Washington State Department of Social & Health Services
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 following amount(s) to your provider:
PROVIDER'S NAME

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.