OFFICE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS
MEDICAL EXPENSE WORKSHEET

This form must be completed by the legal guardian of the patient enrolled in the OCSHCN clinical program or by the patient, if he or she is 18 years of age or older.

Check each of the items listed below for which an out-of-pocket expense has been made in the last twelve (12) months, and that was paid by the patient or legal guardian, or member of the patient's household. (Note: Household members include those individuals recognized by OCSHCN as components of the financial unit used for pay category determination).

For each item checked, please enter the total household dollar amount paid for incurred expenses. For each item listed, written proof of payment must be provided. Do not include expenses paid by an insurance carrier or any other third party payers.

Check Only if Applicable	Allowable Medical Expenses	Total Household Expenditure*
☐	Insurance premiums	$
☐	Medical office or clinic visits	$
☐	Medical supplies	$
☐	Nutritional supplies (e.g. Pedisure)	$
☐	Prescription medications	$
☐	Over-the-counter medications (e.g. Pain reliever)	$
☐	Durable Medical Equipment	$
☐	Hearing Aids	$
☐	Dental or Orthodontia	$
☐	Vision or Eye	$
☐	Hospitalizations	$
☐	OCSHCN payments	$
☐	Additional expenses for consideration_____ _____	$
	Grand Total	$

*For each total household expenditure listed, written proof of payment must be provided.

Relationship to Patient: ☐ Legal Guardian ☐ Patient

_____
Printed Name

_____ _____
Signature Date