DELAWARE HEALTH AND SOCIAL SERVICES Case #: _____

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

DIFFICULTY OF CARE PAYMENT SELF-DECLARATION FORM

Date: _____

Client/Employee Name: _____

I affirm that I receive payments to care for a Medicaid recipient who receives Home and Community Based Services (HCBS) and/or Medicaid Waiver Services (MWS). I understand that these payments may be considered Difficulty of Care payments and may be excluded from my gross income for certain Medicaid programs.

Client/Employee Signature: _____

Please provide all of the requested information below. This will help to determine if the compensation you receive qualifies for the Difficulty of Care Payment exclusion. Sign and mail, fax or email this form to the office listed below.

Health and Human Services Case Manager Name: Office Address:

_____ _____

Office Phone # _____ _____

Office Fax # _____ _____

1) List the name and address of the employer that pays you to care for the HCBS/MWS client.

   Company Name: _____

   Company Address: _____

2) What is the name, date of birth, and address of the HCBS/MWS client you are paid to care for?

   Name: _____ Date of Birth: _____

   Address of Client receiving care: _____

3) How much are you paid per hour, and how many hours per week do you provide non-medical care to the HCBS/MWS client listed above?

   Hourly Rate: _____ Hours per Week: _____

4) At what address do you provide care to the HCBS/MWS client?

   Address: _____

Please note that if multiple individuals within your household receive payments, a separate form will be required for each person.