Leon County Schools
Flexible Spending Account
Annual Expense Estimate Worksheet

	Actual Expenses Last Year	Estimated Expenses New Year
MEDICAL		
Co-pays / expenses		
Prescriptions	$_____	$_____
Physician visits	$_____	$_____
Hospital visit co-pays / expenses (including Emergency)	$_____	$_____
Laboratory / testing expenses	$_____	$_____
Deductible expenses	$_____	$_____
Over-the-counter items (medicines require a prescription)	$_____	$_____
VISION		
Eye examination Eyeglasses	$_____	$_____
Contact lenses and solution	$_____	$_____
Lasik surgery	$_____	$_____
Other expenses	$_____	$_____
HEARING	$_____	$_____
Hearing examination	$_____	$_____
Hearing aid	$_____	$_____
DENTAL		
Co-pays / expenses		
Dental visits	$_____	$_____
Fillings	$_____	$_____
Major work (root canals, crowns, dentures, etc.)	$_____	$_____
Orthodontia (braces)	$_____	$_____
Deductible expenses	$_____	$_____
Other expenses	$_____	$_____
Total annual amounts	$_____	$_____

Dependent Daycare Account Annual Expense Estimate

CHILD DAYCARE *

Full-time daycare (per week)

Child one $_____

Child two $_____

Part-time daycare (per week)

Child one $_____

Child two $_____

1. Estimate the cost per week for each category of care
2. Calculate the annual cost (Weekly full-time daycare plus weekly part-time daycare X number of weeks per year)
3. Total amount $_____

*Child must be less than 13 years of age.

DISABLED / ELDER DAYCARE*

Caregiver monthly cost $_____

Multiply monthly cost times number of months estimated $_____

* Daycare provided for a dependent of any age who requires assistance with the basic tasks of daily life due to physical or mental challenges.

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