West Virginia Department of Health and Human Resources

Children with Disabilities Community Services Program (CDCSP)
Cost Estimate Worksheet

INSTRUCTIONS:

1. COMPLETE DEMOGRAPHIC INFORMATION.

2. INDICATE THE SPECIFIC PERIOD OF TIME: FROM _____ TO _____

3. LIST ALL SERVICES THE CHILD HAD RECEIVED IN THE TWELVE (12) MONTHS PRIOR TO SUBMISSION OF THE PACKET, ON THE FORM "HISTORY OF MEDICAL TREATMENT PRIOR TO SUBMISSION OF THE PACKET". COMPLETE ALL INFORMATION REQUESTED INCLUDING BILLED CHARGES**.

   a. Out-patient Services include: physician, dental, behavioral health, specialized tests, lab work, Children with Special Health Needs Services, home health, private duty nursing, therapies, etc.

   b. In-hospital Services include: all hospital stays (include number of times and days), surgeries, physician visits, anesthesia, tests, medications, procedures, therapies, etc.

   c. School-Based Services: provided by the school system, e.g., physical, occupational, speech, aide, transportation, monthly case management, etc.

   d. Birth to Three Services: provided by the Birth to Three Program

   e. Pharmacy includes: medications that have been dispensed by a pharmacist***, prescribed nutritional supplements, etc.

   f. Durable Medical Equipment includes: diapers, assistive technology, wheelchairs, orthotics, dressings, etc.

4. ON THE FORM "SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE UPCOMING TWELVE (12) MONTHS", LIST ALL SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE NEXT TWELVE (12) MONTHS. SEE ABOVE CATEGORIES.

*IF YOUR CHILD HAS PRIVATE INSURANCE IN LIEU OF THE ABOVE LISTING, PROVIDE COPIES OF THE EXPLANATION OF BENEFITS (EOBS) FROM YOUR INSURANCE COMPANY. ASSURE THAT ALL ABOVE CATEGORIES ARE INCLUDED.

** BILLED CHARGES ARE THE CHARGES THE PROVIDER CHARGES, NOT WHAT YOU HAVE PAID OUT OF POCKET.

***A PRINT-OUT FROM THE PHARMACY SHOULD INCLUDE TOTAL BILLED CHARGES.

___Initial ___ Annual Review
(check only one) ___ ICF/IID ___Nursing Facility ___Acute Care Hospital

HISTORY OF MEDICAL TREATMENT PRIOR SUBMISSION OF THE PACKET
(can be completed by Parent/Guardian, Nurse and/or Case Manager)

West Virginia Department of Health and Human Resources

Bureau for Medical Services – Children with Disabilities Community Services Program

COST ESTIMATE WORKSHEET

Demographic Information

Individual's Full Name:

12-Month Period from _____ to _____

PHYSICIAN AND INPATIENT VISITS DURING THE PAST YEAR

Admission and/or Date Seen	Discharge Date (if applicable)	Name of Medical Facility and/or Physician	Type of Visit Outpatient (OP) Inpatient (IP)	Purpose of Medical Treatment	BILLED CHARGES (EOB)

SCHOOL-BASED SERVICES – BIRTH TO THREE SERVICES (IF APPLICABLE)		
SERVICE	FREQUENCY	BILLED CHARGES

PHARMACY	
MEDICATION	COST OF MEDICATION

DURABLE MEDICAL EQUIPMENT/SUPPLIES	
MEDICATION	BILLED CHARGES

SERVICES THE CHILD IS EXPECTED TO RECEIVE IN THE UPCOMING TWELVE (12) MONTHS			
Type of Services	Anticipated Service(s)	Anticipated Frequency of Service	Estimated Cost
Out-patient Services include: Physician, dental, behavioral health, specialized tests, lab work, Children with Special Health Care Needs services, home health, private duty nursing, therapies, etc.			
In-Hospital Services include all hospital stays (include number of times and days), surgeries, physician visits, anesthesia, tests, medications, procedures, therapies, etc.			
School-Based Services: provided by the school system, e.g., physical, occupational, speech, aide, transportation, monthly case management, etc.			
Durable Medical Equipment includes: diapers, assistive technology, wheelchairs, orthotics, dressings, etc.			

Pharmacy includes: medications that have been dispensed by a pharmacist***, prescribed nutritional supplements, etc.			
TOTAL ESTIMATED COST FOR THE YEAR: $ _____			
The estimated cost for the upcoming year is accurate to the best of my knowledge: Signature: _____ NOTE: REMEMBER TO INCLUDE EXPLANATION OF BENEFITS (EOBS)			