CLIENT PAYMENT FOR HOME AND COMMUNITY BASED SERVICES

300% ACF CLIENTS - Post Eligibility Treatment of Income

See Special Instructions for Spousal Protection Clients

Client Name:		County:	
Client ID:		Case Manager:	
		CM Phone #:	

Client's Gross Monthly Income (from all sources) This includes, but is not limited to: Social Security, Railroad Retirement Benefits, Veterans Assistance, Private Pension/Retirement Benefits, or other.	A	$	700.00
Subtract Client's Monthly Allowance Old Age Pension (OAP) amount plus income disregard. Client is responsible for making the ACF room and board payment out of this amount.	B	$	668.00
Subtotal		$	32.00
Subtract Maintenance Allowance for Other Family Member (See Section 8.486.61 B.2. and B.3.)	C		
Subtotal		$	32.00
Subtract Allowances for Client's Non-covered Medical Needs (See Section 8.486.61(4)) This includes, but is not limited to: Health Insurance Premiums, Non-covered Medical Bills, Non-covered Prescription Drugs, Non-covered Medical Supplies and Equipment, Eye, Ear & Dental, and other Medical or Remedial Care (Please specify the non-covered needs and their amount, if you need more room, please attach on another sheet)	D	$	90.00
Total Adjusted Monthly Income	E	$	(58.00)

Client Payment to ACF (Please use either 1. or 2. below, not both)

Line F ACF Monthly Service Amount $ 1,286.46 Line G Standard R&B Amount $ 571.00

If the total Adjusted Monthly Income from above is greater than or equal to the ACF Service amount then:

1. Client's payment for ACF Services (this equals the ACF service amount)	F		n/a
Clients payment for ACF Room and Board	G		n/a
Client's Total Payment to ACF Client keeps any remaining amount.	H		n/a

If the total Adjusted Monthly Income from above is less than ACF service amount then:

2. Client's Payment for ACF Services (this is the total adjusted monthly income)	E	$	-
Client's payment for ACF room and board	G	$	571.00
Client's Total Payment to the ACF	I	$	571.00
Line F $ 1,286.46 minus Line E $ (58.00)			
Monthly amount billable by ACF to fiscal agent for remaining ACF Services (ACF Service amount minus the client's payment for ACF Services)	J	$	1,344.46
Daily Medicaid payment for services	K	$	42.29

Client Payment Amount

Client's Gross Monthly Income (from Above) minus the	A	$	700.00
Client Monthly Payment to Alternative Care Facility		$	571.00
Amount of client's income remaining after ACF payment (excluding deductions in C & D)		$	129.00

I have reviewed the information included on this page and understand that the payments indicated here are due beginning _____ and the 1st of each following month I receive services. I agree to report immediately to my case manager changes of $50 or more in income, expenses, or household makeup which affect my payment amount.

Client's/Guardian's Signature & Date

Case Manager's Signature & Date

Resident Payment to Facility	$	571.00	a month
Provider Reimbursement	$	42.29	a day

Client has small amount of money