Springfield Regional Office
Budget Summary

Consumer's Name:

DMH ID:

Service Coordinator:

DD Medicaid Waiver Eligibility
☐ None ☐ Lopez
☐ Comprehensive ☐ Partnership ($12,000 annual cap)
☐ Community Support ($22,000 annual cap)
☐ Autism ($22,000 annual cap)
Slot Number:

Plan Year Date:
Amended Budget Date (if applicable):

		Current Service (check only one)			Services/Support							DMH / SB40			
New Service Request	Currently on WL	Current Service	Increase in Units/Cost	Decrease in Units/Cost	Service Code, Service Description, and Unit Designation	Provider Name and Description	One-Time Cost	Funding Source	Number of Units	Rate per Unit	Waiting List, Other Systems, Family, Etc.	SB40 Funds	DD General Revenue	Medicaid Waiver Match	Plan Value
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
For amended budgets only: List the annual on-going cost for each service the consumer will receive during the next plan year (12 months):											$0.00				
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
															$0.00
											$0.00				

Current Plan Year Cost

MRDD Total	$0.00
SB40 Total	$0.00
Plan Value Total	$0.00

Amended Plans: Annualized On-Going Cost

MRDD Total	$0.00
SB40 Total	$0.00
Plan Value Total	$0.00

Service Coordinator/Supervisor Date

Regional Office Director (if applicable) Date

JUSTIFICATION/COMMENTS: