

Attachment I

PA Department of Human Services
Office of Long-Term Living
Attendant Care Program

ACT 150 FEE DETERMINATION/REDETERMINATION FORM

CONSUMER INFORMATION	
Name of Consumer (Last, First MI)	Social Security Number

FAMILY COMPOSITION

NAME – Last, First, M.I.	RELATIONSHIP	SOURCE OF INCOME	MONTHLY GROSS INCOME
	APPLICANT		
TOTAL FAMILY SIZE			
			TOTAL INCOME
			MONTHLY INCOME
			LESS MEDICAL EXPENSE DEDUCTIONS
			ADJUSTED MONTHLY INCOME
			WEEKLY FEE

Change in income/resources which may result in waiver eligibility? YES ___ NO ___

MEDICAL EXPENSE DEDUCTIONS			
ITEM	START DATE	END DATE	EXPENSE

Additional Information attached (check here) | **TOTAL DEDUCTION:**

AFFIRMATION OF INFORMATION
I HEREBY CERTIFY THAT, TO THE BEST OF MY KNOWLEDGE, THE INFORMATION CONTAINED HEREIN IS TRUE, CORRECT, AND COMPLETE. I AGREE TO REPORT ANY CHANGES IN CIRCUMSTANCES IMMEDIATELY TO THIS SERVICE PROVIDER. I UNDERSTAND THAT DOCUMENTATION OF ALL ELIGIBILITY FACTORS MAY BE REQUIRED TO DETERMINE ELIGIBILITY CORRECTLY OR FOR AUDITING PURPOSES. I UNDERSTAND THAT I HAVE A RIGHT TO REQUEST A DEPARTMENT OF HUMAN SERVICES FAIR HEARING. THIS AFFIRMATION STATEMENT COVERS ATTACHMENT REQUIRED FOR THE DETERMINATION OF ELIGIBILITY UNDER THE ACT 150 PROGRAM.

Consumer Signature DATE

Agency Representative Signature DATE