



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: _____ Date Initial 285D filed with Court: _____
 Child Name: _____ Date Entered Licensed Care: _____
 FSFN Person ID: _____ Date of Birth: _____
 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: _____
 Disabled Special Needs Trust aka "Dedicated Account" \$ _____ As of Date: _____
 Long Term Needs Account \$ _____ As of Date: _____
 PASS Account \$ _____ As of Date: _____
 ABLE Account \$ _____ As of Date: _____

Financial Information

Monthly		Source of Income			
Total Income/Benefit Received	\$ _____	<input type="checkbox"/> SSI	\$ _____	<input type="checkbox"/> Wages	\$ _____
Monthly Cost of Care	\$ _____	<input type="checkbox"/> SSA	\$ _____	<input type="checkbox"/> Trust	\$ _____
		<input type="checkbox"/> VA	\$ _____	<input type="checkbox"/> Child Support	\$ _____
		<input type="checkbox"/> 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*



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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: _____

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

Date Fee Waiver request received: _____

Date of Fee Waiver Committee Meeting: _____

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: _____ 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: _____

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.