LDSS-4345 (1/92)

BUDGET WORKSHEET - MEDICAL ASSISTANCE

LEGALLY RESPONSIBLE RELATIVE (LRR) INCOME CONTRIBUTION WORKSHEET *

DATE:	DATE OF MA APPLICATION:	NAME AND ADDRESS OF APPLICANT/RECIPIENT (A/R)
NAME AND ADDRESS OF LEGALLY RESPONSIBLE RELATIVE		NAME AND ADDRESS OF AGENCY

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

DATE OF BIRTH (LRR)	SOCIAL SECURITY NUMBER (LRR)	TELEPHONE (LRR)	

LEGALLY RESPONSIBLE RELATIVE INCOME

SOURCE OF INCOME:	AMOUNT	NOTES/VERIFICATION
1. LRR'S TOTAL GROSS MONTHLY INCOME		
2. **DEDUCTIONS:** a. HEALTH INSURANCE PREMIUM(S) a. _____ b. INCAPACITATED ADULT/CHILD CARE COSTS (ACTUAL) b. _____ c. COURT-ORDERED SUPPORT (PAID OUT) c. _____ d. OTHER_____ d. _____		
3. TOTAL ALLOWABLE MONTHLY DEDUCTIONS		
4. SUBTRACT #3 FROM #1. THIS IS THE OTHERWISE AVAILABLE INCOME OF THE LRR.		
5. ENTER THE MAXIMUM MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA).		
6. IF #4 IS LESS THAN #5, ENTER THE DIFFERENCE. (A CONTRIBUTION FROM THE LRR SHALL NOT BE REQUESTED.)		
7. IF #4 IS GREATER THAN #5, ENTER THE DIFFERENCE.		
a. ENTER THE FAMILY MEMBER ALLOWANCE(S) IF APPLICABLE (#13).	**a.**	
b. SUBTRACT #7a FROM #7, ENTER THE DIFFERENCE. (IF THIS IS LESS THAN OR EQUAL TO ZERO, A CONTRIBUTION FROM THE LRR SHALL NOT BE REQUESTED.)	**b.**	
c. IF #7b IS GREATER THAN ZERO, MULTIPLY BY .25 AND ROUND DOWN TO THE NEAREST DOLLAR. THIS AMOUNT IS REQUESTED TO BE CONTRIBUTED TO THE A/R'S COST OF MEDICAL CARE.	**c.**	

COMMENTS**:**

WORKER'S SIGNATURE	DATE

* ***NOTE:*** THIS WORKSHEET IS NOT TO BE COMPLETED IF THE SPOUSE RECEIVES COURT-ORDERED SUPPORT FROM THE SSI-RELATED A/R.

FAMILY MEMBER ALLOWANCE(S)

A. NAME:	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SOURCE OF INCOME:	AMOUNT	NOTES/VERIFICATION
8. FAMILY MEMBER'S TOTAL GROSS MONTHLY INCOME		
9. **DEDUCTIONS** a. HEALTH INSURANCE PREMIUM(S) a. _____ b. INCAPACITATED ADULT/CHILD CARE COST (ACTUAL) b. _____ c. COURT-ORDERED SUPPORT (PAID OUT) c. _____ d. OTHER _____ d. _____		
10. TOTAL ALLOWABLE MONTHLY DEDUCTIONS		
11. SUBTRACT #10 FROM #8 AND ENTER THE DIFFERENCE. THIS IS THE OTHERWISE AVAILABLE INCOME OF THE FAMILY MEMBER.		
a. FROM 1/12 OF THE APPLICALBE % OF THE FEDERAL POVERTY LEVEL FOR TWO, SUBTRACT #11 AND ENTER THE DIFFERENCE.		
12. DIVIDE #11a BY 3 AND ENTER THE RESULT ROUNDED UP TO THE NEAREST DOLLAR. THIS IS THE FAMILY MEMBER ALLOWANCE.		

B. NAME:	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SOURCE OF INCOME:	AMOUNT	NOTES/VERIFICATION
8. FAMILY MEMBER'S TOTAL GROSS MONTHLY INCOME		
9. DEDUCTIONS a. HEALTH INSURANCE PREMIUM(S) a. _____ b. INCAPACITATED ADULT/CHILD CARE COST (ACTUAL) b. _____ c. COURT-ORDERED SUPPORT (PAID OUT) c. _____ d. OTHER _____ d. _____		
10. TOTAL ALLOWABLE MONTHLY DEDUCTIONS		
11. SUBTRACT #10 FROM #8 AND ENTER THE DIFFERENCE. THIS IS THE OTHERWISE AVAILABLE INCOME OF THE FAMILY MEMBER.		
a. FROM 1/12 OF THE APPLICABLE % OF THE FEDERAL POVERTY LEVEL FOR TWO, SUBTRACT #11 AND ENTER THE DIFFERENCE.		
12. DIVIDE #11a BY 3 AND ENTER THE RESULT ROUNDED UP TO THE NEAREST DOLLAR. THIS IS THE FAMILY MEMBER ALLOWANCE.		
13. ADD ALL OF THE FAMILY MEMBER ALLOWANCE(S) TOGETHER. THIS IS THE TOTAL FAMILY MEMBER ALLOWANCE(S).		