**Residential Fee Collection Worksheet**

Month/Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Representative Payee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Facility (if different than the Representative Payee): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The federal benefit payments received by adults (18 and older) who reside in APD-licensed homes and who whose residential care is funded via a room and board payment may be subject to fee collection by the Agency for Persons with Disabilities. In the space below, please provide accurate and current data for each of those APD clients.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A. CLIENT NAME | B. Social Security Number | C. Enrolled on iBudget? (Indicate Y or N) | D. Tier (If not on iBudget, indicate Tier 1, 2, 3, 4, or TBD) | E. Total Federal Benefits Received for Month | F. Personal Needs Allowance | G. Room and Board rate | H.Exclusion Amount (see below) | I.Amount Due to APD |
|  |  |  |  |  | 93.58 | 543.42 |  |  |
|  |  |  |  |  | 93.58 | 543.42 |  |  |
|  |  |  |  |  | 93.58 | 543.42 |  |  |
|  |  |  |  |  | 93.58 | 543.42 |  |  |
|  |  |  |  |  | 93.58 | 543.42 |  |  |
|  |  |  |  |  | 93.58 | 543.42 |  |  |

Signature of Representative Payee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Payment must be sent to the appropriate APD area office by the 15th day of the month after receipt of said benefit payments.** If the 15th of the month falls on a weekend or national holiday, then the payment due date will be the next business day immediately thereafter. Checks or money orders should be made payable to Agency for Persons with Disabilities (or APD). Individuals or organizations serving as the representative payees for third party benefit payments should submit a single check or money order to the Agency.

**Please sign and date this form in the spaces indicated above and return (along with any required payment) to your area APD office no later than the 15th of each month.**

Exclusions:

The following federal benefit amounts are not subject to residential fee collection:

(1) benefits which were specifically excluded (in writing) by the Social Security Administration,

(2) benefits which were used as a required payment, co-payment, or co-insurance for Medicaid or Medicare services, including but not limited to prescribed drugs, or

(3) benefits which were used to offset a voluntary reduction in a client’s Medicaid waiver services.

**All exclusion requests must include evidence of payments (such as receipts, for example) for the actual services rendered.**