APPENDIX F

New Jersey Department of Health and Senior Services
STATEMENT OF AVAILABLE INCOME FOR MEDICAID PAYMENT

HSP (Medicaid) Case Number _____ LAST, _____ FIRST _____ ELIG. EFF. DATE _____ PRINT DATE _____

SSA Number: _____ Redetermination Date: _____ (MM/YY) _____ COUNTY CODE

Long Term Care Facility: _____ LTCF Provider No.: _____

Address: _____

	LTCF		# 1	# 2	# 3		Remarks
Effective Date							Admit, Change, Redetermination
Social Security Income							Claim #
Buy-In Amount							HIC #
Gross Social Security Benefit							
Railroad/ Veteran							Claim #
Pension/Other Benefit							Specify
Indemnity							Specify
Total Other Income	$		$	$	$		Spouse's S.S.A. #
Total Gross Income	$		$	$	$		M = Married couple same LTCF N = Medically Needy F = Foreign Pension G = VA A+A P = VA Improved Pension
PNA							
Health Premium (Total $)							*Policy #
Other							Specify
Maint./Home							Specify
Month of Adm./ Disch. Exempt							Specify
Med. Needy Spend Down							Specify
Maint./Spouse Dependent							Specify
Discretionary Income							Specify
Total Exempt Income	$		$	$	$		
Available Income	$		$	$	$		R = Representative Payee
Resources Circle One Yes No	SPECIFY (i.e., address)						*Additional Health Insurance Policy Nos.

Name and address of Representative Payee: _____

Signature: IM Worker _____ Date: _____

Supervisor: _____ Date: _____

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