CHILDREN'S DIVISION / DIVISION OF DD INTERDIVISIONAL SERVICE AGREEMENT

This document affirms the Division Director's joint approval for Children's Division to pay the full costs of state match for placement of the child named below, who is in its care and/or custody, under the Medicaid HCBS Waiver for persons with developmental disabilities. Attach other pages as needed.

CHILD:

Last **First** **MI** ***Birth Date*** ***Medicaid DCN***

Name of Residential Provider

Benefits (Specify SSI, etc.) *Benefit Amount* *Payee of Benefits*

DD:

DD Support Coordinator *DD Regional Office*

CD:

Children's Division Caseworker *Children's Division County Office*

Children's Division RCST Coordinator

OTHER PLANNING TEAM MEMBERS:

EFFECTIVE DATE OF AGREEMENT: **From** **To (21st Birthday)**

***Cost Estimates for the Responsible Payer: Attached are the estimated annual costs for the waiver services identified by the planning team. This information is subject to change as the needs of the child are the prime factor in dictating what services are authorized.**

The Undersigned Children's Division staff indicate by their signature that the Children's Division will fund the state match portion of approved and delivered services for the above individual based on need as identified by the local planning team until his/her 21st birthday, or until such time the individual is no longer served under an IDA between the Children's Division and Division of Developmental Disabilities, whichever occurs first.

COMMENTS:

LOCAL APPROVAL:

Children's Division RCST Area Coordinator Signature **Date** **DD Regional Office Director Signature** **Date**

CENTRAL OFFICE APPROVAL:

Children's Division Director or Designee **Date** **DD Division Director or Designee** **Date**

Copies to: **Children's Division Case Manager** ☐ **Children's Division RCST** ☐ **DD Support Coordinator** ☐
DD Regional Office Director ☐ **Specify Others:** ☐