DECD

State of Connecticut
Department of Economic and
Community Development

Office of Housing Development and Finance

All Sponsors – Congregate with Assisted Living Services

Notice: 08-09

Distribution Date: April 16, 2008

Effective: April 1, 2008

SUBJECT: REVISED TENANT CONGREGATE HOUSING WORKSHEET

Please be advised that the W-1523 Applied Income Worksheet has been revised effective retroactive to April 1, 2008.

Enclosed for your use is a revised congregate certification worksheet for persons receiving assisted living services updated to match the Department of Social Services revised applied income.

Please note that the revised congregate certification worksheet is available in an electronic format upon request.

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

Enclosures

Congregate Housing Worksheet - _____

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 $____ / 2persons ____ _____
- c.) Food 1person ____ / 2persons ____ _____
- d.) Medical 1person ____ / 2persons ____ _____

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	1,734.00
+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 $_____)	
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 $_____

Total Assets _____ **Assets of ALSA Receipient** _____
(Note: if joint ownership of these assets, list seperately the portion belonging to the ALSA recepient)

Prepared By: _____ Date: _____

Verified By: _____ Date: _____

W-1523
(Rev. 4/08)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

APPLIED INCOME WORKSHEET

Case Name:_____

Client ID:_____ Telephone Number:_____

FOR ACCESS AGENCY/PROVIDER USE ONLY

Gross Monthly Income: $_____

Minus Personal Needs Allowance: $ 1,734.00

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.	+	$ 517.00	Standard allowance for utilities
6.	=	$_____	Total shelter costs
7.	-	$ 513.37	Deduct Standard Shelter Allowance
8.	=	$_____	Excess shelter costs
9.	+	$ 1,711.25	Base minimum Monthly Needs Allowance
10.	=	$_____	Monthly Needs Allowance (capped by Federal law at $2,610.00)
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 *Monthly* 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: