TOP AID HEALTHCARE, INC

MEMBER NAME:_____ DATE OF ASSESMENT:_____

ASSESSED BY:_____ AFC PROVIDER NAME: TOP AID HEALTHCARE,INC

PART 1: FINANCIAL INFORMATION

		SOURCE	AMOUNT
1. ALL INCOME		SSI	$
		SSDI	$
		SECTION 8	$
		PAID EMPLOYMENT	$
		FOOD STAMPS	$
		VETERANS BENEFITS	$
		OTHER	$
2. How does the member manage funds?		CHECKING ACCOUNT	DEBIT CARD
		CREDIT CARD	OTHER:
		SAVINGS ACCOUNT	
3. Is anyone assisting the member in managing their finances?		NO	
		YES, IF YES: _REPRESENTATIVE PAYEE _GUARDIAN _CONSERATOR _OTHER:	
4. Does the member have a representative payee set up?	NAME:		
	ADDRESS:		
	RELATIONSHIP TO MEMBER:		
	PHONE:		
5. Does the member have a guardian appointed?	NAME:		
	ADDRESS:		
	RELATIONSHIP TO MEMBER:		
	PHONE:		
6. Who is the member's MassHealth designated representative?	NAME:		
	ADDRESS:		
	RELATIONSHIP TO MEMBER:		
	PHONE:		

MEMBER FINANCIAL ASSESSMENT

PART II: ABILITY TO MANAGE FINACES

MEMBER NAME: _____

MEMBER'S CURRENT ALIBILTY TO:	INDEPENDENT	NEEDS PROMPTS	TOTAL ASSISTANCE
1. PURCHASES			
RECOGNIZE MONEY DENOMINATIONS			
MAKE CHANGE			
COMPLETE STORE CHECK OUT PROCESS			
UNDERSRAND THE USE OF CREDIT CARDS			
READ A PRICE TAG			
2. BANKING/ BUDGET PLANNING			
BUDGET OF EXPENSES			
COMPLETE BANKING TASKS			
BALANCE A CHECK BOOK			
USE OF DEBIT CARD			
PAYS BILLS TIMELY			

PART III: SHARED/ DELEGATED MANAGEMENT OF FUNDS

Does the AFC provider assist the member with financial management?	NO
	YES, IF YES: TO WHAT EXTENT: _____

ASSESMENT COMPLETE BY NAME/TITLE:	SIGNATURE:	DATE: