



State of Connecticut
Department of Economic and
Community Development

Office of Housing Development and Finance

**All Sponsors – Congregate with Assisted
Living Services**

Notice: 09-07

Distribution Date: March 30, 2009

Effective: April 1, 2009

SUBJECT: REVISED TENANT CONGREGATE HOUSING WORKSHEET

Please be advised that the W-1523 Applied Income Worksheet has been revised effective April 1, 2009.

Enclosed for your use is a revised sample form for calculating the Tenant Contribution for persons receiving assisted living services updated to match the Department of Social Services revised applied income.

Please note that the form is available in an electronic format upon request.

Should you have any questions, please do not hesitate to contact Christina Keune at 860-270-8204 or Michael Santoro at 860-270-8171.

enclosures

Congregate Housing Worksheet -

SAMPLE

No. of Tenants _____
 No. Receiving ALSA _____
 Effective Date _____

RENT CALCULATION

- 1 Family Gross Income _____
 Medical Deduction Calculation: _____
- 2 For NON ALSA tenant:
 - a.) Total Medical Expenses from previous year _____
 - b.) Less: Amounts Reimbursed to the tenant _____
 - c.) Total Non Reimbursed Medical Expenses _____
- 3 For ALSA tenant:
 - a.) Medical Expenses from previous year _____
 - b.) Plus: Tenants Cost/ALSA services ANNUALIZED current yr _____
 - c.) Less: Amounts Reimbursed to the tenant _____
 - d.) Total Non Reimbursed Medical Expenses _____
- 4 Calculate 3% of Family Gross Income (Line 1 x .03) _____
- 5 TOTAL MEDICAL ALLOWANCE (Lines 2c OR 3d minus line 4) _____
- 6 Adjusted Gross Income (Line 1 minus Line 5) _____
- 7 Adjusted Monthly Income (Line 6 divided 12) _____
- 8 30% of Adjusted Monthly Income (Line 7 x .30) _____
- 9 Utility Allowance: Efficiency unit _____
 Utility Allowance: 1 BR unit _____
- 10 Adjusted Mo. Income Available for Rent (Line 8 minus Line 9) _____
- 11 Base Rent (from Management Plan) _____
- 12 Mo. Income Towards Rent (Lesser of Line 10 or Line 11) _____

SERVICES CALCULATION

- 13 Family Income (Same as Line 1) _____
- 14 50% of non Reimbursed Medical expenses (Line 2c OR 3d x .50) _____
- 15 Adjusted Gross Income (Line 13 minus Line 14) _____
- 16 Adjusted Monthly Income (Line 15 divided by 12) _____
- 17 Monthly Allowable Deductions:
 - a.) 15% of Adjusted Monthly Income (Line 16 x .15) _____
 - b.) Personal
 - 1person \$ 93 _____
 - 2persons 153 _____
 - c.) Food
 - 1person 162 _____
 - 2persons 230 _____
 - d.) Medical
 - 1person 40 _____
 - 2persons 77 _____
- 18 Total Monthly Deductions (Add lines 17 a,b,c,d) _____
- 19 Tenant Paid Utilities (same as Util.Allow. On Line 9) _____
- 20 Mo. Income Towards Services-THE LESSER OF:
 - Line 16 minus Lines 12 & 18 & 19 OR _____
 - Line 22 _____

**ALSA Program
 DECD Clients ONLY**
(DSS will calculate tenant contribution for their clients. The figure for #3b will be provided to you.)

DSS Allowable Level of Income	
Protected Monthly	1,806.00
+ Medicare Part B Prem.	96.40
+ Medical Insurance	
Monthly Premium	
= Amount of income "protected"	
Gross Monthly Income	
Less: protected amount	
= income Available to pay towards ALSA cost	
Level	
Monthly Rate	
Tenant Pmt/Income	
DECD Subsidy (Maximum \$856)	
Balance due from Tenant's Assets/other sources	
Annualized Tenant Cost of ALSA from ALL sources (carry to line 3b)	
Note: the monthly amount due from the tenant for ALSA services will be collected by the MRC and paid to the service provider on behalf of tenant	

- | | Actual Costs | Tenant Contribution | DECD Subsidy |
|--|--------------|---------------------|--------------|
| 21 Monthly Rent (PUM from Management Plan) | _____ | _____ | _____ |
| 22 Monthly CORE Service (PUM from Cong.Serv. M.Plan) | _____ | _____ | _____ |
| 23 TOTAL RENT AND CORE SERVICES (Line 21 + Line 22) | _____ | _____ | _____ |
| 24 Monthly ALSA fee (from rate schedule) | _____ | _____ | _____ |
| 25 Total All Costs and Source of Payment | _____ | _____ | _____ |
- Note: maximum ALSA subsidy for DECD client is \$856**

Total Assets _____ Assets of ALSA Recipient _____
 (Note: if joint ownership of these assets, list separately the portion belonging to the ALSA recipient)

Prepared By: _____ Date: _____

Verified By: _____ Date: _____

**CONNECTICUT HOME CARE PROGRAM FOR ELDERERS
APPLIED INCOME WORKSHEET**

Case Name: _____

Client ID: _____ Telephone Number: _____

FOR ACCESS AGENCY/PROVIDER USE ONLY

Gross Monthly Income: \$ _____

Minus Personal Needs Allowance: \$ _____ 1,806.00

Minus Medicare Part B Premium: \$ _____ 96.40

Minus Monthly Medical Insurance Costs: \$ _____

_____ *Insurance Company Name*

Applied Income: Approximate amount – \$ _____
Subject to adjustment by the information below.

If there is Applied Income indicated above:

Is the client responsible for any other medical expenses? Yes No

If Yes, name of medical service provider: _____

Address of medical service provider: _____

Amount of expense: \$ _____

Type of expense: _____

Date/frequency of expense: _____

Is the client responsible for the support of a related household member? Yes No

If Yes, name of household member: _____
If more than one person, please provide the information described below for each person. (Use the back of this form)

Relationship: _____

Gross monthly income of household member: \$ _____

Monthly shelter costs: \$ _____
(rent, mortgage, property taxes, insurance, condo fees etc.)

Access Agency/
 Provider Worker _____ Date _____

FOR ACU USE ONLY

Community Spousal Allowance Computation

1.	\$ _____	Rent or Mortgage (Spouse's share)
2. +	\$ _____	Property taxes (Spouse's share)
3. +	\$ _____	Property insurance (Spouse's share)
4. +	\$ _____	Condominium fees (Spouse's share)
5. +	\$ 720.00	Standard allowance for utilities
6. =	\$ _____	Total shelter costs
7. -	\$ 525.00	Deduct Standard Shelter Allowance
8. =	\$ _____	Excess shelter costs
9. +	\$ 1,750.00	Base minimum Monthly Needs Allowance
10. =	\$ _____	Monthly Needs Allowance (capped by Federal law at \$2,739.00)
11. -	\$ _____	Spouse's Gross Monthly Income
12. =	\$ _____	Community Spousal Allowance
13. =	\$ _____	Community Family Allowance

Final Applied Income Calculation

	Approximate Applied Income (From other side)	\$ _____
-	Other <i>Monthly</i> Medical Expenses (From other side)	\$ _____
-	Community Spousal Allowance (From above)	\$ _____
-	Community Family Allowance (From above)	\$ _____

= Final Applied Income \$ _____

ACU Worker _____

Date _____

Questions? Call the Alternate Care Unit at (860) 424-5185.

Notes: