

FEE DETERMINATION FORM

CLIENT NAME: _____
 MAILING ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 NO. IN FAMILY UNIT: _____

ANNUAL AMOUNT BY FAMILY MEMBER BY SOURCE
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Income Source	Client	Responsible Party	Spouse	Other Family Member	Total Income for Source
Wage or Salary	\$	\$	\$	\$	\$
Self-Employ (Net)	\$	\$	\$	\$	\$
Social Security	\$	\$	\$	\$	\$
SSI	\$	\$	\$	\$	\$
Dividends, Interest	\$	\$	\$	\$	\$
Retirement	\$	\$	\$	\$	\$
Pensions, Annuities	\$	\$	\$	\$	\$
Veteran's Pension	\$	\$	\$	\$	\$
Unemploy Comp	\$	\$	\$	\$	\$
Alimony	\$	\$	\$	\$	\$
Child Support	\$	\$	\$	\$	\$
Public Assistant	\$	\$	\$	\$	\$
Other:	\$	\$	\$	\$	\$
TOTAL ANNUAL FAMILY INCOME					\$
Number of Dependents					

MEDICAID NUMBER: _____ MEDICARE NUMBER: _____
 INSURANCE CO: _____ POLICY #: _____ INSURED: _____
 INSURANCE CO: _____ POLICY #: _____ INSURED: _____

Facility Representative: _____ Date: _____

I CERTIFY that the information given above is correct to the best of my knowledge. Further, I give my Consent for the agency to verify any of the income listed above through the Department of Labor.

 Signature of Client or Responsible Party

 Date

 NOTARY PUBLIC

This document must be notarized to be considered as a valid proof of income.