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 | FISCAL ASSESSMENT WORKSHEET |  
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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 \_\_\_\_\_