

Clinical Effectiveness Department
Authorization for Expenditure Form

Patient Name _____ MRN _____

Employed Yes ___ No ___ Employer _____

Employer phone _____

Houshold Compositon:

Name	Relationship	Age	Employed (Y/N)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Qualified for Medicaid? _____

Qualified for Public Assistance? _____

Other relevant factors? _____

Support Systems:

Family _____ Church _____ Friends _____

Documentation of need for assistance: _____

SW/Designated Nurse Case Mgr/HSC

Date documented in SW database

Director of Clinical Effectiveness or
Manager, Clinical Effectiveness
(Expenditure > \$50, taxi rides > 50 miles)

John Cooper
Director of Finance
(Expenditures over \$1,000)