Financial Eligibility (Calendar Year 2020)

Behavioral Health Provider Use Only	
☐ Eligible ☐ Ineligible	
BH Provider: HSA	
CID#:	Signature:

Instructions

Please read and complete all questions on this form. This information will be used to determine your eligibility for services funded by Division of Behavioral Health .

Personal Information

Client Name:

First Name: Middle Initial: Last Name:

Parent/Guardian or Representative (if applicable):

First Name: Middle Initial: Last Name:

☐ Yes ☐ No I (CYF and/or A/D Consumer) have applied for and been denied Medicaid and CHIP-NM.

☐ Yes ☐ No I (SPMI Consumer) have applied for and been denied SSI.

Description of Household

Total number of Persons Living in Household (dependent on household income): ____________

Financial Information

Total Household Annual Gross Income: Iinclude all sources of income (wages, TANF, child support) for the household members included above, except for any income from a child under the age of 18).

Household Size	Annual Income
1	$23,606
2	$31,894
3	$40,182
4	$48,470
5	$56,758
6	$65,046
7	$73,334
8	$81,622
9	$89,910
10	$98,198

(1) Earned Income *(i.e. wages)*

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(2) Unearned Income *(i.e. child support, TANF, SSDI)*

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Minus Annual Deductions /Expenses:

(3) Earned Income Deduction *(Deduct 20% of Earned Income. Do not deduct 20% from unearned income.)*

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(4) Childcare Expenses *(up to $6,000/year)*

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(5) Child support payments

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Annual Out of Pocket Disability Related Expenses :

(6) Prescription Medication/Labs *(related to mental illness)*

____________________ ____________________

(7) Health Insurance Premiums ______________________________ ______________________________

(8) Assistive Devices (*related to mental illness)* ______________________________ ______________________________

Equals Annual Net Income:
(9) *(deduct lines 3 through 8 from line 1 and 2)*
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I hereby attest that this information is true and correct. I understand that any false statements that I make and any failure on my part to report changes in circumstances which affect my eligibility could result in my being responsible for reimbursement of services provided and/or ineligibility for services. I understand that if I am determined eligible and my situation should change before my annual review date, it is my responsibility to notify Behavioral Health Provider so that eligibility can be re-evaluated. Eligibility could be affected by increases in my income, changes in the number of persons in my household, and/or any other significant change in financial circumstance.

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Signature (Consumer or Parent/Guardian) **Date**