

**ALCOHL AND DRUG ADMINISTRATION
HALFWAY HOUSES * TERM CARE FACILITES * RESIDENTIAL ICF
ABILITY TO PAY SCHEDULE WROKSHEET**

CLIENT'S NAME _____

SOCIAL: SECURITY NUMBER _____ NUMBER IN FAMILY
(INCLUDING CLIENT) _____

A. **MONTHLY HOSUEHOLD NET INCOME*** \$ _____

- Enter monthly net family or household income.
Net income is the gross income (both earned and unearned) less mandatory Deductions: i.e. State federal FICA taxes.
- Income must be documented and must be retained in the client's record
- A quarterly review of the client's income must be performed to determine any income changes.

B. **MONTHLY PERSONAL ALLOWANCE** \$ _____

- The standard personal allowance is \$60.00
- The Personal Allowance must be increased to \$85.00 for clients who receive SSI Payments
- With the exception of SSI patients, the personal allowance may be reduced at the discretion of the Program Director.
The reason for the reduction must be documented.

C. **MONTHLY FAMILY ALLOWANCE** \$ _____

- Enter **\$0** if the client **does not** have financial responsibility for other persons.
- Enter the Monthly Family Allowance from Table 1 if client **has** financial responsibility for other persons.

D. **ADDITIONAL MONTHLY ADJUSTMENTS**
(e.g. Job Related Transportation. Medical Bills, living expenses in excess Living expenses include rent or mortgage, food, utilities, insurance).
Adjustments must be Documented

E. **NET MONTHLY ALLOWABLE INCOME (A-B-C-D=E)** \$ _____

F. **DAILY AMOUNT AVAILABLE (Sum of E/30=F)** \$ _____

G. **DHMH APPROVED DAILY PROGRAM RATE** \$ _____

- This rate is shown on your most recently approved Schedule of Charges.
- The rate on the Schedule of Charges is the only rate that may be used.

H. **DAILY AMOUNT TO BE CHARGED (Lower amount of F or G)** \$ _____

Clients Signature

Date

Program Official Signature

Date

*This worksheet must be kept in the client's medical record.

**A new worksheet must be completed at any time the client's income changes.

REVISED 06/01/11