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| Transforming Lives |  HOME AND COMMUNITY SERVICES (HCS) **Client Responsibility Notice**Note: Only use this form for state-funded MCS and MAGI-based clients in residential settings. |
| CLIENT NAME | CLIENT ID NUMBER | DATE |
| As a resident of the facility operated by  , you are responsible to pay the PROVIDER’S NAMEfollowing amount(s) to your provider: |
| YOUR ROOM AND BOARD PAYMENT |
| You will pay this amount every month beginning: **This amount will not change unless you receive another letter from HCS with a new amount.**This is based on the following information for the month of:  |
| INCOME SOURCE | AMOUNT | EXPENSES | AMOUNT |
| VA Income |  | Payee / Guardianship Fee |  |
| Unearned Income |  | Other Guardianship Costs |  |
| Earned Income |  | Uncovered Medical Costs |  |
| Total |  | Other Expenses |  |
| Total |  |
| ADDITIONAL COMMENTS / INFORMATION |
| If you wish to review any of the income or expense information or the calculations we used to determine your payment amount(s) please contact your case manager. Authority for these actions can be found in WAC 388-106-0225 and 388-106-0285. |
| CASE MANAGER NAME | CASE MANAGER TELEPHONE | CASE MANAGER E-MAIL |
| Copies sent to Representative / Guardian / Protective Payee. |