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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-21343A (04/2020) | | | | | | | |  | | | | | | **STATE OF WISCONSIN** | | | | | | | | | | |
| **ALZHEIMER’S FAMILY CAREGIVER SUPPORT PROGRAM (AFCSP) FINANCIAL ELIGIBILITY SCREEN—WORKSHEET 1** | | | | | | | | | | | | | | | | | | | | | | | | |
| Financial eligibility is required to enroll in AFCSP.  Instructions: 1. Verify that at least one member of the household or the person who lives in a CBRF, adult family home or assisted living arrangement has received a final, tentative, or preliminary written diagnosis of Alzheimer’s disease or related irreversible dementia from a physician [see WI Administrative Rule DHS 68.02(6m)]. Verified and on file:  Yes  No.  2. Use this worksheet if the applicant / participant is currently eligible for one of the programs listed below, otherwise proceed to Worksheet 2. | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Applicant or Client (Last) | | | | | | (MI) | (First) | | | | | | | | | | | Date of Application | | | | | | |
|  | | | | | |  |  | | | | | | | | | | |  | | | | | | |
| **CURRENT ELIGIBILITY** | | | | | | | | | | | | | | | | | | | | | | | | |
| Check the program for which the person is currently eligible  Supplemental Security Income (SSI)  Supplemental Security Income-Exceptional Expense Supplement (SSI-E)  Food Stamps  Homestead Credit Claim  Medicaid without Supplemental Security Income (SSI)  If the applicant checks any of the above programs, the person is financially eligible for AFCSP. | | | | | | | | | | | | | | | | | | | | | | | | |
| **NOTE:** Only individuals not enrolled in full-benefit Family Care, or individuals who have applied and who are waiting for Family Care, can access AFCSP funding. When individuals become enrolled in Family Care, enrollment in the AFCSP must terminate. | | | | | | | | | | | | | | | | | | | | | | | | |
| **AUTHORIZATION FOR VERIFICATION** | | | | | | | | | | | | | | | | | | | | | | | | |
| I am eligible for the program(s) checked above. The Alzheimer’s Family and Caregiver Support Program agency has my authorization to verify eligibility. This authorization is valid for one year from signature date and can be revoked by me in writing at any time. | | | | | | | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | |  | | |  | | | | | | | |  |
|  | | **SIGNATURE** – Applicant/Participant or Representative | | | | | | | | | | |  | | | Date Signed | | | | | | | |  |
| Relationship to Applicant / Participant | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Eligibility Verified by | | | | | | | | | | | | | | | | Date Verified | | | | | | | | |
| **ALZHEIMER’S FAMILY CAREGIVER SUPPORT PROGRAM (AFCSP) FINANCIAL ELIGIBILITY DETERMINATION—WORKSHEET 2** | | | | | | | | | | | | | | | | | | | | | | | |
| **PART 1—INCOME DECLARATION** | | | | | | | | | | | | | | | | | | | | | | | |
| For this section, use the combined **gross** annual income for the person with dementia and his/her spouse using figures for the current year. If the current year’s income is too uncertain to estimate, the past year’s income may be used.  Indicate which is being reflected:  Current Year  Previous Year | | | | | | | | | | | | | | | | | | | | | | | |
| Income Source | | | | | | | |  | | Applicant | | | | | |  | | Spouse | | | | | |
| Wages, Salary and Tips | | | | | | | | 1. | |  | | | | | | 11. | |  | | | | | |
| Interest and Dividends | | | | | | | | 2. | |  | | | | | | 12. | |  | | | | | |
| Other Income:  Business Income (or loss – deduct) | | | | | | | | 3. | |  | | | | | | 13. | |  | | | | | |
| Rental Income (or loss – deduct) | | | | | | | | 4. | |  | | | | | | 14. | |  | | | | | |
| Farm Income (or loss – deduct) | | | | | | | | 5. | |  | | | | | | 15. | |  | | | | | |
| Unemployment Compensation | | | | | | | | 6. | |  | | | | | | 16. | |  | | | | | |
| Social Security | | | | | | | | 7. | |  | | | | | | 17. | |  | | | | | |
| Pensions, IRAs, 401(k)s, VA, etc. | | | | | | | | 8. | |  | | | | | | 18. | |  | | | | | |
| Annuities | | | | | | | | 9. | |  | | | | | | 19. | |  | | | | | |
| Additional sources of income [see WI Adm. Rule DHS 68.02(11)] | | | | | | | | 10. | |  | | | | | | 20. | |  | | | | | |
| **TOTAL of Lines 1 through 20** | | | | | | | | | | | | | | | | 21. | |  | | | | | |
| **PART 2—DEDUCTION FOR ALZHEIMER’S-RELATED EXPENSES** | | | | | | | | | | | | | | | | | | | | | | | |
|  | Carry forward the annual household income from line 21 here: | | | | | | | | | | | | | | | | | | 22. | | |  | |
| **A. Alzheimer’s-related expenses purchased in the previous year:**  Annual out-of-pocket expenditures for services by physicians, dentists and other medical professionals and for prescribed medications related to dementia. | | | | | | | | | | | 23. | | |  | | | | |  | | |  | |
| Annual expenditures for health insurance premiums and long-term care insurance purchased for the person with dementia. | | | | | | | | | | | 24. | | |  | | | | |  | | |  | |
| Annual unreimbursed amounts paid to rent or purchase medical equipment, make modifications to the person’s home, or lease vehicles in order to accommodate the person with dementia. | | | | | | | | | | | 25 | | |  | | | | |  | | |  | |
| Annual unreimbursed expenditures for transportation to medical appointments or to participate in community events. | | | | | | | | | | | 26. | | |  | | | | |  | | |  | |
| Other unreimbursed expenses related to caring for the person with dementia (e.g., respite care, adult day care, supportive home care, substitute living arrangements). | | | | | | | | | | | 27. | | |  | | | | |  | | |  | |
| Add lines 23 through 27 | | | | | | | | | | | | | | | | | | | 28. | | |  | |
| Subtract line 28 from line 22 to determine **NET ANNUAL INCOME** | | | | | | | | | | | | | | | | | | | 29. | | |  | |
|  | | | | | | | | | | | | | | | | | | |  | | |  | |
| **B.** | **Is amount on line 29 $48,000 or less?** | | | | | | | | | | | | | | | | | | | | | | |
|  | Yes – The family is eligible. (Complete Part 3 of this worksheet to determine services and goods needed.) | | | | | | | | | | | | | | | | | | | | | | |
|  | No – The family is not eligible. | | | | | | | | | | | | | | | | | | | | | | |
| **PART 3—GOODS AND SERVICES NEEDED BY HOUSEHOLD** **[WI Admin Rule DHS 68.06(2)]** | | | | | | | | | | | | | | | | | | | | | | | |
| **Estimated  Annual Expenses** | | **Description** | | | | | | | | | | | | | | | | | | | Cost | | |
| Personal Care Services | |  | | | | | | | | | | | | | | | | | | |  | | |
| Adult Day Care | |  | | | | | | | | | | | | | | | | | | |  | | |
| Respite Services (Delivered meals or food preparation, minor home maintenance, outdoor chores and housekeeping) | |  | | | | | | | | | | | | | | | | | | |  | | |
| Adaptive Equipment | |  | | | | | | | | | | | | | | | | | | |  | | |
| Minor Home Modifications | |  | | | | | | | | | | | | | | | | | | |  | | |
| Personal Hygiene Products | |  | | | | | | | | | | | | | | | | | | |  | | |
| Other(s)—specify: | |  | | | | | | | | | | | | | | | | | | |  | | |
| **TOTAL - Record on line 1 below** | | | | | | | | | | | | | | | | | | | | |  | | |
| 1. Enter the total cost of goods and services determined by the county or tribe needed for the caregiver to maintain the person with dementia as a member of the household. | | | | | | | | | | | | | | | | | | | | |  | | |
| 1. Enter $4,000 **OR** your agency’s established Maximum Annual Service Payment | | | | | | | | | | | | | | | | | | | | |  | | |
| 1. Enter the lesser of lines 1 or 2 This is the annual service payment that can be authorized by the county or tribe. | | | | | | | | | | | | | | | | | | | | |  | | |
| **DECLARATION AND AUTHORIZATION:** I affirm that the information I have given is true to the best of my knowledge.  I authorize the Alzheimer’s Family Caregiver Support Program agency to verify any and all information that I have provided.  This authorization is valid for one year from the signature date.  I understand that I can revoke this authorization in writing at any time. | | | | | | | | | | | | | | | | | | | | | | | |
| Name – Applicant or Client (Last) | | | (MI) | (First) | | | | | **SIGNATURE** | | | | | | | | | | | Date Signed | | | |
|  | | |  |  | | | | |  | | | | | | | | | | |  | | | |