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# Part I

# Consumer Information

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| Name: Last name, first name, middle   | Date of birth:   |
| Social security number:   | Medical assistance number: (If not available, see Service Funding Plan instructions.) |
| Current Address: County:  | Address where services will be received:  County:  |
| Status (New/Transfer/Existing): If individual is a transfer, indicate originating agency:  If individual is an existing consumer with your agency, indicate current service(s) received:   | Describe how this service funding plan was developed.1. Based on the person-centered plan developed on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *or*2. Agency team meeting on \_\_\_\_\_\_\_\_\_\_\_\_\_. Participants were: *or*3. Other (describe):   |
| Eligibility: DD\_\_\_ non-DD \_\_\_ |  |

# Provider Information

|  |  |
| --- | --- |
| Agency name:   | Agency contact person:  Phone: Fax: E-mail address:  |
| Agency address:   |  |

**Part II: Summary of Consumer’s Current Situation**. (Refer to the Service Funding Plan instructions for details about the type of information required here. Use the space below or include attachment.)

**Part III: Proposed Services Requested.** (Please indicate the services requested with this plan with anticipated service start dates.)

|  |  |
| --- | --- |
| **Service Anticipated start date** | **Service Anticipated start date** |
| Residential ALU: Other (describe): | Day Supported Employment: Day habilitation/Vocational: Other (describe): |
| Personal Supports: | Individual Support Services: |
| Family Support Services: | Individual Family Care: |
| Innovative Service Plan: | Other (describe): |

**Part IV: Specific Description of Proposed Services.** (Refer to the Service Funding Plan instructions for details about the type of information required here. Use the space below or include attachment.)

# Part V: Cost Detail.

# A. Attach a Cost Detail page for each service requested in Part III. Each Cost Detail page should reflect the total annual cost of serving the consumer for that service type.

**B.** Complete the following section for individuals whose Service Funding Plans indicate a need for above average funding. DDA will not authorize expenditures for the following services unless this section is accurately and fully completed.

* FPS: Add-on components, supplemental services, start-up/OTO costs
* Personal Supports Payment System: supplemental services, professional services, over 82 hours of service per week.
* Contracted services: Professional services, start-up/OTO costs

 1. Cost Information (annualized and non-annualized): Describe the costs associated with providing the services identified above. Detail hourly rates and fringe benefit costs corresponding to the hours of service requested in Part IV, and itemize start-up/OTO costs. The totals should correspond to the totals on the Cost Detail page. Refer to the Service Funding Plan instructions.

 2. Cost Justification: Describe why these costs are appropriate. Present comparative information, reasons for choosing a specific vendor, the appropriateness of the hourly rate, etc. Attach information as necessary (e.g. copies of advertisements, your agency salary scale, etc.) Refer to the Service Funding Plan instructions.

**Part VI: Modification Request.** Complete this section **only** if this is a request to change the level of service for a consumer currently funded for that service. Identify annual funding amounts for each category below. *(e.g. Consumer A currently receives 12 hours of ISS support per week. This Service Funding Plan describes and justifies in Part IV Consumer A's need for 20 hours of ISS support per week, and the Cost Detail in Part V delineates the cost of the 20 hours of service per week.)*

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| **Total Funding Request** | **Current Funding** | **Modification Request** |
|  |  |  |

# Part VII. Signatures. (Please note: As plans progress through the negotiation and approval process, changes to the original proposal may occur. Final approval of all Service Funding Plans rests with the DDA Director. Providers will receive an Award Letter from the DDA Director when the plan has been approved.)

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| --- | --- |
| Provider: (Signature indicates that the information presented in the Service Funding Plan and attachments is accurate and complete.) | Date: |
| Resource Coordinator: (Signature indicates that the resource coordinator has reviewed the Service Funding Plan and attachments.) | Date: |
| Consumer/Family: (Signature indicates that the consumer/family has reviewed the Service Funding Plan and attachments.) | Date: |
| Regional Program Staff: (Signature indicates that the regional program staff and provider have agreed upon the services to be funded.) | Date: |
| Regional Director: (Signature indicates regional approval of the Service Funding Plan.) | Date: |

Copies of the final approved version of this Service Funding Plan are available upon request.