Special Assistance In-Home Program
Economic Assessment Worksheet

Assess the client's economic status by reviewing all sources of income and expenses, including unmet financial needs. Complete the entire worksheet to obtain a comprehensive financial assessment. The expenses are divided into two categories; "essential" and "non-essential", with a category added for "unmet financial needs" which are not current monthly expenses. When reviewing the client's expenses, **only the essential expenses and essential unmet needs** will be included in the total amount to be considered when calculating any deficit for the SAIH payment. Document additional economic information as needed in sections B through I.

Client's Name: _____ Date Economic Assessment Initiated: _____

A. INCOME AND EXPENSES

Monthly INCOME (enter in Section J.1)		**Monthly EXPENSES** (if expenses are shared with another, list portion for which client is responsible; enter in Section J.2)					**Unmet Essential Needs - Not counted under monthly expenses** (see instructions-page 3 and enter in Section J.5)	
Source (list)*	**Amount**	**Essential (list)****	**Amount**	**Non-Essential (list)**	**Amount**		**Unmet Need*****	**Amount**
	$	PNA	$ 66.00		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
	$		$		$			$
TOTAL	0.00	**TOTAL**	$ 66.00	**TOTAL**	$ 0.00		**TOTAL**	$ 0.00

Client's Name: _____

***Examples of Income Sources:**	Social Security, SSI, Veteran's Benefits, dividends/interest, Railroad Retirement, pensions, other retirement, salary/wages/earnings, income from rental property or other business, child support (portion used toward household expenses), alimony, General Assistance, tribal income/LIEAP/CIP-(prorate), on-going cash from others. (Do not add SAIH payment as income).
****Examples of Essential Expenses**	Rent/mortgage, electricity, heating/cooling fuel costs (prorate to monthly amount), water/sewer, food, clothing (prorate to monthly amount), home repair and household maintenance costs (based on identified safety need), laundry, medical bills/prescriptions and co-pays, property taxes (prorate), essential insurance premiums (pro-rate), transportation costs, other essential expenses. Document the correlation to health and safety.
*****Unmet Financial Need**	May include unmet needs or expenses that are not accounted for in the monthly expenses. This would include one-time purchases or a new service that the client has not had access to but is an essential need. Examples of this might include deposits, purchase of basic furnishings, a life alert system, etc.
Personal Needs Allowance	The client is allowed a $66.00 per month Personal Needs Allowance (PNA). This amount is entered as an essential expense, but can be used by the client for those items not considered essential expenses. The $66.00 is based on the current Special Assistance PNA for individuals residing in a licensed residential care facility. This includes the $20 disregard which applies to most unearned income sources.
Other Benefits	Rental Assistance including tenant-based rental assistance, Energy Assistance (seasonal). List these under monthly income sources.
Resources	Assess the availability of liquid resources that might be available to meet needs.

B. Does Client Have Medical Coverage

Source	Yes	No	Effective Date	Application Date if client is not already eligible	Current Client Cost (include in Essential Monthly Expenses, if appropriate)
Medicaid					$
Medicare					$
Part A					$
Part B					$
Part D					$
Private Health Insurance or Marketplace (include name)					$
Other					$

Client's Name: _____

C. Other Resources

Source	Yes	No	Bank or other Financial Institution Name	Balance
Savings Account				$
Retirement Account				$
Other Assets				$
Burial Plan (Is the Plan Irrevocable?)				$

D. Client's/family's perception of client's financial situation and ability to manage finances. _____

_____

_____

E. Are there any problems/irregularities in the way the client's money is managed (by self or others) ☐ No ☐ Yes
If yes, explain: _____

_____

F. If expenses exceed income, what does the client do to manage?

_____

_____

G. If client has resources that are not being used, document why they are not being used to meet the client's needs.

_____

_____

H. Clients/family's perceived unmet needs include: (Include estimated costs for unmet needs when possible.)

_____

_____

I. Document any In-Kind support or assistance the client receives. Consider this when determining unmet needs.

_____

_____

Client's Name: ____ _____

J. COMPUTATION OF SAIH PAYMENT

1. Total Monthly Available Income including other Resources or Benefits	**$** 0.00
2. Total Monthly Essential Expenses (Includes the $66.00 PNA already entered on Section A)	**$** 66.00
3. Total Monthly Deficit or Surplus (This is the difference between #1 and #2. Show + or -)	**$** (66.00)
4. Compare total in #3 to Maximum Payment Amount . If #3 is deficit, can deficit amount be covered in maximum payment amount? **If #3 is a surplus, apply toward unmet essential needs.**	**Y☐ N☐**
5. If there are legitimate unmet essential needs that must be included in the monthly payment amount, enter amount.	**$** 0.00
6. Authorized SAIH Payment Amount (If need in #3 exceeds maximum payment amount, client may not be eligible, document how needs will be met below) *	**$**

***PARTIAL PAYMENT:** List below those items and amounts that need to be addressed to ensure the client's health and safety using the **one-time partial payment** authorized on the SA program interagency transmittal form.

Unmet Essential Need(s) covered by approved one time SAIH Partial Payment	SAIH Partial Payment Amount	Date need will be met	Need met
	$		
	$		
	$		
	$		
Total	**$** 0.00		

***IF DEFICIT EXCEEDS MAXIMUM PAYMENT- CAN ESSENTIAL NEEDS BE MET, HOW?** _____

_____

Client's Name: _____

Section K: Special Assistance In-Home Payment Agreement

The SAIH authorized payment, effective, _____, is $_____.

The SAIH funds will be used for the following:

Service/Item	Initial Monthly Amount	Change in Service/Item	Revised payment Amount	Date & Initial any change and at Reviews		
				Worker	Client	Date
TOTAL Authorized SAIH Payment	**$** 0.00		**$** 0.00			

Client agrees to use the authorized SAIH payment as specified above. Failure to use this payment as agreed upon may result in reduction or termination of payment. If changes are needed in the SAIH Plan prior to the Annual Economic Reassessment, document above. Worker and client should initial and date.

_____ _____
Client/Representative Signature Date

_____ _____
Worker Signature Date