N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND

DSB MEC FINANCIAL NEEDS SURVEY

Name _____

CURRENT ADDRESS: Street: _____ PO Box _____

Suite/Apt: _____ Zip: _____ City: _____ State: _____

County: _____ Last Updated: _____

☐ Mail Here? ☐ Main Residence? ☐ Ship Here? ☐ Invalid? ☐ Archive? Archive Date: _____

A. CURRENT MONTHLY RESOURCES

(A1) Gross Monthly Income of All Applicable Family Unit Members:

1. Name: _____ Age: _____

Relationship to Client: _____

Income Documentation: ☐ Check Stub ☐ Wage Verification ☐ OLV ☐ Tax Return ☐ Other ☐ No Income

Wage Details: _____

Frequency of Pay: _____ Amount: $ _____

Total Net Monthly Wages: $ _____

2. Pension: _____ Amount: $ _____

3. Compensation Payment: _____ Amount: $ _____

4. Child Support: _____ Amount: $ _____

5. Interest/Dividends: _____ Amount: $ _____

6. Support from Family/Friends: _____ Amount: $ _____

7. Other Income: _____ Amount: $ _____

Subtotal (A1) $ _____

(A2) **Allowed Deductions** Subtotal (A2) $ _____

Total Monthly Resources (A1) - (A2) = (A) $ _____

(A2) MONTHLY ALLOWED DEDUCTIONS- WORKSHEET

1. Federal $ _____
2. FICA $ _____
3. Medicare $ _____
4. State $ _____

Total Allowed Deductions (A2) = $ _____

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B. ALLOWABLE GROSS MONTHLY INCOME

1	2	3	4	5
$1089.00	$1469.00	$1848.00	$2228.00	$2607.00
6	7	8	9	10
$2987.00	$3367.00	$3749.00	$4129.00	$4510.00

Add $381.00 for each additional family member above (12) # _____

Total (B) $ _____

C. COUNTABLE MONTHLY INCOME A-B

A. Total Monthly Resources (A2) -

B. Allowable Gross Monthly Income = $_____

Based on Economic Needs Survey, individual is _____

I certify that the above information is a true statement of my financial situation, and I will notify the Division of Services for the Blind (DSB) of any changes in my financial situation.

Client: _____ Date: _____

Social Worker for the Blind: _____ Date: _____