

FINANCIAL ASSESSMENT WORKSHEET

The Finance Department is available for assistance.
Please contact the Accounts Receivable group from 8 a.m. to 4 p.m.
Monday through Friday, except holidays at 941-552-7500.

(PLEASE PRINT)

PATIENT NAME:	PATIENT NUMBER:
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STEP 1 INSTRUCTIONS

This form is applicable to:

- A patient who has NO Medicare, Medicaid or Insurance Coverage.
- A patient who has applied for Medicaid. (Medicaid Pending)
- A patient within the hospice house under the residential level of care.

Follow each step below:

STEP 2 List all current liquid assets of the hospice patients household.

If household liquid assets exceed \$10,000 the patient is responsible for the FULL daily per diem and skip to Step 6. The percentage applied to each per diem would be 100%.

ASSETS

Checking	
Savings	
Cert. Deposits	
Stock/Bonds	
Other	
TOTAL ASSETS	

STEP 3 List all monthly household sources of income, and then total.

INCOME MONTHLY

Salary / Wages	
SSA - Soc. Sec	
SSI - Supplement	
SSD - Disability	
VA	
Investments	
401(k), 403(b)	
Pension	
Annuity/Trust	
Child Support	
Other	
TOTAL INCOME	

STEP 4 Multiply the monthly income amount times 12 to calculate the Annual Income.

Monthly Income	X 12 =	Annual Income
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(PLEASE PRINT)

PATIENT NAME:	PATIENT NUMBER:
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STEP 5 Using the Annual Income you can determine the percentage owed from the *Cost of Care Calculation Matrix* worksheet attachment.

STEP 6 Enter the percentage owed from the worksheet to each level of care. Multiply each Per Diem Rate by that percentage to determine amount due. (The current per diem rates are listed on the *Cost of Care Calculation Matrix*)

	Per Diem	X	Percent	=	Amount Due/Day
Routine Care		X		=	
Inpatient Care (House Only)		X		=	
Respite Care		X		=	
Crisis Care		X		=	
Residential Room/Board**		X		=	

STEP 7 By signing below the patient, or responsible party, has agreed to pay the amount due per day to offset a portion of the total cost of care provided by Tidewell Hospice.

Patient Name	
Patient Signature	Date
Responsible Party	Date
Tidewell Representative	Date

BILLING ADDRESS

Name _____

Street _____

City/State/Zip _____

*** Residential Room and Board amounts due are collected in advance. Seven (7) days payment is due upon placement in the residential level of care within the hospice house. Residential Room and Board amounts due will continue to be billed every seven days. Amounts due for all other levels of care will be invoiced monthly.*

STEP 8 Hospice patients or responsible party need to complete STEP 8. Payment can be made in cash, check or credit card payable to Tidewell Hospice. Check the appropriate box below.

Attach cash or check to this worksheet and place in a sealed envelope and forward with original copy of the worksheet to the Accounts Receivable group.

[] CASH

[] CHECK

[] CREDIT CARD

	Card Number	Exp. Date
MasterCard	_____	_____
Visa	_____	_____
American Express	_____	_____
Discover	_____	_____