WV Department of Health and Human Resources
Bureau for Medical Services
Children with Disabilities Community Services Program (CDCSP)

COST ESTIMATE WORKSHEET

Child's Full Name	**Date of Birth**

☐ **INITIAL** ☐ **RENEWAL**

LEVEL OF CARE

☐ **ICF/IID** ☐ **NURSING FACILITY** ☐ **ACUTE HOSPITAL**

12 MONTH TIME PERIOD

FROM _____ TO _____

Please either provide Explanation of Benefits from the Private Insurance or a Summary of Charges/Allowed Amounts/Patient Responsibility
OR
Complete the following attachment

Please sign

The estimate cost for the upcoming year and/or EOBs are accurate to the best of my knowledge.

_____ _____ _____
Parent Printed Name **Parent Signature** **Date**

Child's Full Name	Date of Birth

MEDICAL SERVICES

Date	Physician/Facility	Charges that are Patient Responsibility/Deductible Co-pays
		$

PHARMACY

Date	Medication	Charges that are Patient Responsibility/Deductible Co-pays
		$

DURABLE MEDICAL EQUIPMENT/SUPPLIES

List Medical Equipment/Supplies	Amount that is patient responsibility
	$