ATTACHMENT B

2008

COMMUNITY CARE FOR THE ELDERLY (CCE) and ALZHEIMER'S DISEASE INTITATIVE (ADI)
ELIGIBILITY /FINANCIAL WORKSHEET
AND ASSESSED CO-PAYMENT FORM

EXEMPTIONS: Completion of this form is not required for Adult Protective Services (APS) high-risk referrals and clients receiving Home Care for the Elderly and Medicaid waiver services.

1. CLIENT'S NAME _____ **SPOUSE'S NAME** _____

2. MONTHLY INCOME INFORMATION - Fill in all sources received.

	Individual	Spouse	Total
a. Social Security (SSA), including Medicare premium	$	$	$
b. Supplemental Security Income (SSI)			
c. Veterans Administration (VA) benefits			
d. Disability Payments, including Worker's Compensation (Exclude disability payments reported under a. and c.)			
e. Retirement Pension (Railroad, Union, Government and Private)			
f. Interest/Dividend Income: Individual Retirement Accounts (IRAs); Certificates of Deposits (CDs); bank accounts and 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 (TANF)			
l. Other Income			
Total Gross Monthly Income			

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

4. ASSET INFORMATION – Fill in all sources.

	Individual	Spouse	Total
a. More than one car (if car is less than 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(s)			
e. Cash on hand			
f. Certificate(s) of Deposit (CDs)			
g. Individual Retirement Account(s) (IRAs)			
h. Revocable Burial Contract			
i. Trust(s)			
j. Stocks/Bonds/Mutual Funds			
k. Real Property (not homestead)			
Total Assets:			
Deduct up to $2,500 in burial funds for an individual (up to $5,000 in burial funds for a couple)			
Subtotal Assets:			

5. CLIENT'S STATEMENT AND SIGNATURE

By my signature below, I do hereby affirm that the income and asset information I have provided is a true and correct statement of my present financial circumstances. I also authorize and agree to release to any appropriate representative of the Community Care for the Elderly program or Alzheimer's Disease Initiative, as applicable, any financial records needed to verify financial information. I agree to pay the co-pay amount assessed for services delivered. I understand that 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 understand that I may appeal to the area agency on aging.

Signature of Client or Responsible Party **Date**

Name of Worksheet Preparer **Date**