

SERVICES BUDGET (ISB Worksheet)

FY09

LAST NAME: 0 FIRST NAME: 0 CLIENT ID #: 0 MEDICAID (XIX) ELIGIBLE: Y
 DATE OF BIRTH: 1/0/1900 DCF CHILD #: _____ SSI ELIGIBLE: _____ BUDGET TYPE: _____
 DATE SUBMITTED: 1/0/1900 QSR #: _____ IV-E ELIGIBLE: 0
 THERAPEUTIC CASE MANAGER: 0 CMHC CHILD #: _____ PERIOD OF THIS BUDGET: 0
 HOME CLINIC: 0 SERVICE PROVIDER: 0 SOC.SEC/MED.#: 000-00-0000 NUMBER OF MONTHS: 0

| Budget Service Code | Service Description | Provider Agency | Cost/ Unit | Hours Per Week | Units Per Month (x 4.35 weeks per month) | Monthly Total | One-Time Cost | Crisis PRN | Federal Share Medicaid (T.XIX) | CMHC | DCF | LEA | Other | If Other Funding Source/ Contract Name |
|--------------------------------|-------------------------------|-----------------|------------|----------------|--|---------------|---------------|------------|--------------------------------|------|------|------|-------|--|
| MEDICAID (XIX) SERVICES | | | | | | | | | | | | | | |
| A01 | Service Planning & Coordinati | | 0.00 | | 0.00 | 0.00 | | | 0.00 | | 0.00 | | | |
| B01 | Individual Community Support: | | 0.00 | | 0.00 | 0.00 | | | 0.00 | | 0.00 | | | |
| E02 | Individual Therapy | | 0.00 | | 0.00 | 0.00 | | | 0.00 | | 0.00 | | | |
| E04 | Group Therapy | | 0.00 | | 0.00 | 0.00 | | | 0.00 | | 0.00 | | | |
| E03 | Family Therapy | | 0.00 | | 0.00 | 0.00 | | | 0.00 | | 0.00 | | | |
| E05 | Chemotherapy | | 0.00 | | 0.00 | 0.00 | | | 0.00 | | 0.00 | | | |
| E01 | D&E | | 0.00 | | 0.00 | | 0.00 | | 0.00 | | 0.00 | | | |
| | MEDICAID SUBTOTAL | | | | | 0.00 | 0.00 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| | | | | | | | | | | | | | | |
|---|------------------------------|--|------|--|--|-------------|-------------|-------------|--|------|------|------|------|------|
| RESIDENTIAL AND OTHER SERVICES PROVIDED BY SUBMITTING AGENCY | | | | | | | | | | | | | | |
| H04 | Therapeutic Foster Care | | 0.00 | | | 0.00 | | | | | 0.00 | | | |
| 020 | Personal Expenses | | 0.00 | | | 0.00 | | | | | 0.00 | | | |
| D01 | Respite-Hourly | | 0.00 | | | 0.00 | | | | | 0.00 | | | |
| D02 | Respite-Overnight/Weekend | | 0.00 | | | 0.00 | | | | | 0.00 | | | |
| G01 | Crisis Supports | | 0.00 | | | | | 0.00 | | | | | | |
| B01 | Flex Funds | | 0.00 | | | | 0.00 | | | | | | | |
| | NON-MEDICAID SUBTOTAL | | | | | 0.00 | 0.00 | 0.00 | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| | | | | | | | | | | | | | | |
|---|-----------------|--|--|--|--|------|------|------|------|------|------|------|------|------|
| SERVICES NOT PROVIDED BY SUBMITTING AGENCY | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | SUBTOTAL | | | | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| | | | | | | | | | | | | | | |
|----|----------------------------------|------------------|-------------|--|--|-------------|------|------|------|------|------|------|------|------|
| | MONTHLY TOTAL COST | | | | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| A. | TOTAL TREATMENT (ABOVE THE LINE) | # of Days | 0.00 | | | 0.00 | | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| B. | TOTAL BELOW THE LINE | | | | | 0.00 | | | | | | | | |
| B. | TOTAL BUDGET ONE TIME EXPENSES | | | | | | 0.00 | | | | 0.00 | | | |
| C. | TOTAL BUDGET CRISIS/PRN SERVICES | | | | | | | 0.00 | | | 0.00 | | | |
| D. | GRAND BUDGET TOTAL | | | | | 0.00 | | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

| | | |
|--------------------------|---|---------|
| ISB DAILY RATE | → | #DIV/0! |
| DCF MATCH DAILY RATE | → | #DIV/0! |
| DCF DAILY RATE | → | #DIV/0! |
| DCF CRISIS (unmatched) | → | 0.00 |
| DCF ONE-TIME (unmatched) | → | 0.00 |