

## Financial Screening and Co-Payment Determination Form

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Enrollment Worker ID Number: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Individuals who have a Federal Adjusted Gross Income (FAGI) below \$50,000 per year are eligible for ADAP. Please indicate ALL sources of income in the table in Section A. Only those amounts deemed taxable will be used to calculate the applicant's adjusted gross income and eligibility for the program.

Identify all sources of income by checking "Yes" or "No." Provide the income amounts from the client's income documentation. If income is not reported as an annual amount, annualize the income (i.e. weekly income x 52, bi-weekly income x 26, monthly income x 12, semi-monthly income x 24).

### Section A

Source of Income	Yes	No	How much income/money is received? (amount on the income documentation provided)	How often is income/money received? (annually, monthly, semimonthly, weekly, biweekly)	Total Gross Income (if the income is not an annual amount, annualize the income)
Employment					
Self-Employment					
Social Security Disability Insurance (SSDI)					
State Disability Income (SDI)					
General Assistance/General Relief					
Private Disability					
Unemployment Insurance (UI)					
Retirement/Pension					
Worker's Compensation					
Investment or Interest Income					
Veteran's Administration (VA) Benefits					
Alimony					
Other:					
Other:					
Other:					
<b>GRAND TOTAL</b> (sum of all annual income amounts reported in the last column)					\$

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### Section B Identify the income documentation provided by checking all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> California State Tax Returns * | <input type="checkbox"/> Support Affidavit         |
| <input type="checkbox"/> Federal Income Tax Return*     | <input type="checkbox"/> Self-Employment Affidavit |
| <input type="checkbox"/> W-2 or 1099                    | <input type="checkbox"/> Bank Statement            |
| <input type="checkbox"/> Pay Stub                       | <i>(Acceptable for SSDI, SSA, VA)</i>              |
| <input type="checkbox"/> Disability Award Letter        | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Benefit Receipt or Check Stub  |  |

\* Copies of Schedule C, W-2, 1099 forms must be included with tax return documents.

Total Gross Income Amount \$ \_\_\_\_\_

OR

Federal Adjusted Gross Income Amount \$ \_\_\_\_\_

(Indicate FAGI only if client provides tax documentation indicating FAGI)

Is the FAGI calculated in Section A less than 400% of federal poverty level for the family size as listed below?

<u>Family Size</u>	<u>400% of Poverty</u>
1	\$41,600
2	\$50,000
3	\$50,000

<sup>1</sup>Actual 400 percent of FAGI for a family size of two is \$56,000 and for a family size of 3 is \$70,400. However, only persons who have a FAGI below \$50,000 per year are eligible for ADAP, as legislatively required.

**YES \_\_\_\_\_ ELIGIBLE. STOP HERE.** The applicant is eligible for ADAP with no copayment obligation. Client must sign this form in the signature section on the bottom of this page.

**NO \_\_\_\_\_** If the applicant's FAGI exceeds \$50,000, the applicant is **NOT ELIGIBLE** to receive drugs under ADAP.

If the applicant's FAGI exceeds 400% of poverty for their family size, but is less than \$50,000, the applicant is **ELIGIBLE FOR ADAP** but will have a COPAYMENT OBLIGATION. Proceed to the application copayment determination calculator on the following pages to determine this amount.

### Applicant's Signature

*I certify that the above financial information is accurate, true and complete. I understand that failure to provide accurate information may result in suspension or termination of services. I also understand that Office of AIDS staff are permitted to request additional income verification if income reported appears to be inconsistent or incorrect.*

Applicant's signature: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Date: \_\_\_\_\_

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**SECTION C: SHOULD ONLY BE COMPLETED IF CLIENT'S INCOME EXCEEDS  
400% OF POVERTY LEVEL BASED ON THE FAMILY SIZE.**

### Copayment Determination Calculator #1

(Using pay-stubs and/or award letter as the income documentation source)

Use this calculator to determine copayment obligation ONLY when client provides a pay stub, disability award letter, etc.

(1) **Federal Adjusted Gross Income (FAGI)** (1) \$ \_\_\_\_\_  
[Obtain from Section A.]

(2) **Federal Deduction allowed from 1040EZ Form** (2) \$ \_\_\_\_\_  
[Enter deduction amount.]

<u>Filing Status</u>	<u>Amount</u>
(1) Single	\$ 8,750
(2) Married filing joint return	\$17,500

(3) **Taxable Income Form** (3) \$ \_\_\_\_\_  
[Subtract (2) from (1).]

(4) **Tax Liability** (4) \$ \_\_\_\_\_  
[Tax liability is found on the California Tax Table  
using the taxable income and filing status.]

(5) **Gross Monthly Co-payment** (5) \$ \_\_\_\_\_  
[Divide tax liability in number (4) above by 6]

(6) **Monthly Health Insurance Premium** (if paid for by client) (6) \$ \_\_\_\_\_  
[Enter premium amount, if applicable.  
Client must provide proof of premium payment]

(7) **Net Monthly Co-Payment** (7) \$ \_\_\_\_\_  
[Subtract (6) from (5).]

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### Co-Payment Determination Calculator #2

(Using a tax return as the income documentation source.)

Use this form to determine co-payment obligation ONLY when client provides a California state or Federal tax return. The state or federal tax return will show both the client's Federal Adjusted Gross Income (FAGI) and taxable income.

**NOTE:** It is in the client's best interest to provide the California tax returns.

- |     |   |              |
|-----|---|--------------|
| (1) | <b>Taxable Income</b><br>[Obtain from California State Tax Return or Federal Tax Return]  | (1) \$ _____ |
| (2) | <b>Tax Liability</b><br>[Tax liability is found on the California Tax Table using the taxable income and filing status.]                                  | (2) \$ _____ |
| (3) | <b>Gross Monthly Co-payment</b><br>[Divide tax liability in number (2) above by 6]  | (3) \$ _____ |
| (4) | <b>Monthly Health Insurance Premium</b> (if paid for by client)<br>[Enter premium amount, if applicable.<br>Client must provide proof of premium payment] | (4) \$ _____ |
| (5) | <b>Net Monthly Co-payment</b><br>[Subtract (4) from (3)]  | (5) \$ _____ |