

## SERVICES BUDGET (DMH Matched Waiver Worksheet) FY09

LAST NAME:           0                FIRST NAME:           0                CLIENT ID #:           0                MEDICAID (XIX) ELIGIBLE:   Y        INTERNAL CODE: \_\_\_\_\_  
 DATE OF BIRTH:           1/0/1900                DCF CHILD #: \_\_\_\_\_      SSI ELIGIBLE: \_\_\_\_\_  
 DATE SUBMITTED:           1/0/1900                QSR #: \_\_\_\_\_      IV-E ELIGIBLE: \_\_\_\_\_      BUDGET TYPE:           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 <small>(x 4.35 weeks per month)</small>	Monthly Total	One-Time Cost	Federal Share Medicaid (T.XIX)	CMHC	DCF	LEA	Other	If Other Funding Source/ Contract Name
<b>MEDICAID (XIX) SERVICES</b>													
A01	Service Planning & Coordination		0.00		0.00	0.00		0.00	0.00				
B01	Individual Community Supports		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				
H04	Therapeutic Foster Care		0.00		0.00	0.00		0.00	0.00				
E05	Chemotherapy		0.00		0.00	0.00		0.00	0.00				
G01	Crisis Supports		0.00		0.00	0.00		0.00	0.00				
G01	Crisis Response System		0.00		0.00	0.00		0.00	0.00				
D02	Respite-Overnight		0.00		0.00	0.00		0.00	0.00				
D01	Respite-Hourly		0.00		0.00	0.00		0.00	0.00				
B03	Consultation		0.00		0.00	0.00		0.00	0.00				
E01	D&E		0.00		0.00		0.00	0.00	0.00				
	<b>MEDICAID SUBTOTAL</b>					<b>0.00</b>	<b>0.00</b>	0.00	0.00	0.00	0.00	0.00	0.00
<b>RESIDENTIAL AND OTHER SERVICES PROVIDED BY SUBMITTING AGENCY</b>													
045	Room & Board		0.00			0.00			0.00				
020	Personal Expense		0.00			0.00			0.00				
	<b>NON-MEDICAID SUBTOTAL</b>					<b>0.00</b>			0.00	0.00	0.00	0.00	0.00
<b>SERVICES NOT PROVIDED BY SUBMITTING AGENCY</b>													
	<b>SUBTOTAL</b>					0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	<b>MONTHLY TOTAL COST</b>					0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
A. TOTAL TREATMENT (ABOVE THE LINE)		<b># of days</b>	<b>0.00</b>			<b>0.00</b>		0.00	0.00	0.00	0.00	0.00	0.00
B. TOTAL BELOW THE LINE						<b>0.00</b>							
B. TOTAL BUDGET ONE TIME EXPENSES							0.00	0.00					
<b>D. GRAND BUDGET TOTAL = A + B + C</b>						<b>0.00</b>		0.00	0.00	0.00	0.00	0.00	0.00

WAIVER DAILY RATE → #DIV/0!  
 DMH MATCH DAILY RATE → #DIV/0!  
 DMH DAILY RATE → #DIV/0!