Form EI-17

ſoday's Date	Child's Name	Child's DOB	ETID Number
Extraordinar	y Medical Expenses	Worksheet	
Parent Name(s):			
Parent Income: V	Veekly (52) Bi-weekly (26)	Monthly (12) Bi-month	ly (24) Family Size:
Pay Stub Date(s)			
Gross Amount(s)			
Parent Income: 🗌 V	Veekly (52) 🗌 Bi-weekly (26) 📘]Monthly (12) 🗌 Bi-month	ly (24) Family Size:
Pay Stub Date(s)			
Gross Amount(s)			
Total Annual Income			
	ly income at 210-401% or greate rvention.org/system-of-payment		may be found at
<u>inteps, y on ocanymed</u>	inention.org/system of payment	<u>.</u> .	
Total Annual Income	e x EME	=	-of-Pocket Medical Expense
	anticipated out-of-pocket medie e US Department of Health and H	•	, ,
	rmation with the parent. DCY wi inary medical expenses.	Il use this information to mak	te the final determination of
, ,			
El Service Coordinate	or Name	Da	ate
El Service Coordinate	or Signature		
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