



Home and Community Based Services Waiver  
Guidance Document  
Division of Children and Families

Individualized Care Budget

|                           |               |               |        |
|---------------------------|---------------|---------------|--------|
| Date Budget was Prepared: | Program Name: | Child's Name: | ID No: |
| Date Budget was Reviewed: |               |               |        |

| Type of Service                | Provider | Effective Date | Number of Weeks/Months | Frequency & Duration | Rate | Total Annual Cost |
|--------------------------------|----------|----------------|------------------------|----------------------|------|-------------------|
| <b>Waiver Services:</b>        |          |                |                        |                      |      |                   |
| ICC                            |          |                |                        |                      |      |                   |
| Respite                        |          |                |                        |                      |      |                   |
| Family Support                 |          |                |                        |                      |      |                   |
| Skill Building                 |          |                |                        |                      |      |                   |
| Int. In-Home                   |          |                |                        |                      |      |                   |
| Crisis Response                |          |                |                        |                      |      |                   |
| <b>Non-Waiver MH Services:</b> |          |                |                        |                      |      |                   |
| Outpatient Psych:<br>(clinic)  |          |                |                        |                      |      |                   |
| Day Treatment                  |          |                |                        |                      |      |                   |



**Office of  
Mental Health**

|  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
| Inpatient Psych.                             |  |  |  |  |  |  |
| Psychiatrist                                 |  |  |  |  |  |  |
| CPEP   |  |  |  |  |  |  |
| <b>Medical Services:</b>                     |  |  |  |  |  |  |
| Inpatient                                    |  |  |  |  |  |  |
| Physician                                    |  |  |  |  |  |  |
| Specialist (specify)                         |  |  |  |  |  |  |
| Dental                                       |  |  |  |  |  |  |
| Pharmacy                                     |  |  |  |  |  |  |
| Managed Care<br>Premium                      |  |  |  |  |  |  |
| Other (Specify)                              |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| <b>Projected Total Cost<br/>of Services:</b> |  |  |  |  |  |  |

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

**ICC Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**ICC Supervisor Signature** \_\_\_\_\_ **Date** \_\_\_\_\_