

VERIFICATION FORM FOR MAABD MAIL REDETERMINATIONS

MA CASE # _____ FS CASE # _____
 MA DISTRICT/WORKER # _____

CASE NAME _____

TYPE OF ASSISTANCE-Check all that apply
 OTHER _____

REVIEW CHANGE IN SITUATION
 MAABD DUAL, Includes MQB-Q/B/E

REQUIREMENTS	VERIFICATION SOURCE & DATE
A. AGE/DISABILITY; ENUMERATION/IDENTITY/ CITIZENSHIP/RESIDENCE	<input type="checkbox"/> See Base Document
B. UNEARNED INCOME (Mo. Amount) (Source) (BU Member) \$ _____ \$ _____ \$ _____ \$ _____ \$ _____ Total Unearned	Deduct operational expenses for rental Income.
C. EARNED INCOME of B.U. Wage Earner: Employer: Mo. Gross _____ Standard WR EXPENSES _____	Deduct operational expenses for self-employment
D. TOTAL INCOME:	
PATIENT MONTHLY LIABILITY 1. TOTAL GROSS INCOME (Earned plus unearned without deductions) _____ 2. Operational Expenses - _____ 3. Personal Needs - _____ 4. Court-Ordered Guardianship Fees - _____ 5. Mandatory Deductions - _____ 6. Work Incentive - _____ 7. Spouse/Dependents (Attach DMA-5008C) - _____ 8. Maintenance of Home - _____ 9. Unmet Medical Needs - _____ Effective _____ : _____ PML Effective _____ : _____ PML	DEDUCTIBLE COMPUTATION (Attach DMA-5008A/E if needed) (Attach DMA-5036 if needed)
Certification Period FROM _____ TO _____	AID PROGRAM/CLASS Deductible Balance Effective Date of Authorization

