
MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-310 - STATEMENT OF HOUSEHOLD EXPENSES

PURPOSE & USE

This form is used only for individuals in Former SSI Recipients coverage groups who must have SSI policy applied to their case. When such a client has Income-In-Kind and alleges that the cash value of In-Kind Support & Maintenance (ISM) is less than the Presumed Maximum Value (PMV) or alleges that household expenses are shared, the client must complete this form to determine the income to count or the living arrangement in which the client will be placed.

INSTRUCTIONS

Prepare an original to mail or give the client for completion.

STATEMENT OF HOUSEHOLD EXPENSES

Client's Name _____

Medicaid ID # _____

RETURN BY: _____

PLEASE COMPLETE ITEMS BELOW FOR THE PERSON NAMED ABOVE WHO LIVES
IN YOUR HOUSEHOLD.

1. Total number of persons living in this household: _____
2. Rent or mortgage payment for this household: _____
City and county taxes, if not included above: _____
House insurance, if not included above: _____
TOTAL MONTHLY SHELTER EXPENSES: \$ _____
3. Average monthly expenses for utilities for this household:

Lights	\$ _____
Water	\$ _____
Heating Fuel	\$ _____
Sewer	\$ _____
Garbage Collection	\$ _____
TOTAL	\$ _____
4. Average monthly expenses for food for this household: \$ _____
5. TOTAL amount person named above pays each month: \$ _____

WHEN COMPLETE, MAIL TO:

✓ _____
Signature of Person Completing the Form

Date _____