

**NORTH CAROLINA DIVISION OF MENTAL  
HEALTH/DEVELOPMENTAL DISABILITIES/  
SUBSTANCE ABUSE SERVICES**

**Central Regional Hospital  
Butner, North Carolina**

Addressograph

APSR 75-1, 8/1/08

**FINANCIAL DATA**

Name of Client: \_\_\_\_\_ Account No.: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Client's Soc. Sec. No.: \_\_\_\_\_

Parent, Spouse, Guardian, Other: \_\_\_\_\_

Admission Date: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

I. THIRD PARTY COVERAGE: If covered by Medicare, Medicaid, Insurance, and/or CHAMPUS, specify below. Indicate type of coverage and proper identification date.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. INCOME: Include all income of client and/or responsible party. Indicate type(s) of income and annual amount(s). If working income, indicate occupation and indicate payee of benefits, if other than client.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Total Gross Annual Income:  
\_\_\_\_\_

III. PROPERTY ASSETS: Include all real property, assets of client and/or responsible party. Use tax value of property and describe the property.

\_\_\_\_\_  
\_\_\_\_\_ Total Real Property  
\_\_\_\_\_

(a) Property has been verified by: \_\_\_\_\_ Call to: \_\_\_\_\_

County Tax Supervisor \_\_\_\_\_ Property Records on File: \_\_\_\_\_  
Written letter in financial file.

IV. OTHER ASSETS: Include all assets of client and/or responsible party. Other assets include savings, stocks, bonds, etc.

\_\_\_\_\_  
\_\_\_\_\_ Total Other Assets  
\_\_\_\_\_  
\_\_\_\_\_

**ABILITY TO PAY WORKSHEET**

A. PROVISIONAL RATE \_\_\_\_\_

\*B. RATE OF CHARGE \_\_\_\_\_

(Add 1B & 10)

- 1. Total Gross Annual Income (From Item II, Page 1). \_\_\_\_\_  
 1A. Fixed Income (client)..... \_\_\_\_\_  
 \*\*\*1B. Rate-Fixed Income..... \_\_\_\_\_
- 2. Total Real Property (Tax Value) (From Item III, Page 1)..... \_\_\_\_\_  
 Less Homestead Allowance..... \_\_\_\_\_  
 Net Value of Property..... \_\_\_\_\_
- 3. Total Other Assets (Item 4, Financial Date)..... \_\_\_\_\_
- 4. TOTAL ASSETS (Add 2 & 3 above)..... \_\_\_\_\_
- 5. 10% of Total Assets..... \_\_\_\_\_
- 6. TOTAL (Add 1 & 5)..... \_\_\_\_\_
- \*7. Allowances
  - A. Number of Exemptions X 1000 (Includes Client) \_\_\_\_\_
  - B. Dependent Blind or Handicapped..... \_\_\_\_\_  
 (Federal Allowance)
  - C. Dependent 65 and Older..... \_\_\_\_\_
  - D. Dependent in College (State Allowance \$660)... \_\_\_\_\_
  - E. Less 10% of Income (Exclude Fixed Income....  
 Line 1A)..... \_\_\_\_\_
- 8. Total Allowances..... \_\_\_\_\_
- 9. Annual Adjusted Income (Subtract line 8 from Line 6)..... \_\_\_\_\_
- 10. Provisional Rate..... \_\_\_\_\_  
 (Use Provisional Rate Schedule)

\* If B is different from A, explain in detail the reason for the difference  
 \*\* Allow Deductions According to Legal Responsibility  
 \*\*\* If Fixed Income Only (2B, page 2), no other assets, use fixed Income Guidelines in Accordance with SSA, VA, etc., regulations.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SIGNED: \_\_\_\_\_  
 Interviewer

DATE: \_\_\_\_\_

SIGNED: \_\_\_\_\_  
 Director of Reimbursement

DATE: \_\_\_\_\_