



DETERMINATION OF NEED

Case Name:	Prior Medical Period		From:		Through:		
Case Number:	Redetermination Period		From:		Through:		
	Eligibility Base Periods		From:		Through:		
			From:		Through:		
	1	2	3	4	5	6	7
From:							
Through:							
A .MONTHLY EARNED INCOME							
1. Gross Income							
2. Pre-Tax Deduction*	-	-	-	-	-	-	-
3. IRWE/BWE Dependent Care exp.	-	-	-	-	-	-	-
4. Adjusted Gross Earned Income	=	=	=	=	=	=	=
B .MONTHLY UNEARNED INCOME							
5. Gross Income							
6. Pre-Tax Deduction*	-	-	-	-	-	-	-
7. IRWE/BWE Dependent Care exp.	-	-	-	-	-	-	-
8. Adjusted Gross Earned Income	=	=	=	=	=	=	=
C. FINAL COMPUTATION							
9. Total Income (4+8)							
10 SSI Disregard	-	-	-	-	-	-	-
11. Allocated Income/Child Support	-	-	-	-	-	-	-
12. IRS Income Tax Deduction*	-	-	-	-	-	-	-
13. Countable Income	=	=	=	=	=	=	=
14. Number of months in period	x	x	x	x	x	x	x
15. Income for Period	=	=	=	=	=	=	=
16. Irregular Income in Period	+	+	+	+	+	+	+
17. Total Countable Income	=	=	=	=	=	=	=
18. Medically Needy Income Standards (pg. 2 of F-8) in period	-	-	-	-	-	-	-
19. Total Spenddown	=	=	=	=	=	=	=
20. Medical Insurance and Other in period	-	-	-	-	-	-	-
21. Client Obligation or Adjusted Spenddown	=	=	=	=	=	=	=
*Does not apply to WH, presumptive SSI, PMG, or LTC.							
Choose appropriate radio button for each column used.							
Approved with Spenddown, Patient Liability, or Client Obligation.							
Approved with no share of cost.							
Denied							
Date form completed:							

Please see the [ES-3103.5 SSI Disregard Worksheet \(IL and HCBS only\)](#) for the line item 10 calculation. Also see the [F-8 Kansas Medical Standards](#) while using this form.