



Financial Eligibility Form

We are required by law to keep information about you confidential. The information is not to be passed on to anyone else or to be used for any purpose other than to establish financial eligibility to access state funded services.

Client's Legal Name: _____
Client ID: _____
Provider Name: _____
Client Social Security Number: _____

Submission Type	
<input type="checkbox"/>	Initial
<input type="checkbox"/>	Financial Eligibility Update
Date Completed	

ELIGIBILITY DETERMINATION

All dollar amounts should be for the prior month.

1. Do You Have Insurance? To include Medicare, Veteran's benefits or other third party insurance.	
2. Do You Have Medicaid? If yes, include Medicaid number here: _____	
3. Number of People in Residence: Number of all individuals related to you by blood or marriage living on the property, including applicant, excluding those adults whose income is not considered.	
4. Current Gross Income for Residence: When calculating the gross income of the family household, an adult residing with one or more parents, relatives or unrelated individuals shall constitute a separate family household as long as that adult is not claimed as a dependent of any parent, relative or unrelated individual for income tax purposes. Therefore, only that individual's income and the income of his or her spouse and dependent children (if residing in the same household) shall be considered when establishing the family unit for purposes of calculating his or her ability to pay consistent with IDAPA 16.07.01.	
5. Court-Ordered Obligations All Financial payments which have been ordered by a court that may include victim's restitution, courts costs and fees, fines, supervision costs, the drug court or mental health court fees, child support, and alimony.	
6. Dependent Support Amount paid for an individual that is dependent on his family's income for over fifty percent (50%) of his financial support; to include child support, elder care, and alimony.	
7. Child care payments necessary for employment	
8. Medical expenses Amount paid for insurance premiums, payments to doctors and hospitals, medication, physical therapy, and dental	

9. Transportation: Amount paid for car payments, gas, insurance, and public transportation.		
10. Extraordinary rehabilitative expenses Those payments incurred as a result of the disability needs of the person receiving services. They include monthly costs for items including, but not limited to, wheelchairs, adaptive equipment, medication, treatment, or therapy which were not included in the medical payments deduction and the annual estimate of the cost of services received.		
11. State and federal tax payments, including FICA		
12. Total Deductions: (Add lines 5 through 11)		
13. Income Amount Used to Determine Eligibility: (Subtract line 12 from line 4)		
14. Reimbursement Rate: (See reimbursement table)		
CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification and/or criminal or civil action. I understand that I may be asked to provide verification of my statements of income, statements of expenses and dependents.		
Client Name and Signature:	Staff Signature:	
Date:	Parent or Guardian Signature:	