ATTACHMENT B

2005
CCE/ADI ELIGIBILITY /FINANCIAL WORKSHEET
AND ASSESSED CO-PAYMENT FORM

1. Client's Name _____ Spouse's Name _____

2. **MONTHLY INCOME INFORMATION**

What is your monthly income? Please fill in all sources received:

	Individual	Spouse	Total
a. Social Security (SSA) (including Medicare premium)	$	$	$
b. Supplemental Security Income (SSI)			
c. Veteran=s Administration (VA)			
d. Disability Payments including Worker=s Compensation (SSA and VA disability are under a. or c.)			
e. Retirement Pensions (Railroad, Union, Government, Private)			
f. Interest and Dividend (IRAs, CDs or Bank Accounts), or annuity Income including Civil Service			
g. Rental Property Income			
h. Estate/Trust Fund Income			
i. Alimony			
j. Regular Contributions from another person			
k. Temporary Assistance for Needy Families (AFDC)			
l. Other income			
Total Gross Monthly Income			

3. **ASSESSED CO-PAYMENT MONTHLY AMOUNT (FROM ATTACHMENT B) $_____**

EXEMPTIONS: Medicaid Waiver, HCE, ESI clients and other individual clients or couples with less than $1.00 per month in income.

4. ASSET INFORMATION

Complete this information if the client has income under $579 a month ($869 for a couple) or is functionally eligible for Medicaid Waiver services and has $1,737 or less in monthly income ($3,474 for a couple).

Include the following:

	Individual	Spouse	Total
a. More than one car (if car is under 7 years old or over 25 years old)	**$**	**$**	**$**
b. Cash surrender value of Life Insurance Policies (only if total face value is over $2,500)			
c. Checking Account(s)			
d. Saving Account			
e. Cash on hand			
f. Certificate(s) of Deposit			
g. Individual Retirement Account(s)			
h. Revocable Burial Contract			
i. Trust(s)			
j. Stocks/Bonds/Mutual Funds			
k. Real Property (not homestead)			
Total Assets:			
Deduct $2,500 for an individual burial or $5,000 for a couple burial			
Subtotal Assets:*			

***If the individual client has $2,000 or less in assets or the couple has $3,000 or less in assets, refer the client to the Department of Children and Family Services for a complete Medicaid eligibility determination.**

5. CLIENT STATEMENT AND SIGNATURE

By my signature below, I do hereby swear or affirm that the income and asset information that I have provided is a true and correct statement of present financial circumstances. I also authorize and agree to release to any appropriate representative of either the Community Care for the Elderly or Alzheimer's Disease Initiative program, as applicable, any financial records needed to verify any financial information. I agree to pay the co-pay amount assessed for services delivered. The co-pay amount will not exceed the cost of the services I receive each month. I have been informed of my right to request a review by the provider agency to resolve any disagreements regarding the co-payments to be charged for services. If the resolution is still unsatisfactory to me, I can appeal to the area agency on aging.

_____

Client or Responsible Party's Signature **Date**

_____ _____

Worksheet Prepared By **Date**

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2005 Update