



FIRST STEPS COST PARTICIPATION EXPENSES WORKSHEET

State Form 51359 (R / 4-06) / BCD 0093
Division of Disability and Rehabilitative Services



First Steps

Effective May 01, 2006

This form is to be reviewed with the family during the intake process by the intake coordinator and is completed upon the family's request. The form is also reviewed annually, coinciding with the IFSP. Once requested by the family, the SC is to review and complete this form within 30 days.

Name of child	Date of birth (month, day, year)	First Steps ID
Name of parent(s) / guardian(s)		

Medical Expenses: Out-of-pocket medical/healthcare expenses from the previous 12 months in which the family has not or will not be reimbursed.

Personal Care Needs Expenses: Out-of-pocket expenses from the previous 12 months that are related to the health or medical needs, in which the family has not, nor will not be reimbursed.

Expenses must be directly related to the health or medical condition of a family member. Expenses must be out-of-pocket expenses from the previous 12 months and those for which the family will not be reimbursed. Verification of expenses must be attached. **Document the expense and check the frequency it occurred. Expenses may be considered initially and annually.**

Health insurance premiums	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Insurance co-payments	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Dental and Vision expenses	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Hospital expenses	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Prescriptions	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Nutritional supplements as ordered by a physician	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Durable medical equipment / assistive technology / adaptations	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Specialized clothing as required per medical condition	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Specialized respite care or child care above that of typical costs	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Medical transportation costs	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Other related medical costs (attach list)	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
Other personal care needs expenses relating to a medical condition (attach list)	\$ _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Annually
TOTAL EXPENSES	\$ 				

I have supplied accurate information and agree with the calculations above:	
Signature of parent / guardian	Date (month, day, year)
I have reviewed all documentation and agree with the calculations above:	
Signature of service coordinator	Date (month, day, year)

DISTRIBUTION: Original - SPOE, Copy - Service Coordinator and family