

ABILITY-TO-PAY DETERMINATION

RECORD #: _____

DATE: _____

FINANCIAL EVALUATION

NAME: _____

EMPLOYER: _____

ADDRESS: _____

SPOUSE'S NAME: _____

SPOUSE'S EMPLOYER: _____

TYPE OF INSURANCE: _____

SS # _____

NET MONTHLY INCOME (list all Sources):

_____ \$ _____

_____ \$ _____

_____ \$ _____

TOTAL NET MONTHLY INCOME . . . \$ _____ (A)

ADJUSTED INCOME—Line A Less Line B \$ _____ (C)

DAILY INCOME—Line C Divided by 30 \$ _____ (D)

ABILITY-TO-PAY for 15 minutes of Services – (20% of Line D) \$ _____ (E)

ABILITY-TO-PAY for 60 minutes of Service – (4 X line E) \$ _____

Rounded \$ _____ *

LESS: 15% of Line A \$ _____

\$65 x Number Dependents # _____ \$ _____

\$65 x Dependents who are Blind, Handicapped, over 65 or in College # _____ \$ _____

TOTAL DEDUCTIONS \$ _____ (B)

*Minimum Acceptable Payment for any Service is \$ _____ per visit. Maximum payment for each 15 minutes is \$ _____ (i.e. \$ _____ per hour).

FEE *

\$ _____ per 60 minutes/hour

\$ _____ per 45 minutes

\$ _____ per 30 minutes

\$ _____ per 15 minutes

The above information regarding my Income and Dependents is correct and I understand that of the total charge per visit (\$ _____ per hour) I am responsible for payment of the fee.

SIGNED _____

I do not wish to disclose income information and I am willing to pay full cost (\$ _____ per hour).

DATE: _____

SIGNED _____

Reimbursement Clerk _____