

Supported Living Client Financial Profile for an In-Home Subsidy

Name:		Social Security #*:	
Address:			Phone #:
Savings Account Balance as of _____ (date)	\$ _____	Checking Account Balance as of _____ (date)	\$ _____
Name (s) Persons Living in the home/age:			
Name(s) of Roommates Sharing Expenses: IHS Yes <input type="checkbox"/> No <input type="checkbox"/>			
Person Assisting In Completion of Profile: Agency:		Phone #: Date:	

I. Monthly Income Received By Client/Income of Minor children/others wards *

A. Employment	\$ _____	A. Child Support*	\$ _____
B. VA Benefits	\$ _____	B. TANF*	\$ _____
C. Food stamps	\$ _____	C. SSI*	\$ _____
D. SSI	\$ _____	D. SSA*	\$ _____
E. SSA	\$ _____	E. Other*	\$ _____
F. Other	\$ _____	Total *	\$ _____
Total	\$ _____	Grand Total*	\$ _____

*Indicate portion of income available to be used for housing expense only

II. Projected Monthly Expenses

Allowable Housing Expense Items	Previous Approved Amount	Present Requested Amount	APD Allowable Amount
Rent	\$ _____	\$ _____	\$ _____
Utilities	\$ _____	\$ _____	\$ _____
Telephone	\$ _____	\$ _____	\$ _____
Food	\$ _____	\$ _____	\$ _____
Clothing	\$ _____	\$ _____	\$ _____
Toiletries (personal items)	\$ _____	\$ _____	\$ _____
Household supplies	\$ _____	\$ _____	\$ _____
Other (attach reason)	\$ _____	\$ _____	\$ _____
Housing Subtotal	\$ _____	\$ _____	\$ _____

Other Personal Expense Items (Must be funded by other resources available to the individual)

Entertainment	\$ _____	\$ _____	\$0
Health Related	\$ _____	\$ _____	\$0
Transportation	\$ _____	\$ _____	\$0
Other:	\$ _____	\$ _____	\$0
Subtotal	\$ _____	\$ _____	\$ _____
Total Monthly Expenses	\$ _____	\$ _____	\$ _____

III. Recurring In-Home Subsidy Request

Total Monthly Income	minus	Total monthly Expenses	equals	Shortage (-)/Surplus (+)
\$ _____	-	\$ _____	=	\$ _____

* The collection of social security number is for record keeping purposes and is imperative to the agency's duties and responsibilities as prescribed by law. The social security number collected will not be available to the general public.

Supported Living Client Financial Profile for an In-Home Subsidy

Note: If requesting both Recurring and One-time In-Home Subsidy it is not necessary to complete "Information Section" on this page again.

Information Section. COMPLETE THIS SECTION IF ONLY REQUESTING A ONE-TIME IN-HOME SUBSIDY.

Name:	Social Security #*:
Address:	Phone #:
Savings Account Balance as of _____ (date) \$	Checking Account Balance as of _____ (date) \$
Name (s) Persons Living in the home/age:	
Name(s) of Roommates Sharing Expenses: IHS Yes <input type="checkbox"/> No <input type="checkbox"/>	
Person Assisting In Completion of Profile: Agency:	Phone #: Date:

IV. One-time In-Home Subsidy Request Worksheet

Reason for Move:

Proposed Move date: _____ or Check box if Emergency Subsidy only (Attach reason)

Category	Estimated Need Request Amounts	APD Estimated Approval Amount	Actual Need Request Amounts	APD Actual Approved Amounts
A. First month rent	\$	\$	\$	\$
B. Last month rent	\$	\$	\$	\$
C. Security deposit	\$	\$	\$	\$
E. Electric deposit	\$	\$	\$	\$
F. Electric hook-up	\$	\$	\$	\$
G. Telephone deposit	\$	\$	\$	\$
H. Telephone hook-up	\$	\$	\$	\$
I. Furnishings	\$	\$	\$	\$
J. Household supplies	\$	\$	\$	\$
K. Pantry stocks	\$	\$	\$	\$
L. Moving costs	\$	\$	\$	\$
M. Other:	\$	\$	\$	\$
Total start-up expenses	\$	\$	\$	\$

Comparison of Client's Available Funds With Start-up Expenses

Client total funds available (Savings/checking account, family contribution, other sources)	+	
Total start-up expenses (see above)	-	
(A positive total (+) represents a surplus/no start-up needed. A negative (-) total indicates that a start-up is needed.	Total	

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****** V. APD USE ONLY—DO NOT COMPLETE THIS SECTION******

RECURRING IN-HOME SUBSIDY APPROVAL

Total Monthly Income	minus	Approved Monthly Expenses	equals	Shortage (-)/Surplus (+)
\$	-	\$	=	\$

Based on review of information provided in the Financial Profile and documentation submitted, APD is authorizing the following In-Home Subsidy payments for the periods indicated:

MONTH/YEAR	APPROVED AMOUNT
1.	
2.	
3.	

ONE-TIME IN-HOME SUBSIDY APPROVAL

Date Requested by Client:	Requested One-time In-Home Subsidy Amount	Date of APD Action	APD Approved One-time In-Home Subsidy
	\$		\$

Note: A One-time and/or Recurring In-Home Subsidy request must be approved by APD prior to the signing of a lease/mortgage agreement.

EMERGENCY SUBSIDY APPROVAL

Approval for up to 90 days from date of action.

Date Requested by Client	Requested Emergency Subsidy Amount	Date of APD Action	APD Approved Emergency Subsidy
	\$		\$

The client's income and other personal financial resources *are sufficient to meet the client's expenses*. No financial assistance is requested from The Agency for Persons with Disabilities (APD) at this time.

By signing below all parties are attesting to their participation in the completion of this request and that all information provided is true and accurate.

Client _____	Date _____
Guardian (if appropriate) _____	Date _____
Supported Living Coach _____	Date _____
Support Worker (if appropriate) _____	Date _____
Fiscal Agent _____	Date _____
Support Coordinator _____	Date _____
APD Authorizing Signatures	
Supported Living Liaison _____	Date _____
Budget Manager _____	Date _____
Regional Administrator/Designee _____	Date _____