FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ADULT FAMILY CARE HOME
INCOME AND EXPENSE STATEMENT

Provider Name: _____

Provider Address: _____

Street Address City Zip Code

Current Assets

MONTHLY INCOME		**MONTHLY EXPENSES**	
Employment: Self	$_____	Rent/Mortgage Payment	$_____
Spouse	$_____	Insurance: Car	$_____
Other	$_____	Home	$_____
Interest Income	$_____	Health	$_____
Income From Investments	$_____	Other	$_____
Retirement/Social Security	$_____	Auto Payment	$_____
Income from Current Residents	$_____	Utilities	$_____
Rental Income	$_____		
Other Income (Specify)	$_____	Telephone	$_____
	$_____	Loans	$_____
	$_____	Food Costs	$_____
		Credit Cards	$_____
		Other Liabilities (Specify):	
		$_____	
		$_____	
Total Monthly Income	$_____	**Total Monthly Expenses**	$_____

Cash on Hand/Savings $_____ Checking Account Amt. $_____

Stocks/Bonds (Value) $_____ Other $_____

_____ _____

DATE SIGNATURE

AHCA Form 3180-1017, Sept