



**Home and Community Based Services Waiver Guidance
Document
Individualized Care Budget**

Date Budget was Prepared: _____	Program Name:	Child's Name:	Medicaid No:
Date Budget was Reviewed:			

Type of Service	Provider	Effective Date	Number of Weeks/Months	Frequency & Duration	Rate	Total Annual Cost
Waiver Services:						
ICC						
Transitional Case Management						
Respite						
Family Support						
Skill Building						
Int. In-Home						
Crisis Response						
Youth Peer Advocacy						
Prevocational						
Supported Employment						
Other (Please specify, including Flex Funds)						
SUBTOTAL (Waiver Services):						
Non-Waiver MH Services:						



**Office of
Mental Health**

Outpatient Psych: (clinic)						
Day Treatment						
Inpatient Psych.						
Psychiatrist						
CPEP						
Other (Please specify)						
SUBTOTAL (Non HCBS Services):						
Medical Services:						
Inpatient						
Physician						
Specialist (specify)						
Dental						
Pharmacy						
Managed Care Premium						
Other (Specify)						
SUBTOTAL (Medical Services):						
Projected Total Cost of Services:						

LGU Signature _____ **Date** _____
(Required for Initial Service Plan's Budget only)

ICC Signature _____ **Date** _____

ICC Supervisor Signature _____ **Date** _____