Apr 9, 2024

For Private Duty Nurses

Re: New Policy for Submitting Private Duty Nurse Expenses to CSNCE

DIRECTORS

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**Connie Stamos**

**P.O. Box 5621**

**Pasadena, CA 91117**

**Phone: 714-687-5313**

**Email: csnurscare@gmail.com**

**Website: www.csnce.org**

Dear Caregiver,

We recognize that Private Duty Nurses may be providing care for patients who are not residing in a Christian Science Nursing Facility. Accordingly we have updated our policy and procedures for submitting nursing care-related expenses to the Christian Science Nursing Care Endowment (CSNCE) for consideration for reimbursement for such patients. Attached is a submittal form for this purpose.

Support for nursing care provided to patients is considered on a per patient basis. CSNCE limits benefits to $20,000 for each patient regardless of the facilities entered or nurses who provided care. Only expenses directly related to nursing care are considered. Personal financial concerns of nurses providing care do not weigh in to considerations for benefits. The attached form should be used to submit all expenses related to private nursing care that you or the patient desire to be submitted for consideration. Completed forms, with receipts for supplies purchased attached, should be scanned and emailed to csnurscare@gmail.com or printed and mailed to:

 **CSNCE**

 **P.O. Box 5621**

 **Pasadena, CA 91117**

We are so grateful to be supporting your work as a Christian Science Nurse for those patients who fit our profile for providing aid!

Please let us know if you have any questions. You may call or email us and we will respond as soon as we can. Thank you!

Sincerely,

Executive Board, Christian Science Nursing Care Endowment

PRIVATE DUTY NURSE CARE EXPENSE SUBMITTAL

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Submitted\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CA ZIP\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner or Family Member who can attest to care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Providing Care\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hourly Rate $\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CA ZIP\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best days/hours to be reached\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please itemize expenses for which you are seeking reimbursement from CSNCE. Only those expenses related directly to nursing care for the above patient should be submitted and will be considered. **Scan and email completed form to:** **csnurscare@gmail.com** **or print and mail to: CSNCE, P.O. Box 5621 Pasadena, CA 91117**. Questions, please call (714) 687-5313 or email csnurscare@gmail.com.

**NURSING CARE PROVIDED:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Day | Hours Worked  | Nature of Care Provided | Total Hours | Daily Total (Hrs x Rate) |
| From | To |  |  |
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 **Total for all nursing Support Provided**

**NURSING SUPPLIES PROVIDED: (Please attach receipts for all supplied itemized)**

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| --- | --- | --- |
| **Date** | **Items** | **Cost** |
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 **Total for all Supplies**

Total Nursing Support Provided: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Supplies Provided: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOTAL AID REQUESTED: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Nurse\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient/Conservator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_