South Carolina Department of Health and Human Services
Regular Foster Care Worksheet and Budgeting Record

Primary Individual:				
	First	Middle	Last	Household Number:
Date:	☐ Application	☐ Review	☐ Re-budget	

Parent's Name(s)		
First	Middle	Last

Name of Child	Date Of Birth	Citizenship	Source of Verification of Birth	Social Security Number and Verification
1.				
2.				
3.				
4.				
5.				

Living Arrangement: (Give method and date of verification. Document license number and expiration date.)

Name of Child	Living Arrangement	Date and method of Verification	Name of Facility	Facility License Number	License Expiration Date
1.					
2.					
3.					
4.					
5.					

Remarks/Documentation:	
DHHS-3230? ☐ Yes ☐ No	

Verification of Income (Give amount, method, and date of verification.)

Type of Income	Amount of Income	Method of Verification	Date of Verification
Child Support			
SSA/SSI Benefits			
VA Benefits			
Cash Contributions			
Other (Specify)			

Computation of Income

Name Of Child>>>				TOTAL
Child Support Payments	$	$	$	$
Cash Contributions	$	$	$	$
SSA/SSI Benefits	$	$	$	$
VA Benefits	$	$	$	$
Other (Specify)	$	$	$	$
Total Income (Rounded)	$	$	$	$

Budget Summary

Total Rounded Income: $	FI Need Standard: $

IF TOTAL INCOME EQUALS OR EXCEEDS THE APPROPRIATE FI NEED STANDARD, THE BUDGET GROUP IS INELIGIBLE FOR MEDICAID.

		Case Disposition	☐ Approved
		☐ Eligible for Retro? ☐ Yes ☐ No	☐ Denied
			☐ Closed
Eligibility Worker's Signature	Decision Date	Date of Eligibility	☐ Continued Eligible