LDSS-4346 (1/95)

BUDGET WORKSHEET – MEDICAL ASSISTANCE
INSTITUTIONALIZED SPOUSE BUDGET WORKSHEET

ASSESSMENT OF:		NAME AND ADDRESS OF INSTITUTIONALIZED SPOUSE
DATE:	DATE OF APPLICATION	
CASE NAME (And C/O Name if Present) AND ADDRESS		NAME AND ADDRESS OF AGENCY

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

DATE OF BIRTH (Client's Spouse)	SOCIAL SECURITY NUMBER (Client's Spouse)	TELEPHONE (Client's Spouse)	DATE OF INSTITUTIONALIZATION

PART I – ASSESSMENT OF RESOURCES

LIST RESOURCES (Include Name and Numbers of Accounts)	OWNER	VALUE	VERIFICATION
BURIAL FUND: (Amount to be Excluded $)			
BURIAL FUND: (Amount to be Excluded $)			

1. TOTAL COMBINED COUNTABLE RESOURCES	
2. MAXIMUM COMMUNITY SPOUSE RESOURCE ALLOWANCE	
3. RESOURCES OWNED BY THE COMMUNITY SPOUSE	
4. THE COMMUNITY SPOUSE RESOURCE ALLOWANCE (THE MAXIMUM COMMUNITY SPOUSE RESOURCE ALLOWANCE MINUS THE RESOURCES OWNED BY THE COMMUNITY SPOUSE). THIS IS THE TRANSFERABLE AMOUNT TO THE COMMUNITY SPOUSE.	
5. RESOURCES ATTRIBUTED TO THE INSTITUTIONALIZED SPOUSE (THE COMBINED RESOURCES MINUS THE MAXIMUM COMMUNITY SPOUSE RESOURCE ALLOWANCE).	
IF THE INSTITUTIONALIZED SPOUSE APPLIED FOR MEDICAL ASSISTANCE: 6. SUBTRACT THE MEDICAL ASSISTANCE RESOURCE LEVEL FOR ONE.	
7. SUBTRACT DESIGNATED BURIAL FUND(S) (IF NOT LISTED ABOVE).	
8. ENTER ANY EXCESS RESOURCES.	

COMMENTS:

PART II – COMMUNITY SPOUSE INCOME		
A. SOURCE OF MONTHLY INCOME: (INCLUDE ANY COURT-ORDERED SUPPORT RECEIVED)	AMOUNT	NOTES/VERIFICATION
1. 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 ALLOWANCE MONTHLY DEDUCTIONS		
4. SUBTRACT #3 FROM #1. THIS IS THE OTHERWISE AVAILABLE INCOME OF THE COMMUNITY SPOUSE.		
5. ENTER THE MAXIMUM MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA) OR HIGHER AMOUNT ESTABLISHED BY FAIR HEARING OR COURT ORDER.		
6. IF #4 IS LESS THAN #5, ENTER THE DIFFERENCE. THIS IS THE COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE (IF AVAILABLE FROM THE INSTITUTIONALIZED SPOUSE'S INCOME).		
7. IF #4 IS GREATER THAN #5, ENTER THE DIFFERENCE.		
a. IF COMMUNITY SPOUSE RECEIVES COURT-ORDERED SUPPORT FROM THE INSTITUTIONALIZED SPOUSE, GO TO PART III. NO CONTRIBUTION TOWARDS THE COST OF CARE IS REQUESTED NOR IS INCOME AVAILABLE TO OFFSET ANY FAMILY MEMBER ALLOWANCE(S).		
b. IF COMMUNITY SPOUSE **IS NOT** IN RECEIPT OF ANY COURT-ORDERED SUPPORT, ENTER THE FAMILY MEMBER ALLOWANCE(S) (FROM #21), IF APPLICABLE.	b.	
c. SUBTRACT #7b FROM 7, ENTER THE DIFFERENCE. (IF THIS IS LESS THAN OR EQUAL TO ZERO, ENTER THE RESULT IN #12e AS A POSITIVE AMOUNT.)	c.	
d. IF #7c IS GREATER THAN ZERO, MULTIPLY BY .25 AND ROUND DOWN TO THE NEAREST DOLLAR. THIS AMOUNT IS REQUESTED TO BE CONTRIBUTED TO THE INSTITUTIONALIZED SPOUSE'S COST OF CARE.	d.	

PART III – INSTITUTIONALIZED SPOUSE INCOME

B. SOURCE OF MONTHLY INCOME:	AMOUNT	NOTES/VERIFICATION
8. TOTAL GROSS MONTHLY INCOME		
9. **DEDUCTIONS:**	MONTH OF INSTITUTIONALIZATION	CHRONIC CARE
a. $20 INCOME DISREGARD FOR MONTH OF INSTITUTIONALIZATION	a. -20	
b. HEALTH INSURANCE PREMIUM(S)	b.	bb.
c. OTHER _____	c.	cc.
10. TOTAL DEDUCTIONS FROM GROSS INCOME		
11. SUBTRACT #10 FROM #8. THIS IS THE NET MONTHLY INCOME OF THE INSTITUTIONALIZED SPOUSE.		
12. DEDUCTIONS FROM NET MONTHLY INCOME:	(MA LEVEL)	(PNA)
a. SUBTRACT APPROPRIATE INCOME ALLOWANCE.	a.	aa.
b. REMAINING INCOME	b.	bb.
c. SUBTRACT COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE (#6) OR THE AMOUNT OF COURT-ORDERED SUPPORT (PAID OUT TO COMMUNITY SPOUSE) WHICHEVER IS HIGHER. *NOTE*: IF #12b (REMAINING INCOME) IS LESS THAN #6 OR THE AMOUNT OF COURT-ORDERED SUPPORT, ENTER THE AMOUNT FROM #12b. **THIS IS THE ACTUAL AMOUNT OF INCOME AVAILABLE FOR THE COMMUNITY SPOUSE.**	c.	cc.
d. REMAINING INCOME	d.	dd.
e. SUBTRACT AMOUNT FOR FAMILY MEMBER ALLOWANCE(S) (#7 IF COMPLETED, OR #21). *NOTE:* IF #12d (REMAINING INCOME) IS LESS THAN AMOUNT NEEDED FOR FAMILY MEMBER ALLOWANCE(S), ENTER THE AMOUNT FROM #12d. **THIS IS THE ACTUAL AMOUNT OF INCOME AVAILABLE FOR THE FAMILY MEMBER ALLOWANCE(S).**	e.	ee.
f. REMAINING INCOME	f.	ff.
g. SUBTRACT COST OF MEDICAL/REMEDIAL CARE.	g.	gg.
h. REMAINING INCOME	h.	hh.
13. ADD AMOUNT FROM #7d OR THE AMOUNT ACTUALLY CONTRIBUTED FROM THE COMMUNITY SPOUSE.		
14. ADD ANY RESTRICTED INCOME.		
15. TOTAL AMOUNT OF INCOME AVAILABLE FOR THE INSTITUTIONALIZED SPOUSE'S COST OF CARE (NAMI).		

THIS AGENCY WILL PAY FOR HEALTH INSURANCE PREMIUM(S) WHEN IT IS DETERMINED TO BE COST EFFECTIVE AND WHEN THE RECIPIENT'S NET MONTHLY INCOME IS LESS THAN THE AMOUNT NEEDED FOR THE APPROPRIATE INCOME ALLOWNCE(S), THE COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE AND/OR THE FAMILY MEMBER ALLOWANCE(S). WE HAVE MADE THE FOLLOWING DETERMINATION ABOUT YOUR HEALTH INSURANCE PLAN(S):

YOUR HEALTH INSURANCE PLAN FROM (*INSURER*) _____ (*IS/IS NOT*) _____COST EFFECTIVE.

YOUR HEALTH INSURANCE PLAN FROM (*INSURER*) _____ (*IS/IS NOT*) _____COST EFFECTIVE.

THEREFORE, THIS AGENCY (*WILL/WILL NOT*) _____REIMBURSE YOU $_____ FOR YOUR MONTHLY PREMIUM(S) FOR THE PERIOD _____ TO _____. THE PAYMENT OF YOUR MONTHLY PREMIUM(S) (REIMBURSEMENT) WILL BE MADE DIRECTLY TO YOUR **COMMUNITY SPOUSE**. HE/SHE WILL RECEIVE A PAYMANT OF $ _____FOR THE PERIOD INDICATED ABOVE, IN ADDITION TO THE $ _____ THAT IS BEING MADE AVAILABLE FROM YOUR MONTHLY INCOME.

NOTE: **THIS NOTICE ONLY CONCERNS YOUR ELIGIBILITY FOR REIMBURSEMENT FOR YOUR HEALTH INSURANCE PREMIUM(S) UNDER THE MEDICAL ASSISTANCE PROGRAM. THIS IS NOT A DETERMINATION OF YOUR ELIGIBILITY FOR MEDICAL ASSISTANCE PAYMENT OF BENEFITS UNDER THE MEDICARE BUY-IN PROGRAM.**

WORKER'S SIGNATURE	DATE:

PART IV – FAMILY MEMBER INCOME

A. NAME:	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SOURCE OF INCOME	AMOUNT	NOTES/VERIFICATION
16. FAMILY MEMBERS'S TOTAL GROSS MONTHLY INCOME		
17. **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. _____		
18. TOTAL ALLOWABLE MONTHLY DEDUCTIONS		
19. SUBTRACT #18 FROM #16 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 #19 AND ENTER THE DIFFERENCE.		
20. DIVIDE #19a BY 3 AND ENTER THE RESULT ROUNDED UP TO THE NEAREST DOLLAR. THIS IS THE FAMILY MAMBER ALLOWANCE.		
B. NAME:	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SOURCE OF INCOME:	AMOUNT	NOTES/VERIFICATION
16. FAMILY MEMBER'S TOTAL GROSS MONTHLY INCOME		
17. **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. _____		
18. TOTAL ALLOWABLE MONTHLY DEDUCTIONS		
19. SUBTRACT #18 FROM #16 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 #19 AND ENTER THE DIFFERENCE.		
20. DIVIDE #19a BY 3 AND ENTER THE RESULT ROUNDED UP TO THE NEAREST DOLLAR. THIS IS THE FAMILY MEMBER ALLOWANCE.		
21. ADD ALL OF THE FAMILY MEMBER ALLOWANCE(S) TOGETHER. THIS IS THE TOTAL FAMILY MEMBER ALLOWANCE(S).		