

Financial Statement

Need will be determined on the:
 Family Unit
 Customer

Only complete items D1, F, and G (page 2) if you receive SSI, SSDI, Medicaid or DSHS Income Assistance.

CUSTOMER'S NAME

The purpose of this form is to document your financial status. Your contribution to the cost of your rehabilitation plan will be determined based on your available monthly income and funds from real and personal assets which must be converted to cash. This information will be used by the Division of Vocational Rehabilitation (DVR) to calculate your ability to financially contribute to the costs of your rehabilitation plan. This form is to be completed by you and a DVR representative based on information provided by you, your parent, guardian, or other representative. Your income, assets, and liabilities will be calculated on the basis of either your family unit or you as an individual customer depending on your federal income tax filing status during the last tax year.

A. MONTHLY INCOME		B. REAL AND PERSONAL ASSETS (continued)		
1. Net wages, tips and salaries (after mandatory withholdings)		6. Inheritance/gifts		
2. Compensation, insurance, pensions, monthly annuities from trusts or dividends		7. Loans owed to you		
3. Interest, dividends, rents		8. Other personal property (value over \$500 per item), excluding disability related items; specify below:		
4. Maintenance and/or child support				
5. Other				
A. TOTAL MONTHLY INCOME				
B. REAL AND PERSONAL ASSETS		9. Total all lines 1-8		
1. Checking/savings (total) - attach current monthly statement(s)		10. BASE EXEMPT AMOUNT		- \$5,000.00
2. Motor Vehicles - excluding one vehicle per household member if vehicle is needed for work, school, or VR/IL services; specify below:		B. TOTAL REAL AND PERSONAL ASSETS (subtract line 10 from 9)		
		C. ACTUAL MONTHLY LIABILITIES		
		1. Rent/Mortgage payments		
		2. Property Taxes		
		3. Utilities, telephone, etc.		
		4. Insurance Payments, specify below:		
		Auto Insurance		
3. Recreational Vehicles (boats, trailers, motorcycles, collector cars, etc); specify below:		5. Charge Accounts; specify below:		
		CREDITOR	TOTAL OWED	MINIMUM MONTHLY PAYMENT
4. Real estate and structures - excluding primary residence				
5. Stocks, bonds, trusts, certificates of deposite, etc.; not counted as monthly income (a.2. above)				

C. ACTUAL MONTHLY LIABILITIES (CONTINUED)					
6. Loan payments; specify below:				8. Ongoing Disability Related Expenses (e.g. attendant, therapy, prescriptions, equipment, etc.)	
CREDITOR	LOAN TYPE	TOTAL OWED	MINIMUM MONTHLY PAYMENT		
				9. Transportation Expenses	
				10. Vehicle license(s) (per month)	
				11. Food	
7. Medical expenses; specify below:				12. Clothing	
CREDITOR		TOTAL OWED	MINIMUM MONTHLY PAYMENT	13. Other; specify below:	
C. ACTUAL MONTHLY LIABILITIES					
D. INCOME ASSISTANCE/SSI/MEDICAID VERIFICATION/BANK STATEMENT WAIVER (COMPLETED BY DVR STAFF)					
1. I have verified that the customer is receiving DSHS Income Assistance, SSI, SSDI or Medicaid and have attached appropriate documentation to the Financial Statement, and waived the bank statement requirement.					VRC Initials
2. I have waived the bank statement requirement.					VRC Initials
E. CALCULATION OF CUSTOMER'S CONTRIBUTION TO THEIR REHABILITATION PLAN (CALCULATED BY DVR STAFF)					
1. Total monthly income (from section A)			A		
Please enter estimated number of months in IPE					
2. Total Real and Personal Assets (Section B) divided by the number of months in the plan, equals the monthly assets available to contribute to the plan.			Plus B		
3. Total monthly resources (Line 1 plus Line 2 above)			TOTAL		
4. Total actual monthly liabilities (from Section C)			Minus C		
5. Monthly total of funds available for rehabilitation programs above (subtract line 4 from line 3)			MONTHLY TOTAL		
6. Total Funds available for rehabilitation programs based on the estimated number of months in IPE			TOTAL FOR IPE		
If the funds available for rehabilitation programs above (Items 5 & 6) are greater than zero, this amount and services will be documented in the customer's rehabilitation plan (in the sections identifying "costs associated with the plan").					
F. CUSTOMER'S DECLARATION					
I understand by law, if I provide verification that I receive SSI, SSDI, Medicaid, or DSHS Income Assistance I am not required to pay any portion of VR services. I can choose to pay for some of the services if I wish but I am not required to do so					
I understand this information is confidential and only used to accomplish my rehabilitation plan in accordance with Washington Administrative Code (WAC) 388-890 891.					
I swear under the penalty of perjury, all information provided and entered on this form is true and constitutes a full disclosure of my income, assets, and liabilities. I understand my responsibility to immediately report to DVR any change in my financial status. I further understand that DVR may deny or suspend services if this information provided by me is found to be inaccurate or incomplete. A copy of my current savings and checking statement(s) has been provided or waived. I will furnish other documentation of my financial status, upon request. I further understand DVR's requirement to document my contribution to the cost of my rehabilitation plan based on my financial status.					
CUSTOMER SIGNATURE					DATE
G. COUNSELOR DECLARATION					
I have accurately completed this form based on information provided by the customer, parent, guardian, or other representative. I have informed the customer, parent, guardian, or other representative of the purpose of this form, his or her responsibility to immediately report any change in his or her financial status, and to comply with any DVR requests to furnish additional documentation of his or her financial status. I have also informed the customer, parent, guardian, or other representative of DVR's requirement to document his or her contribution to the cost of the customer's rehabilitation plan based on his or her financial status.					
COUNSELOR SIGNATURE					DATE