agency for persons with disabilities
State of Florida

Individual Financial Profile

The Individual Financial Profile ("IFP") is a client financial profile developed to assist the client in a supported living setting with money management, by:

1. documenting the client's current living situation and supports (section I);
2. documenting the client's budget for housing and household expenses (sections II, III, and IV);
3. comparing the resources available with the cost of a client moving into his or her own home (sections V and VI);
4. requesting an in-home subsidy from APD (section VII); and
5. ensuring the appropriate supports have reviewed and verified the plan and provided financial guidance to ensure supported living is appropriate for the client (section VIII).

IFP INSTRUCTIONS

Sections I through IV and VIII must be completed. Sections V and VI must only be completed if a client is seeking to move into his or her own home or change his or her own home. Section VII must only be completed if the client is requesting either a start-up and/or monthly in-home subsidy.

In-Home Subsidy Requests

(relates to section VII)

For a client to be eligible for an in-home subsidy, he or she must live in a supported living setting. The Agency for Persons with Disabilities ("Agency") may provide an in-home subsidy when it is determined that the cash supplement to the client's income is the least costly alternative to meeting the client's needs and there are no other available resources for the type of assistance required. The purpose of an in-home subsidy is to enable the client to remain in the client's own home and is based on an individual determination of need.

A client requesting an in-home subsidy must submit a complete and accurate IFP to the Agency and attach substantiating documentation demonstrating the need for their request. All in-home subsidy funding is limited to essential needs to enable a client, in supported living, to remain in his or her own home based on the information contained in the IFP and supporting documentation. Failure to submit accurate and complete information may result in the denial, partial approval, or termination of an in-home subsidy. Approval of in-home subsidies are subject to the availability of Agency funds.

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I. Basic Information	
Client name:	Current client address:
(if applicable) client legal representative name(s):	
(If applicable) supported living coach name:	
(if applicable) support coordinator name:	
(if applicable) social security representative payee name:	
(if applicable) social security representative payee telephone #:	
Does the client currently live in his or her own home? Yes ☐ No ☐	
Is the client seeking to move into or change his or her own home? Yes ☐ No ☐	
Is the client residing in Section 8 Housing? Yes ☐ No ☐	
Does/will the client have roommates? Yes ☐ No ☐ # of roommates:	
Does/will the client have live-in personal supports? Yes ☐ No ☐	
Does the client have children living in the home? Yes ☐ No ☐ If yes, # of children:	
Select IFP type: ☐ Initial ☐ Quarterly Reassessment ☐ Other: Update or Change	
This IFP reflects the following for the client (check all that apply): ☐ Change in income since last IFP ☐ Temporary loss of roommate(s) ☐ Change in expenses since last IFP ☐ Financial emergency / housing at risk	
If applicable, describe changes / updates since last IFP:	

II. Monthly Income Received

Income includes all earned and unearned money received from any source. All monthly income must include supporting documentation, which must be attached.

Income Type	**Description / Notes** (if applicable)	**Monthly Amount**
Employment (gross)		
Social Security Disability Insurance (SSDI)		
Supplemental Security Income (SSI)		
Rental Assistance (HUD or other)		
Food Assistance (SNAP or other)		
Cash Assistance (TANF or other)		
Gifts		
Grants		
Annuities		
Other (specify):		
Other (specify):		
Other (specify):		
	Total Monthly Income:	

III. Projected Monthly Expenses

This is to be used by the supported living coach to identify the monthly expenses of the client. This will also be used to help determine the need for an in-home subsidy. An in-home subsidy may be used to pay for basic living necessities including, but not limited to: rent, utilities, food, clothing, toiletries, household supplies, and other household items. An IHS must not be used for restricted items, which are listed in Rule 65G-13.006, F.A.C. Even if an item is listed as allowable it must be cost-effective to enable the client to remain in one's own home. All monthly expenses must include supporting documentation to substantiate the projected amount.

Expense Type	**Client**	**Live-in Personal Support** (If cost is shared)	**Roommate(s)** (If cost is shared)	**Total Monthly Expense By Row**	**Allowable Expenses for APD** (For APD use only)
A. Housing					
1. Rent					
2. Utilities					
3. Landline Telephone					
4. Cellular Phone Service[1]					
5. Waste Disposal Service					
6. Lawn Service					
7. Subscription Television Service					-----n/a-----
8. Internet					-----n/a-----
9. Principal & Interest of a Mortgage					-----n/a-----
10. Property Tax					-----n/a-----
11. Home / Renter's Insurance					-----n/a-----
12. Home Improvement[2]					-----n/a-----
13. Repairs / Maintenance					-----n/a-----

[1] R. 65G-13.004(4)(b): In-home subsidy funds may be used to pay the cost of cellular phone service instead of a landline telephone service if it does not cost more than a landline telephone service.

[2] Includes but is not limited to adaptive equipment or aids.

14. Other (Specify):					-----n/a-----
15. Other (Specify):					
16. Other (Specify):					
Housing Subtotal:					
B. Food / Household Supplies					
1. Groceries					
2. Household Supplies/ Items					
3. Other (Specify):					
Food / Supplies Subtotal:					
C. Transportation					
1. Public Transit					-----n/a-----
2. Taxicab or similar service					-----n/a-----
3. Fuel					-----n/a-----
4. Other (Specify):					-----n/a-----
Transportation Subtotal:					
D. Personal Expenses					
1. Clothing					
2. Toiletries					
3. Personal Supplies / Items[3]					
4. Medical / Medicines					-----n/a-----
5. Dental					-----n/a-----
6. Insurance Premiums[4] and co-pays					-----n/a-----
7. Recreational item, event, and/or activity (Specify):					-----n/a-----
8. Nonessential / Discretionary[5]					-----n/a-----

[3] "Personal Supplies/Items" are basic tangible consumer goods which are necessary for the client to remain in the client's own home.
[4] Personal insurance includes life, auto, medical/health and does not include renters or homeowner's insurance.
[5] Includes all non-essential purchases not already included.

9. Other (Specify):					
10. Other (Specify):					
Personal Expenses Subtotal:					
Total Monthly Expenses *(add column subtotals)**:***					

IV. Comparison of Monthly Income with Projected Monthly Expenses		
Comparison for review of client's monthly income and expenses		
a. Total Monthly Income (From Section II.)	a.	
b. Total Monthly Expenses (Client's total monthly expenses from Section III.)	b.	
c. Total Monthly Income minus Total Expenses (a – b = c)	c.	
If the amount entered for "c" is a negative number, the client's income may not be sufficient to meet projected monthly expenses. This may indicate that request for an in-home subsidy is appropriate.		
----For APD Use Only----		
Calculation for monthly in-home subsidy		
a. Total Monthly Income (From Section II.)	a.	
d. Total Monthly Allowable Expenses (From Section III, APD Use Only.)	d.	
e. Total Monthly Income minus Total Monthly Allowable Expenses (a – d = e)	e.	

V. Start-Up Expenses & Available Funds

Only complete if the client is seeking to move into or change his or her own home.
Only include basic living expenses that will be incurred that are necessary for the client to move into his or her own home. The start-up expenses must be known and are not projected. If there are no live-in personal supports and/or roommates, then leave those columns blank. The Supported Living Coach must document all efforts in applying for rental assistance. All expenses must be supported by documentation.

Startup Expenses

Expense Type	**Client**	**Live-in Personal Supports** (if cost is shared)	**Roommate(s)** (If cost is shared)	**Total Expense by Row**
A. First month rent				
B. Last month rent				
C. Security deposit				
D. Electric deposit				
E. Electric hook-up				
F. Water deposit				
G. Water hook-up				
H. Telephone deposit				
I. Telephone hook-up				
J. Furnishings				
K. Household supplies				
L. Pantry stocks				
M. Moving costs				
N. Other (specify):				
Total Start-up Expenses:				

Available Funds

Source	**Description / Notes** (if applicable)	**Date of availability**	**Available Funds**
Checking Account			
Savings Account			
Cash on hand			
Access Florida Card f			
Security deposit refund			
Other (specify):			
		Total Available Funds:	

Description/Notes for Section V. (if applicable):

VI. Comparison of Available Funds with Start-up Expenses

Only complete if the client is seeking to move into or change his or her own home.

Start-up Calculations		
a. Total Available Funds (From Section V.)	a.	
b. Total Start-up Expenses (From Section V.)	b.	
c. Total Available Funds minus Total Start-up Expenses (a – b = c)	c.	
If the amount entered for "c" is a negative number, the client's available funds may not be sufficient to meet projected start-up expenses. This may indicate that a request for a start-up in-home subsidy is appropriate.		

VII. In-Home Subsidy Request(s)[6]

Only complete if the client is requesting an in-home subsidy.

The types of in-home subsidies are as follows:

1. **Start-Up In-Home Subsidy**: Financial assistance the Agency may provide to a client who is moving to his or her own home, which is provided on a one-time basis as a single supplement to the client's income to cover start-up costs based on the client's individual needs. Start-Up subsidies must be requested prior to the client moving into his or her own home.
2. **Monthly In-Home Subsidy**: Financial assistance the Agency may provide on a monthly basis for a set amount of time to a client who has demonstrated an ongoing need for financial assistance in order to live in his or her own home.

Based on the figures in the sections above, the following subsidy (or subsidies) is requested**:**

Subsidy Type	**Description of Need(s) Addressed by the Subsidy** (you may describe in an attachment and this must be supported by documentation)	**Time frame[7]**	**Amount Requested**
☐ Start-up Subsidy		Date:	
☐ Monthly Subsidy		Start Date: End Date:	

Requirement Questions (these must be answered)**:**

Have you described (just above) and attached supporting documentation of the specific client need for the subsidy request(s)?
Yes ☐ No ☐

Have you attached supporting documentation as required in the instructions of sections II through VI?
Yes ☐ No ☐

Have all other resources and options been utilized, other than moving into the family home, to reduce the cost of living?
Yes ☐ No ☐
If yes, describe such efforts and attach documentation, if any:

Required for startup subsidy only. Have you attached a copy of the proposed lease prior to the client signing? Yes ☐ No ☐

Required for monthly subsidy only. Have you attached a copy of the current written lease signed by the client and landlord? Yes ☐ No ☐

[6] Must meet the conditions of chapter 65G-13

[7] The end date for a subsidy should not exceed June 30th of the current fiscal year.

VIII. Signature & Certification

By signing below, I certify that the information contained herein is true and correct to the best of my knowledge. I further acknowledge that any individual who submits a claim containing documentation that has been falsified or that contains misrepresentations shall be held liable under the False Claims Act pursuant to sections 68.081-68.092, Florida Statutes.

Client: _____ Date: _____

(if applicable) Legal Representative: _____ Date: _____

By signing below, I certify that I have reviewed and verified the information contained herein and the have attached the necessary documentation to substantiate the statements made.

Supported Living Coach: _____ Date: _____
Date submitted to Support Coordinator or APD: _____

Support Coordinator: _____ Date: _____
Date submitted to APD and Supported Living Coach: _____

Regional office, mark all that apply:

Start-up Amount Approved: $_____ Date: _____
Ongoing Amount Approved: $_____ Start/End Date: _____

Authorizing Signature: _____ Date: _____