ESTIMATED ANNUAL EXPENSES

Care Coordinator:
Working with the parent(s) please complete this form making the best projections for the coming year.

Name of Child:	Date of Birth:	Date form completed:

Equipment Rental:		**Expendable Supplies:**	
Hospital Bed:	$	Incontinence Pads:	$
Patient Lift:	$	Diapers:	$
Oxygen Equipment:	$	Ostomy Equipment:	$
Oxygen Monitor:	$	Tracheotomy care items:	$
Apnea Monitor:	$	Catheters:	$
Ventilator:	$	Bandages/Dressings:	$
Special Mattress:	$	Other:	
Portable Commode:	$		$
Other:			$
	$		$
	$		$
Total per month:	$	Total per month:	$

Medications:		**Physician Services (provide name of physician):**	
	$		$
	$		$
	$		$
	$		$
	$		$
Total per month:	$	Total per month:	$

Non-Physician Professional Services: Provide name of provider. **(**i.e. RT, OT, PT, ST, dental, etc.)		**Other Professional Services:**	
Provider	Monthly Cost	Provider	Monthly Cost
	$	Medical Laboratory:	$
	$	Radiology Services	$
	$		$
	$		$
	$		$
	$		$
Total per month:	$	Total per month:	$

Other Expenses Not Listed Above Incurred in the Care of this Child:

Item:	Frequency Used	Cost per Use	Annual Cost
Personal Care (Attendant Hours)			
Home Health (Chore Services)			
Private Duty Nursing			
Hospice Services			
Other (Please List):			

For agency use only:	
Total Annual Costs Incurred by Client:	
Equipment Rental:	$
Expendable Supplies:	$
Medications:	$
Physician Services:	$
Transportation:	$
Non-Physician Professional Services:	$
Other Professional Services:	$
Other Expenses NOT Listed Above:	$
TOTAL:	$