SUPPLEMENT TO FEE AGREEMENT FOR REDUCED FEES
SERVICE: _____

Please fill out the following information as completely as possible and circle month of year for each income and expense item.

Client's name: _____Age: _____ Date:_____
Address: _____
Number of People in Household:_____

TOTAL LIQUID ASSETS
Savings Acct. _____
C.D.'s _____
Money Market _____
Mutual Funds _____
Stocks & Bonds _____

NET HOUSEHOLD INCOME
Employment _____
Pension _____
Social Security _____
Rental Property _____
Dividends _____
Financial Support
From Family _____
Other Income _____

Total Income _____

ALLOWABLE EXPENSES
(complete if income exceeds income guidelines)
Housing _____
Utilities _____
Food/Household Expenses _____
Drugs _____
Transportation _____

Insurance _____
Clothing _____
Medical Bill _____
One-Time Medical Bills _____

Total Expenses _____

(Expenses) divided by (income) =_____

Amount of Home/Hospice services covered by insurance: _____%
Deductible amount: _____ (met/unmet)
Applied for Medicaid: Yes _____ No _____
Applied for Disability, SSI: Yes _____ No _____
*** Payor/client will be billed □ per **diem** or □ **fee for service**?
Explanation/Comments: _____
_____

_____
Signature of person completing form

EVENTIDE VISITING NURSE/SOCIAL WORKER TO COMPLETE
Diagnosis: _____
Eligible services to be provided for reduced fee, frequency and duration:
For Home Health Care, clients must be homebound and require medically necessary skilled services.
HOME HEALTH AIDE SERVICES ARE NOT ELIGBLE FOR REDUCED FEES FOR HOME HEALTH CARE.
_____ VN _____ x/wk x _____wks; _____ PT _____ x/wk x _____ wks;
_____ ST _____ x/wk x _____ wks;
For Hospice ONLY: _____ HHA _____ SW _____
Comments: _____
_____

_____
Nurse/SW Signature

Approved Rate: Client to pay _____ % of charges.

_____
Administrator's Signature