TBI/NHTDW WAIVER RESPONSE FORM
Spousal/Family Impoverishment

Your name _____ Program _____

Your Address _____

Street city zip

E-mail _____ Phone _____

You do not need to give us the name of the client(s) now, but we may ask you for it later. If you don't give name, please use initials or first name so that you will know which client this is for follow-up. You of course need your client to sign a release in order to give their name to us.

1. Name of person in or applying for waiver: _____Age _____

   ☐ TBI waiver participant since _____

   ☐ New applicant for TBI waiver since 9/1/08

   ☐ Applicant for NHTDW

2. Waiver applicant/participant's INCOME (monthly):

   Social Security Disability _____

   Pension _____

   Earnings (GROSS AMOUNT on paycheck _____ and indicate how often paid - ☐ weekly ☐ bi-weekly ☐ monthly

   Other (specify type and amount) _____

3. Spouse not in waiver -- Age _____

   INCOME (monthly): Social Security _____

   Pension _____

   Earnings (GROSS AMOUNT on paycheck _____ and indicate how often paid - ☐ weekly ☐ bi-weekly ☐ monthly

   Other (specify type and amount) _____

4. Does waiver participant/applicant pay a health insurance premium – such as Medigap or retiree insurance? If so, cost $_____ per ☐ month ☐quarter ☐ _____ (other)

5. Do any other relatives live with waiver participant?
   - **Child** of either spouse under age 18? ☐ YES ☐ NO
   - **Child** older than age 18 who depends on either spouse for more than half of his support? ☐ YES ☐ NO
   - **Parent** who depends on either spouse for more than half of his support?

     ☐ YES ☐ NO
   - **Sibling** who depends on either spouse for more than half of his support?

     ☐ YES ☐ NO

   If any of the above relatives are checked YES, please write here the **age** and **relationship** of these relative(s)

   _____

   - For each relative, indicate whether s/he receives a Family Member Allowance through the TBI waiver budget ☐ YES ☐ NO ☐ Don't know
   - For each relative, indicate the family member's own income, if known e.g. a child under age 18 might receive Social Security based on the disability of parent

     $ _____ Source _____

6. **Do you have or can you get a copy of the Medicaid waiver budget** showing the support allowances? If so, please fax it. If you do not have a privacy release, please redact the individuals' names, social security numbers, Medicaid numbers, and addresses.

7. **Please give any information you have about how elimination of the spousal/family allowance will cause a financial hardship.** How high is their rent/mortgage? What are their other significant expenses?

8. **What are individual's/ couple's savings?**

   Participant - Cash/stocks/CDs $_____ IRA/retirement $ _____
   Spouse -Cash/stocks/CDs $_____ IRA/retirement $ _____

9. **When was the last renewal** of the waiver participant's Medicaid budget (month and year)? _____

PLEASE RETURN FORM OR SEND QUESTIONS TO:

	E-mail	Fax	Tel
Trilby de Jung	tdejung@empirejustice.org	585-454-4019	585-454-6500 x 8
Julie Morse	jmorse@wnylc.com	315-475-2706	866-475-9967
Valerie Bogart	vbogart@selfhelp.net	212-947-8737	212-971-7693