N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

DSB ILS FINANCIAL NEEDS SURVEY

Name _____

CURRENT ADDRESS: Street: _____ PO Box _____

Suite/Apt: _____ Zip: _____ City: _____ State: _____

County: _____ Last Updated: _____

☐ Mail Here? ☐ Main Residence? ☐ Ship Here? ☐ Invalid? ☐ Archive? Archive Date: _____

A. CURRENT MONTHLY RESOURCES

(A1) Net Monthly Income of All Applicable Family Members:

1. Name: _____ Age: _____

Relationship to Client: _____

Income Documentation: ☐ Check Stub ☐ Wage Verification ☐ TPQY
☐ Tax Return ☐ Other ☐ No Income

Subtotal (A1) $ _____

(A2) **Allowed Deductions** Subtotal (A2) $ _____

Total Monthly Resources (A1) - (A2) = (A) $ _____

(A2) MONTHLY ALLOWED DEDUCTIONS- WORKSHEET

1. Medical Expenses $ _____
2. Disability- Related Equipment Expenses $ _____
3. Personal Assistant Expenses $ _____
4. Disability- Related Housing / Vehicle Expenses $ _____
5. Child Care Expenses $ _____
6. Post-Secondary Training Expenses $ _____
7. Legally Mandated Payment Expenses $ _____
8. Dental Expenses $ _____
9. Other Expenses _____ $ _____

Total Allowed Deductions (A2) $ _____

B. ALLOWABLE GROSS MONTHLY INCOME

1	2	3	4	5
$1485.00	$2003.00	$2520.00	$3038.00	$3555.00
6	7	8	9	10
$4073.00	$4592.00	$5112.00	$5632.00	$6152.00

Add $520.00 for each additional family member above (8) # _____

Total (B) $ _____

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C. EXCESS MONTHLY INCOME

A. Total Monthly Resources (A1-A2) - B. Allowable Net Monthly Income = $ _____

D. AVAILABLE ASSETS

1. Cash	$ _____	Less ANMI x 3	$ _____	$ _____
2. Real property	$ _____	Less $25,000		$ _____
		Total (D)		$ _____

E. CONTRIBUTIONS

_____ $ _____

Total Contributions: $ _____

F. EXCESS RESOURCES

Excess Monthly Income		(C)	$ _____
X Appropriate Time Period			_____ mos
Total Excess Resources	(C) x (3 or more months) =	(F1)	$ _____
Assets		(D)	$ _____
Contributions		(E)	$ _____
Total	(F1) + (D) & (E) =	(F)	$ _____

G. ESTIMATED COST OF REHABILITATION PROGRAM

_____ $ _____

Total Cost of Rehab	(G)	$ _____
Excess Resources	(F)	$ _____
Estimated Agency Expenditure		$ _____

H. EXTENUATING CIRCUMSTANCES - JUSTIFICATION

_____

I. FINANCIAL ELIGIBILITY DETERMINATION

_____

I certify that the above information is a true statement of my financial situation, and I will notify my counselor of any changes in my financial situation. Providing false or inaccurate financial information could result in the termination of services.

Client: _____ Date: _____

Social Worker for the Blind: _____ Date: _____