FISCAL ASSESSMENT WORKSHEET

ATTACHMENT 5

RECIPIENTS NAME _____ ClIENT ID # _____

DATE _____

PERSONAL CARE	DATES TO-FROM	COST PER HOUR/VISIT	HOURS OR VISITS	DAYS PER WK	COST PER WEEK	NUMBER OF WEEKS	ANNUAL COST
P.C. LEVEL I							
P.C. LEVEL II							
PRIVATE DUTY NURS							
H.H.A. SERVICES							
NURSING SERVICES							
PHYSICAL THERAPY							
SPEECH THERAPY							
OCCUPAT THERAPY							

TOTAL ANNUAL COST _____

DIVIDE BY 12 MONTHS - 12 _____

AVERAGE MONTHLY COST _____

90% RHCF _____

AMOUNT OVER 90% RHCF _____ AMOUNT UNDER 90% RHCF _____