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

FINANCIAL NEEDS SURVEY

Name _____ County _____ # In Family Unit _____

A. MONTHLY RESOURCES

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

Name _____ Age: _____

☐ Zero Income **Individual must complete the attached statement if zero income reported.**

Relationship to Client _____

Income Documentation Attached: ☐ Check Stub ☐ TPQY ☐ Wage Verification ☐ Tax Return ☐ Other ☐ Bank Statement

Frequency of Pay: _____

If tax return (1040) used, complete attached worksheet to calculate monthly net income.

Wage Details: _____ Amount: $ _____

1. Total Net Monthly Wages: $ _____
2. Pension: _____ Amount: $ _____
3. Compensation Payment: _____ Amount: $ _____
4. Commodities Sold: _____ Amount: $ _____
5. Other Income: _____ Amount: $ _____

Name _____ Age: _____

Relationship to Client _____

Income Documentation Attached: ☐ Check Stub ☐ TPQY ☐ Wage Verification ☐ Tax Return ☐ Other ☐ Bank Statement

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Subtotal (A1) $ _____

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

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

(A2) MONTHLY ALLOWED DEDUCTIONS- WORKSHEET

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

Total Allowed Deductions (A2) $ _____

B. ALLOWABLE NET MONTHLY INCOME

1	2	3	4	5
$1238.00	$1669.00	$2100.00	$2531.00	$2963.00

6	7	8
$3394.00	$3826.00	$4259.00

Add $433.00 for each additional family member above (8) # _____

Total (B) $ _____

FINANCIAL NEEDS SURVEY

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. DETERMINATION OF FINANCIAL NEED

_____

Enter the amount that the individual is expected to contribute and the service to which the contribution is to be applied.

Amount: $ _____ Service(s): _____

FINANCIAL NEEDS SURVEY

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.

Client: _____ Date: _____

Counselor: _____ Date: _____

Supervisor (when indicated): _____ Date: _____

Resurveyed Date: _____ and no significant change found. Counselor: _____

Resurveyed Date: _____ and no significant change found. Counselor: _____

ZERO INCOME STATEMENT

1. I am signing this statement to declare that I currently do not have any income from any source. My financial support comes from: _____

   ☐ I did not file a Federal Income Tax Return in the past two years

   ☐ I filed a Federal Income Tax Return in the past two years and have provided my counselor a copy

2. I agree to notify my counselor about changes in my income within 30 days of the change.
3. I understand that by completing, signing, and dating this statement, I decare I have no household income and that the information I am providing is correct. I understand that providing false information may result in denial or termination of services.

Client Signature: _____ Date: _____