DETROIT WAYNE MENTAL HEALTH AUTHORITY (DWMHA)
DETERMINATION OF ELIGIBILITY WORKSHEET

Program Name: Elmhurst Home, Inc.

1. INCOME
(Use Annual Income figures, rounded to the nearest whole dollar)

Client's Earned Income:	1.	$_____
Add (where applicable):		
Spouse (cohabitant) Income:	2.	$_____
(If minor living with parents) Father/Guardian Income:	3.	$_____
Mother/ Guardian Income:	4.	$_____
TOTAL EARNED INCOME: (Add lines 1 thru 4)	5.	$_____
ADD: Additions to Income: (i.e., SSI, SSDI, Unemployment, Workers Compensation, Child Support) Specify:	6a.	$_____
	6b.	$_____
SUBTOTAL: (Add lines 5 thru 6b)	7.	$_____
DEDUCT: Child Support paid for (Children not claimed as dependents) On Income Tax Forms	8.	$_____
Adjusted Annual Income: (Line 7 minus line 8)	9.	$_____

2. DEPENDENTS:

Number of children living in the home: (Include client if minor)	10.	_____
(Number of children not living in the home) but claimed as dependents on Income Tax Forms:	11.	_____
TOTAL DEPENDENTS: (Add Lines 10 & 11)	12.	_____

3. **ABILITY TO PAY:**

Cost per unit of service (treatment day, individual, group, etc.)	13	_____
% Rate Obligation to pay: (on Federal Fee Scale)	14.	_____
Client's Cash Obligation: (unit cost x % rate)	15.	_____
If 15 is less than $1.00 enter $1.00 on line 16)	16.	_____
Expected number of treatment Units:	17.	_____
Total Client Obligation: (16 x 17)	18.	_____

This is a preliminary agreement. The provider may revise this agreement, if changes occur in the client's financial status.

The undersigned client certifies the above income and family information to be true and understands that providing **false infonnation constitutes fraud.**

The client is responsible for paying the client portion of the treatment cost as shown on line 18.

The identified client obligation may be waived by the AMS if the provider provides justification that the identified amount will cause the client undue financial hardship. The AMS will review all pertinent information. See attached Waiver of Client Financial Ability To Pay For services

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

_____ _____
Witness Signature Date

PROVIDER NAME: Elmhurst Home, Inc.

DECLARATION OF INCOME AND SERVICE COST

All questions should be answered; those not applicable must be marked with NA.

I understand that a portion of the cost of services provided to me is being subsidized by public funds. As required by eligibility guidelines, I hereby certify that my personal and household income for the past 12 months was $_____.

I further understand and agree that this amount and the dates that I receive service may be subject to further verification by DWMHA or its treatment contractors. Additionally, this information will be reviewed every 90 days after admission to treatment.

I understand that the co-payment portion of my service cost is my responsibility to pay.

_____ _____

Print Client Name Date

_____

Client Signature

_____ _____

Print Witness Signature Date

_____

Witness Signature