

**DSHS Family & Community Health Services Division
HOUSEHOLD Eligibility Worksheet**



PART I – APPLICANT INFORMATION

Name (Last, First, Middle)	Today's Date (MM-DD-YYYY)	Eligibility Effective Date (MM-DD-YYYY)
Case Record Action <input type="checkbox"/> Adjunctive <input type="checkbox"/> Presumptive <input type="checkbox"/> Supplemental <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Client/Case #	Type of Determination <input type="checkbox"/> New <input type="checkbox"/> Re-certification
Texas resident <input type="checkbox"/> Yes <input type="checkbox"/> No		
Other benefits or health care coverage (Medicaid, Medicare, CHIP, private health insurance, VA, TRICARE, etc.)		
Special circumstances		

PART II – HOUSEHOLD INFORMATION

1.	Notes
2.	
3.	
4.	
5.	
6.	

PART III – INCOME INFORMATION

Income Type	Name(s) of household member(s) with income		Documentation of income (if applicable)
Gross earned income			
Cash gifts/contributions			
Child support income			
Dividends/interest/royalties			
Loans (non-educational)			
Lawsuit/lump-sum payments			
Mineral rights			
Pensions/annuities			
Reimbursements			
Social security payments			
Unemployment payments			
VA payments			
Worker's compensation			
Total countable income			
Deductions	-	-	
Net countable income			
	Household FPL		%

PART IV – PROGRAM ELIGIBILITY

1. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	2. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	3. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
4. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	5. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH	6. <input type="checkbox"/> BCCS <input type="checkbox"/> EPHC <input type="checkbox"/> DSHS FP <input type="checkbox"/> PHC <input type="checkbox"/> Title V/MCH
Co-Pay/Fees		

Name of Agency	Signature – Agency / Staff Member	Date
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DSHS Family & Community Health Services Division HOUSEHOLD Eligibility Worksheet Instructions



PART I - APPLICANT INFORMATION

Fill in the boxes with the applicant's information.
Check the appropriate boxes.

Other benefits or health care coverage: Document other benefits received/denied. (An applicant or family member eligible for Medicare Part A/B must be referred to the Medicare Prescription Drug Plan (Part D) for prescription drug benefits.)

Special circumstances: Document any special circumstances.

PART II – HOUSEHOLD INFORMATION

Fill in the boxes with members of the household.

This number will include a person living alone or two or more persons living together where legal responsibility for support exists.

Legal responsibility for support exists between: persons who are legally married (including common-law marriage), a legal parent and a minor child (including unborn children), or a legal guardian and a minor child.

(Title V contractors may add whether household members are US citizens, eligible immigrants, or non-US citizens.)

Program Eligibility by 2014 Federal Poverty Level (FPL)

Effective April 1, 2014

Family Size	Title V - MCH	PHC EPHC BCCS	FP
	185% FPL	200% FPL	250% FPL
1	\$1,800	\$1,945	\$2,432
2	2,426	2,622	3,277
3	3,051	3,299	4,125
4	3,677	3,975	4,970
5	4,303	4,652	5,815
6	4,929	5,329	6,662
7	5,555	6,005	7,507
8	6,181	6,682	8,352
9	6,807	7,359	9,200
10	7,433	8,035	10,045
11	8,059	8,712	10,890
12	8,685	9,389	11,738
13	9,311	10,065	12,583
14	9,937	10,742	13,428
15	10,562	11,419	14,275

PART III - INCOME INFORMATION

Income may be either earned or unearned. If actual or projected income is not received monthly, convert it to a monthly amount using one of the following methods:

- weekly income is multiplied by 4.33;
- income received every two weeks is multiplied by 2.17;
- income received twice a month is multiplied by 2.

Fill in the *Income Type* table with name(s) of household member(s) and income amounts.

Calculate the *Total countable income*.

Calculate the *Deductions*:

- child support payments;
- dependent childcare;
 - up to \$200 per child per month for children under age 2;
 - up to \$175 per child per month for children age 2 and older;
- adults with disabilities;
 - up to \$175 per adult per month.

Total the *Net countable income*.

Calculate the household FPL using the applicable DSHS program policy and fill in the *Household FPL* box.

Use the *Documentation of income* box for notes (if applicable).

PART IV – PROGRAM ELIGIBILITY

Determine program eligibility for each household member using the corresponding numbers from the household information section.

Document applicable copayments and fees by program in the *Co-Pay/Fees* box.

Fill in the *Name of Agency*, sign, and date.