Assisted Living Facility Patient Pay Liability

PR-2 WORKSHEET

1. Name of Participant	2. Medicaid Number
3. Name of Facility/Agency	☐ALR ☐CPCH ☐AFC
4. County	5. Effective Date to

☐ **INITIAL PATIENT PAY LIABILITY** (paid to facility for enrollment month) ☐ N/A

6. Date participant was enrolled in Medicaid: ____/____/_____ *(mm/dd/yyyy)*

a. Room and Board fees you pay for enrollment month: **$**

Patient Pay Liability you pay for enrollment month: **0.00**

b. Total amount you pay the facility for enrollment month: **$**

☐ **MONTHLY PATIENT PAY LIABILITY** (Income paid to facility after month of enrollment)

7. Your Gross Monthly Income **$**

8. 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 PR-2) **$**

9. Total Deductions (add lines 8a through 8f) **- $**

10. Patient Pay Liability that you must pay the facility **= $**

* Medical Expenses that you pay from your monthly income (8e 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 CWA (enter on Line 8e above): **= $**

11. **In order to participate in this program, the beneficiary must submit current financial information to the CWA when applying and at the time of redetermination of financial eligibility. The beneficiary is responsible for paying the Assisted Living/Adult Family Care provider the "Room and Board" fee (Line 8b) plus the "Patient Pay Liability" amount (Line 10).**

The total monthly amount you pay the facility is: $ _____

*** Facility Administrator/Designee is responsible for forwarding this information to the appropriate Billing Department.*