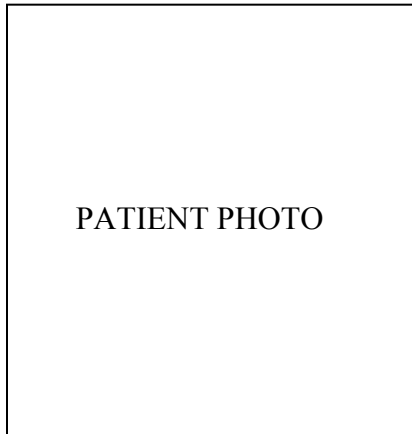


**ATTACHMENT C –Patient Financial Obligation Prior to Receiving Home Care Services**

**TEMPLATE: HOME HEALTH “POSTER PATIENT”**



**NAME:** Mary Smith

**RESIDENCE:** Bakersfield, CA

**AGE:** 87

**HOUSEHOLD COMPOSITION:** Widowed,  
Lives alone

**CONDITION(S):** CVA, Diabetic, high blood  
Pressure

**RECENT CARE:** Hospital (4 days for \_\_\_\_\_)  
SNF (length of stay)  
MD

**CURRENT:** Patient, XYZ Home Care

**PATIENT PAYMENT OBLIGATIONS (During recent spell of illness)**

Hospital Deductible: \$  
SNF Copay:  
Part B Deductible:  
MD Copay:

**PATIENT CONTRIBUTION TO HOME CARE**

Monthly living expenses: \$  
Supplemental care:  
Drug expenses:  
Other:

**TOTAL PATIENT CONTRIBUTION TO CARE** \$