

ELDERLY, BLIND OR DISABLED (EBD) RELATED DETERMINATION

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

Primary Person Name	Social Security Number
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			Certify From _____ To _____ New Recertification Change Date _____ Worker _____	Certify From _____ To _____ New Recertification Change Date _____ Worker _____	Certify From _____ To _____ New Recertification Change Date _____ Worker _____
1	ENTER	Number in MA Group			
		Number in Fiscal Test Group			
2	ENTER	Asset Limit (CAT)			
3	ENTER	Asset Limit (MED)			
4	ENTER	Nonexempt Assets			
5	ENTER	Gross Monthly Earned Income			
6	ENTER	Room and Board Profit			
7	ADD	(Line 5) + (Line 6)			
8	ENTER	\$65 + ½ of his/her gross earnings			
9	SUBTRACT	(Line 7) – (Line 8)			
10	ENTER	Total Unearned Income			
11	ADD	(Line 9) + (Line 10)			
12	ENTER	Special Exempt Income			
13	SUBTRACT	(Line 11) – (Line 12)			
14	ENTER	\$20 Disregard			
15	SUBTRACT	(Line 13) – (Line 14) <i>Monthly Budgetable Income</i>			
16	ENTER	Categorically Needy Monthly Income Limit			
17	ENTER	Shelter Cost			
18	ADD	(Line 16) + (Line 17) <i>Shelter Adjusted Categorically Needy Income Limit</i>			
19	ENTER	Medically Needy Monthly Income Limit			
20	SUBTRACT	(Line 15) – (Line 19)			
21	MULTIPLY	(20) x 6 (Months) = Deductible			

RETAIN COMPLETED FORM IN CASE RECORD