

<b>Home and Community Based Services Waiver</b>  <b>Individualized Service Plan Budget</b>  Date this budget plan was prepared: _____ Date Reviewed (list each date): _____	ICC Agency Name:	Child's Name:	ID No:
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Type of Service	Provider Agency	Effective Date	Number of Weeks Or Months	Frequency & Duration	Rate	Total Annual Costs
<b>Waiver Services:</b>						
ICC						
Respite Care Hourly						
Respite Care 6 Hours and Over						
Family Support						
Skill Building						
Intensive In-Home						
Crisis Response						
<b>Non-Waiver Mental Health Services:</b>						
Outpatient Psych: (clinic)						
Day Treatment (DT)						
Inpatient Psych:						
Psychiatrist						
CPEP						

Type of Service	Provider Agency	Effective Date	Number of Weeks Or Months	Frequency & Duration	Rate	Total Annual Costs
<b>Medical Services:</b>						
Inpatient						
Physician					average waiver child	\$66.00
Specialist (specify)						
Dental					average waiver child	\$90.00
SSPHS					average waiver child	\$873.00
Pharmacy					average waiver child	\$3,287.00
<b>Managed Care Premium</b>					average waiver child	\$437.00
<b>Other:</b> (Specify) (hearing test etc., include flex dollars and in kind.)						

Type of Service	Provider Agency	Effective Date	Number of Weeks Or Months	Frequency & Duration	Rate	Total Annual Costs
<b>Projected Total Cost of Services:</b>						

\_\_\_\_\_  
**LGU Signature**  
 (required for Initial Service Plan's Budget only)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**ICC Supervisor Signature**  
 (required at each Service Plan review)

\_\_\_\_\_  
**Date**

**Note:** At each Service Plan Review the budget is to be compared to services the child actually received during the period under review. Adjustments to the budget need to be accordingly made.