AND RETU	RN THE BOTTOM PORT	ION OF THIS STATEMEN	T WITH YOUR PAYMENT TO ENSURE PROP	ER CREDIT			
ANNUAL FAMILY PROGRAM FEE - PAYMENT FORM							

Indicate Regional Center and UCI # on all inquiries and payments.

Consumer's Name RC # UCI # Fiscal Year of Assessment Amount Paid

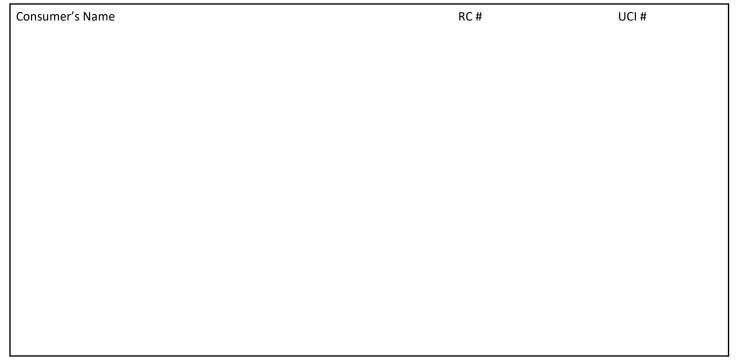
(Please provide information on the back for other siblings receiving regional center services.)

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

Mail to: California Department of Developmental Services
Client Financial Services
1600 Ninth Street, Room 205, MS 2-3
Sacramento CA 94244-2020

ANNUAL FAMILY PROGRAM FEE - PAYMENT FORM

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 you qualify for a reduced fee, contact your regional center for reassessment instructions. DO NOT PROVIDE INCOME INFORMATION TO DDS.

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)