



Connecticut Department of Mental Retardation IFS Waiver Individual Budget

Region: ▼ Consumer Name: _____ DMR #: _____

Case Manager/Broker Name: _____ Phone # _____

Individual Budget Type: INITIAL REVISION RENEWAL

Budget Period: Start Date: _____ End Date: ▼ Year: _____ Number of Months in Budget: _____

IFS WAIVER NONE ENHANCED FAMILY SUPPORT AGENCY WITH CHOICE

Annualized Amount (12/M0): _____ **One Time \$** _____ **Allocated Amount:** \$0.00 **Budgeted Amount:** \$0.00
(For Current Budget Period)

Home and Community Supports

Agency Service Only	Vendor/Agency Name	Rate/Unit	Hours/Week	Hours/Month	Monthly Cost	Budgeted Amount
IS Habilitation		\$29.47		0	\$0.00	\$0.00
Personal Support		\$24.54		0	\$0.00	\$0.00
Adult Companion		\$15.49		0	\$0.00	\$0.00
▼				0	\$0.00	\$0.00
▼				0	\$0.00	\$0.00
Personal Emergency Response System						\$0.00
Subtotal						\$0.00

Ancillary Supports

Service	Vendor/Agency Name	Unit Cost	Units/Week	Units/Month	Monthly Cost	Budgeted Amount
Transportation (Per Mile)		\$0.39		0	\$0.00	\$0.00
Transportation (Per Trip)				0	\$0.00	\$0.00
Consultative Service				0	\$0.00	\$0.00
Interpreter Services				0	\$0.00	\$0.00
Subtotal						\$0.00

Other Supports One Time Cost

Specialized Medical Equipment	Vendor/Agency Name	Limit and Conditions (Over Three Years)	OneTime Cost for Current F.Y.
Specialized Medical Equipment		<i>\$750/year (\$3000 over 3 years) prior approval required</i>	
Enviromental Adaptations		<i>\$10,000 one time limit W/prior approval \$300/year maintenance</i>	
Vehicle Adaptations		<i>\$10,000 one time limit W/prior approval \$300/year maintenance</i>	
Subtotal			\$0.00

Service	Vendor/Agency Name	Unit Cost	Units/Week	Units/Month	Monthly Cost	Budgeted Amount
Family/Individual Consultation		\$47.14		0	\$0.00	\$0.00

Day and Vocational Supports

Agency Service Only	Vendor/Agency Name	Rate/Unit	Hours/Day	Daily Rate	# of days	Budgeted Amount
Group Day Sheltered		\$6.24		\$0.00		\$0.00
Supported Employment Group		\$9.01		\$0.00		\$0.00

Group Day (Day Support Options)		\$13.12		\$0.00		\$0.00
Staff Modifier (Group Services Only)		\$9.89		\$0.00		\$0.00
Supported Employment Individual		\$53.19		\$0.00		\$0.00
Individualized Day (Rate Negotiated)				\$0.00		\$0.00
Subtotal						\$0.00

Current Fiscal Year

Next Fiscal Year

F.Y. _____ SID \$ _____ F.Y. _____ SID \$ _____ Annualized \$ _____
 F.Y. _____ SID \$ _____ F.Y. _____ SID \$ _____ Annualized \$ _____

Other DMR Services (Not in above budget)

Support	Service	Vendor/Agency Name
Residential Habilitation	<input type="button" value="v"/>	
Day Program	<input type="button" value="v"/>	

Optional: Payment Spread

Jan. 1 - Mar. 31 _____ Apr. 1 - Jun. 30 _____ Jul. 1 - Sep. 30 _____ Oct. 1 - Dec. 31 _____

Recipient/ Sponsoring Family Member: _____ Date: _____
 Case Manager: _____ Date: _____
 Case Management Supervisor: _____ Date: _____
 (For new Budgets)
 DMR Regional Designee: _____ Date: _____
 Title: _____

Fiscal Intermediary _____
 Assigned by C.O. (Contact Stacie Albert @ 860-418-6029)

CC: Individual, Case Manager, Business Office, FI, CO-Operations Center, Regional PRAT Coordinator

Instructions on how to fill out Budget

- 1 Fill in Region, Consumer Name , DMR Number, Case Manager/Broker Name & Phone #
- 2 Check off appropriate Budget type (new, revision, renewal of existing budget)
- 3 Fill in Budget period (Start Date must begin on the first of any month and End Date has to end on a quarter.)
- 4 Enhanced Family Support check box- this is used to indicate if this type of waiver is being used.
- 5 Fill in the Number of months in the Budget
- 6 Fill annualized amount (the amount of dollars for a 12 month cycle)
- 7 One Time \$ - Only use if One Time \$ is not included in annualized funding
- 8 Allocated Amount- this will auto fill after you have filled in the number of months and the annual amount. This amount is the available funds for the budget period.
- 9 Budgeted Amount- this will auto fill as you start to fill in the actual budget below. (you want to get the total in this box as close to the allocated amount as possible.) This is primarily a guide to help you budget your supports.
- 10 Fill in the supports by number of hrs/units a week. The totals will auto fill.
- 11 When using Respite 24 hr use # of days not hrs per week
- 12 Current Fiscal Year & Next Fiscal Year- Fill in the totals for each SID (If Budget Crosses Fiscal Years, fill in totals for each F.Y.)
- 13 Optional Payment Spread - If the budget isn't spread evenly throughout budget use this area to indicate how much each quarter.
- 14 Signatures - get required signatures as outlined on form.
- 15 Fiscal Intermediary - this will be assigned by C.O.



**Connecticut Department of Mental Retardation
Individual Family Support Waiver
Vendor Service Authorization**

Consumer Name: _____ DMR #: _____ Fiscal Intermediary: | _____ ▼
 Case Manager/Broker: _____ Phone # _____ Region: _____ ▼

_____ is authorized to provide the following
Agency/Vendor name
 services to: _____ Effective Date: _____
Consumer Name

Service:	Unit	Rate/Unit	Units/Month	Monthly Cost
▼	▼			
▼	▼			
▼	▼			
▼	▼			

The Agency/Vendor shall invoice the applicable Fiscal Intermediary monthly for services provided.
 Check the assigned Fiscal Intermediary below:

F. I. Addresses:

Allied Community Resources, Inc
 PO Box 1086
 Enfield, CT 06082-1086

Public Partnerships, LLC
 6 Admirals Way
 Chelsea, MA 02150

SUNSET SHORES
 720 Barnum Ave. Cut Off
 Stratford, CT 06614

Authorized by: _____
Print Name

Signature

Title: _____
 Date: _____

