OFFICE FOR CHILDREN WITH SPECIAL CARE NEEDS
GUARANTY OF PAYMENT AGREEMENT

I, _____,
Full Printed Name

agree that I will be responsible to pay billed charges for care provided to me through the Office for Children with Special Health Care Needs (OCSHCN) and will send OCSHCN payment I receive through medical, sickness, liability or accident insurance for care provided by OCSHCN so that these monies may be applied to the actual cost of my treatment as required by state law (KRS 200.470)

_____ _____
Signature Date

The Office for Children with Special Health Care Needs does not discriminate against any person based on political belief, race, color, national origin, religion, age, mental or physical disability, or sex.

_____
(*OCSHCN Use Only – CUP ID*)