FEE DETERMINATION FORM INSTRUCTIONS

Complete the top of the form.

The left side is for any unearned income – SSI and SSDI as well as VA benefits, Civil Service Annuity (or Retirement) and income from assets such as savings accounts or other investments. As you enter the amounts, they will automatically be added up to total the Monthly Net Unearned Income*. The mandated $20.00 disregard is also automatically included in this total.

The right side is for any earned income from paid employment. Again, as you enter the amounts, they will automatically be added up to total the Monthly Gross Earned Income**. It is very important to inform your clients that this amount may change monthly due to changes in hours of work and/or pay. That is why copies of pay stubs must be turned in every month.

Please note that by completing the top of the form, most of the fee formula lines at the bottom of the page will be automatically entered. DO NOT type over these lines.

LINE 1: Based on the top right half of the form, the total monthly gross income from work earnings will be automatically entered here. If the client is not working, then it will remain 0.

LINE 2: The program should negotiate with each individual client to determine their contribution from earned income to their cost of care. The negotiated amount is designed to maintain work incentives for the client. Based on the top of the form there are three options for this line:

- The 0 will remain here if the client does not work and receives unearned income only (i.e. SSI, SSDI, VA, etc.)
- $65.00 will be entered if the client both works and receives unearned income (i.e. SSI, SSDI, VA etc.)
- $85.00 will be entered if the client works and receives earned income only.

LINE 3: Automatically line 1 minus line 2 will be entered. This is the amount that is available for cost of care calculations. The client is entitled to ½ of this amount.

LINE 4: Divides line 3 in half. This gives you the amount of earned income that must be turned over to the agency for cost of care.

LINE 5: Based on the top left half of the form, the total monthly net unearned income will be automatically entered here. If the client has no unearned income, then it will remain 0.

LINE 6: Subtract any agency allowances. This will vary by agency. You can customize this form as needed. For example, some agencies provide allowance for transportation, food, and/or laundry. Once you enter these amounts in column H, they will automatically total and be entered in to the last column I.

LINE 7: This number adds lines 4 & 5 then subtracts line 6 to give the client's total monthly cost of care based upon their income.

LINE 8: This number is the maximum monthly cost of care approved by MHA. ($54/day = $1620/month)

LINE 9: This amount is what is to be charged to the client. It is the lower of line 7 or line 8.

**__Gross__ income refers to the total amount of income (earned or unearned) before any deductions are taken.

*__Net__ income refers to the amount of income (earned or unearned) actually received (i.e. after deductions have been made).

Mental Hygiene Regulations -Fee Schedule Policy from 10.21.25.08 states the following:

"C. RRP Services. The Department shall reimburse an RRP for providing services to an individual with a serious and persistent mental disorder and whose functioning is severely impaired, as follows: (1) Room and board ... $11.70 per day;
(2) A provider may collect additional fees from an individual not covered by the rate established in C(1) of this regulation to cover a portion of costs of food, shelter, and other household expenses associated with an individual's basic needs in an RRP residence, not to exceed the provider's cost of care."

Providers may collect fees from consumers to pay towards their cost of care. Cost of care is estimated to be $54.00 per day. Programs should maintain fiscal documentation of revenues and expenditures to support the cost of the RRP service. The costs include RRP staff services that are not reimbursed by Medical Assistance or other payment sources. Upon request, this information is to be provided to consumers to explain how their income is used to pay for their cost of care.

The following form may be used as a guide.

FEE DETERMINATION FORM

Name:	**Date:** **Date Effective:**
UNEARNED INCOME	**EARNED INCOME**
Entitlement Income Eligible for Disregard: **SSI** _____ **SSDI** _____ **Other Entitlement Income:** **Other:** _____ **Other:** _____ **Total:** _____ **Other Unearned Income:** **Interest** _____ **Dividends** _____ **Alimony** _____ **VA benefits** _____ **Retirement** _____ **Other:** _____ Less $20.00 disregard: _____ ($20.00) (SSI / SSDI) **Monthly Net Unearned Income** -- (See Line 5) $0.00	**Pay Schedule** / **Day of Month Paid** ☐ **Weekly** _____ ☐ **Bi-weekly** _____ ☐ **Semi-monthly** _____ ☐ **Monthly** _____ ☐ **Occasional** _____ **Income based on pay dates:** **Gross Pay** Pay dates: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ **Monthly Gross Earned Income=** $0.00 (See line 1) ***This amount may change monthly due to changes in pay. Copies of paystubs must be turned in each month to figure cost of care.***

Fee Formula:		
1. Total monthly gross earned income		$0.00
2. Minus employment disregard ($65 for both earned and unearned income,)		$0.00
($85 for only earned income)		$0.00
3. Remainder (line 1 minus line 2)		$0.00
4. Divide line 3 in half (this is the earned income available for fee)		$0.00
5. Plus 100% of total NET unearned income		$0.00
6. Less any agency allowances (see agency instructions*)		$0.00
Other:	$0.00	
Other:	$0.00	
Other:	$0.00	
7. Client's total monthly cost of care (add lines 4 and 5 and subtract line 6)		$0.00
8. This number is the maximum monthly cost of care approved by MHA. ($54/day)		$1,620.00
9. Monthly amount to be charged (lower of line 7 or line 8)		$0.00

SIGNATURES:

Resident: _____ **Date:** _____

Program Representative: _____ **Date:** _____

CSA Residential Specialist: **Date:** _____