				INITIAL	ANNUAL	UPDATE
CLIENT NAME				**PROVIDER**		
				HOME NAME		
STATE ID #	**CLIENT MEDICAID #**			**CASE MANAGER**		
STREET ADDRESS		**CITY**	**ZIP**	**PLAN IMPLEMENTATION DATE**		
				From:	To:	
# OF CLIENTS SHARING HOUSEHOLD	**FORMER PLACEMENT**			**BUDGET AUTHORIZATION PERIOD**		
				From:	To:	

BUDGET PLAN

ROOM AND BOARD

Room & Board	Total Cost	Other Resources	Source	Remaining Cost
Food	$ -	$ -	Food Stamps	$ -
Laundry				$ -
Household Supplies				$ -
				$ -
				$ -
				$ -
Rent				$ -
Telephone				$ -
Trash				$ -
				$ -
				$ -
				$ -
				$ -
Utilities				$ -
Electricity				
Water/Sewer				
Natural gas/propane				

TOTAL MONTHLY ROOM & BOARD	$ -
TOTAL DAILY ROOM & BOARD	$ -

PAYEE STATUS

- ☐ **OTHER** Name:
- ☐ **DMH** Address:
- ☐ **Consumer** City/State/Zip

BENEFITS:	SSA	$ -	SSI	$ -
	VA	$ -	OTHER:	$ -
			CLIENT DIRECT PAY	$ -
			PERSONAL ALLOWANCE	$ -
			SPEND DOWN	$ -

RESIDENTIAL HABILITATION

Community Specialist	$ -	X	0	hrs	=	$ -
Community Integration Skills Trainer	$ -	X	0	hrs	=	$ -
Direct Care Staff 1	$ -	X	0	hrs	=	$ -
Direct Care Staff 2	$ -	X	0	hrs	=	$ -
Community RN	$ -	X	0	hrs	=	$ -
Staff Mileage	$ -	X	0	miles	=	$ -

Other Expenses:

Case Coordination	$ -
Sub-Total Residential Habilitation	$ -
Administrative Costs	$ -
TOTAL MONTHLY RESIDENTIAL HABILITATION	$ -
TOTAL DAILY RESIDENTIAL HABILITATION	$ -

Keeping the Medicaid application current is the Responsibility of the provider agency.

PROVIDER SIGNATURE	DATE
CASE MANAGER SIGNATURE	DATE
CASE MANAGER SUPERVISOR SIGNATURE	DATE
REGIONAL CENTER DIRECTOR/DESIGNEE	DATE