

DEPARTMENT FOR THE BLIND AND VISION IMPAIRED Financial Determination/Redetermination Statement

Name: _____

Address: _____

Participant's Case No.: _____

A. SOURCE GROSS MONTHLY INCOME					
(1)	(2)	(3)	(4)	(5)	(6)
W A G E S	S S D I	S S I	O A S I	O T H E R	Total Amount

MEMBERS OF FAMILY UNIT:		
Name	Age	Relationship

B. TOTAL GROSS MONTHLY INCOME: ----- \$

C. HOSPITALIZATION:

Name of Company: _____ Policy Number: _____

Check appropriate block(s) and enter insurance number(s). Check Part B block if customer is insured under Medicare – Part B.

Medicare #: _____ Part B Medicaid #: _____

Other Comparable Benefits:

D. Liquid assets & allowance: E. Monthly income & allowance

1. Cash	+ \$ _____	1. Monthly income from B	+ \$ _____
2. Bank Deposits	+ \$ _____	2. Standard Allowance	+ \$ _____
3. Stocks/Bonds	+ \$ _____	3. Exceptional Allowance:	
4. Other	+ \$ _____	a. Medical Debts	+ \$ _____
5. Total Liquid Asset =	\$ _____	b. Educational/Customer	+ \$ _____
6. Standard Allowance -	\$ _____	c. Educational/Family	+ \$ _____
7. Surplus	= \$ _____	4. Total of E2 thru E3c	- \$ _____
		5. Surplus/Difference (-)	= \$ _____

F. FINANCIAL VERIFICATION = (Check one)

To the best of my knowledge, this is an accurate financial statement. I understand it is my responsibility to apply for, and use, any comparable benefit for which I may be entitled and to inform DBVI within 10 days of any changes in my financial situation. I realize if I knowingly provide incorrect information, I may be subject to legal action.

I understand, by choosing not to disclose my financial status, I am ineligible for services based on financial need.

Signature: Consumer, Parent, or Guardian

Date

Signature of Worker Collecting Financial Data

G. CONSUMER'S PARTICIPATION IN COST OF SERVICES:

1. Consumer has no participation in cost of services. Proceed to G7.

Consumer is responsible for participation in cost of services with monthly contribution.

If D7 Equal zero and E5 greater than zero, complete G4, and sign G7
If D7 & E5 are greater than zero, complete G2, G3, G4, G5, & sign G7
If D7 Greater than zero & E5 zero or less, complete G3, G4 (negative number), G6, & sign G7.

2. The number of months anticipated to complete the rehabilitation plan is 12.

3. Liquid Assets and Allowance:

Line D7 _____ divided by line G2 _____ = \$ _____ monthly contribution.

4. Monthly Income & Allowance:

(Enter E5 in G4 monthly contribution space) = \$ _____ monthly contribution.

5. If Liquid Assets and Allowance Exceed Zero AND Monthly Income and Allowance Exceed Zero then:

Line G3 _____ plus line G4 _____ = \$ _____ monthly contribution.

