

**MARYLAND MEDICAL ASSISTANCE PROGRAM
INCOME AND SHELTER EXPENSE REPORTING FORM
FOR COMMUNITY SPOUSE**

CASE NAME: _____

C.I.D. _____

My monthly income is _____.

My monthly expenses for shelter are _____.

(Please indicate monthly amounts and attach form (s) of verification below.)

<u>Source of income</u>	<u>INCOME</u> Monthly Amount	<u>How Verified</u>
Social Security	\$ _____	_____
Veterans Benefits	_____	_____
Pension	_____	_____
Earned Income	_____	_____
Other	_____	_____
Total	\$ _____	

<u>Source of Expenses</u>	<u>SHELTER EXPENSES</u> Monthly Amount	<u>How Verified</u>
Rent	\$ _____	_____
Mortgage Payment	_____	_____
Condo Fees	_____	_____
Property Taxes	_____	_____
Homeowner's Insurance	_____	_____
Heat (if not included in rent)	_____	_____
Water	_____	_____
Gas and Electric	_____	_____
Total	\$ _____	

I do not want a Spousal Allowance.

I, the undersigned, declare the information provided above to be accurate and true.

Signature of Spouse

Date