

New Jersey Department of Human Services
Division of Aging Services

COST-SHARE WORKSHEET

1. Effective Date _____ to _____

2. Name of Participant _____

3. Name of Facility/Agency _____ ALR CPCH AFC

4. Medicaid Number _____ 5. Date of Birth (DOB) _____ 6. County _____ 7. Check if Income is from SSI

INITIAL COST SHARE (Income paid to facility for enrollment month) N/A

8. Date participant was enrolled in program: / / (mm/dd/yyyy)

a. <u>Room and Board</u> fees you pay for enrollment month:.....	\$ _____
<u>Cost Share</u> you pay for enrollment month:	<u>0.00</u>
b. <u>Total</u> amount you pay the facility for enrollment month:.....	\$ _____

MONTHLY COST SHARE (Income paid to facility after month of enrollment)

9. Your Gross Monthly Income	\$ _____
10. How your monthly income is to be used each month (allowable deductions):	
a. Money you keep for Personal Needs Allowance	\$ _____
b. Room and Board fee that you pay to the Assisted Living Facility	\$ _____
c. Medical Insurance Premium you pay each month	\$ _____
d. Medicare Premium deducted from your Social Security check	\$ _____
e. Medical Expenses* you pay each month (see below)	\$ _____
f. Other (spousal allowance, guardianship, child support, etc.) (see instructions) .	\$ _____
11. Total Deductions (add lines 10a through 10f).....	- \$ _____
12. Cost Share that you must pay the facility	= \$ _____

* Medical Expenses that you pay from your monthly income (10e above)

i. Money you pay each month for past medical bills that you owe:.....	\$ _____
ii. Payments you make each month for medicines/vitamins/supplies/ medical services that are prescribed by doctor but not paid by Medicaid and for which you have receipts:	+ \$ _____
iii. Total Medical Expenses you have documented for the Care Manager (enter on Line 10e above):.....	= \$ _____

13. In order to participate in this program, you must submit current financial information to your Care Manager. You are responsible for paying the Assisted Living/Adult Family Care provider the "Room and Board" fee (Line 10b) plus the "Cost Share" amount (Line 12).
The total monthly amount you pay the facility is: \$ _____

SIGNATURES

14. Signature of Participant or Representative	Date
15. Signature of Care Manager	Date
16. Signature of Facility Administrator/Designee **	Date

REVIEW OF COST SHARE AMOUNT (Six-month review or Other)

17. Cost Share: Amount remains the same or Amount has changed and requires a new AL-3 Form.

18. EFFECTIVE DATE: / / to / /

19. Signature of Care Manager	Date
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20. Signature of Facility Administrator/Designee **	Date
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** Facility Administrator/Designee is responsible for forwarding this information to the appropriate Facility Billing Department.