

# Form EI-17

Today's Date

Child's Name

Child's DOB

ETID Number

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## Extraordinary Medical Expenses Worksheet

Parent Name(s): \_\_\_\_\_

Parent Income:  Weekly (52)  Bi-weekly (26)  Monthly (12)  Bi-monthly (24) Family Size: \_\_\_\_\_

Pay Stub Date(s) \_\_\_\_\_

Gross Amount(s) \_\_\_\_\_

Parent Income:  Weekly (52)  Bi-weekly (26)  Monthly (12)  Bi-monthly (24) Family Size: \_\_\_\_\_

Pay Stub Date(s) \_\_\_\_\_

Gross Amount(s) \_\_\_\_\_

Total Annual Income: \_\_\_\_\_

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Calculations for family income at 210-401% or greater Federal Poverty Level (FPL) may be found at <https://ohioearlyintervention.org/system-of-payments>.

\_\_\_\_\_ x \_\_\_\_\_ = \_\_\_\_\_  
Total Annual Income EME Out-of-Pocket Medical Expense

I have calculated the anticipated out-of-pocket medical expenses based on the most recent federal poverty level as determined by the US Department of Health and Human Services and published in the Federal register, and have shared this information with the parent. DCY will use this information to make the final determination of the family's extraordinary medical expenses.

\_\_\_\_\_  
EI Service Coordinator Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
EI Service Coordinator Signature



**Department of  
Children & Youth**

Help Me Grow Early Intervention