DBVI-70-06
Rev 09/23/14

DEPARTMENT FOR THE BLIND AND VISION IMPAIRED
Financial Determination/Redetermination Statement

Name: _____

Address: _____

_____

_____

Participant's Case No.: _____

A. SOURCE GROSS MONTHLY INCOME						
	(1) WAGES	(2) SSDI	(3) SSI	(4) OASI	(5) OTHER	(6) Total Amount
MEMBERS OF FAMILY UNIT:						
Name / **Age** / **Relationship**						

B. TOTAL GROSS MONTHLY INCOME: - - - - - - - - - - - - - - - $

C. HOSPITALIZATION:

Name of Company: _____ Policy Number: _____

Check appropriate block(s) and enter insurance number(s). Check Part B block if customer is insured under Medicare – Part B.

☐ Medicare #: ☐ Part B ☐ Medicaid #:_____

Other Comparable Benefits:

_____

_____

D. Liquid assets & allowance: E. Monthly income & allowance

1. Cash	+ $ _____	1. Monthly income from B	+ $_____
2. Bank Deposits	+ $ _____	2. Standard Allowance + $_____	
3. Stocks/Bonds	+ $ _____	3. Exceptional Allowance:	
4. Other	+ $ _____	a. Medical Debts + $ _____	
5. Total Liquid Asset =	$_____	b. Educational/Customer + $_____	
6. Standard Allowance	- $_____	c. Educational/Family + $ _____	
7. Surplus	= $ _____	4. Total of E2 thru E3c	- $_____
		5. Surplus/Difference (-)	= $

F. FINANCIAL VERIFICATION = (Check one)

☐ To the best of my knowledge, this is an accurate financial statement. I understand it is my responsibility to apply for, and use, any comparable benefit for which I may be entitled and to inform DBVI within 10 days of any changes in my financial situation. I realize if I knowingly provide incorrect information, I may be subject to legal action.

☐ I understand, by choosing not to disclose my financial status, I am ineligible for services based on financial need.

_____ _____ _____

Signature: Consumer, Parent, or Guardian Date

_____
Signature of Worker Collecting Financial Data

G. CONSUMER'S PARTICIPATION IN COST OF SERVICES:

1. ☐ Consumer has no participation in cost of services. Proceed to G7.

   ☐ Consumer is responsible for participation in cost of services with monthly contribution.

If D7 Equal zero and E5 greater than zero, complete G4, and sign G7 If D7 & E5 are greater than zero, complete G2, G3, G4, G5, & sign G7 If D7 Greater than zero & E5 zero or less, complete G3, G4 (negative number), G6, & sign G7.

2. The number of months anticipated to complete the rehabilitation plan is 12.

3. Liquid Assets and Allowance:
   Line D7 _____ divided by line G2 _____ = $ _____ monthly contribution.

4. Monthly Income & Allowance:
   (Enter E5 in G4 monthly contribution space) = $ _____ monthly contribution.

5. If Liquid Assets and Allowance Exceed Zero AND Monthly Income and Allowance Exceed Zero then:
   Line G3 _____ plus line G4 _____ = $ _____ monthly contribution.

6. If Liquid Assets and Allowance Exceeds Zero and Monthly Income and Allowance is Zero Or Less:
   Then Line G3 _____ plus G4 _____ = $ _____ monthly contribution.

7. Signatures:

_____ _____

Signature: Consumer, Parent, or Guardian Date

_____ _____

Signature: VR Counselor/Rehabilitation Teacher Date