

FISCAL ASSESSMENT WORKSHEET

RECIPIENT'S NAME _____ CLIENT ID # _____

DATE _____

| CHHA SERVICES | DATES TO-FROM | COST PER HOUR/VISIT | HOURS OR VISITS | DAYS PER WK | COST PER WEEK | NUMBER OF WEEKS | ANNUAL COST |
|----------------------------|---------------|---------------------|-----------------|-------------|--------------------------------------|-----------------|-------------|
| H.H.A. SERVICES | | | | | | | |
| NURSING SERVICES | | | | | | | |
| PHYSICAL THERAPY | | | | | | | |
| SPEECH THERAPY | | | | | | | |
| OCCUPAT THERAPY | | | | | | | |
| | | | | | TOTAL ANNUAL COST _____ | | |
| | | | | | DIVIDE BY - 12 12 MONTHS _____ | | |
| | | | | | SUBTRACT MONTHLY EXCESS INCOME _____ | | |
| | | | | | AVERAGE MONTHLY COST _____ | | |
| | | | | | 90% RHCf _____ | | |
| AMOUNT OVER 90% RHCf _____ | | | | | AMOUNT UNDER 90% RHCf _____ | | |