

## Self-Direction Cost Neutral Budget Amendment

Use this form to reflect a cost neutral change when there is no request for new services. Cost Neutral Amendments must occur within the same funding source (Medicaid or State). If the amendment is approved, it must be attached to the budget and sent to the Fiscal Intermediary (FI). Amendments will be effective on the first of the month following approval by the DDRO.

Note: If this amendment includes an increase in service units and/or a change in provider, the participant's MSC may need to complete and submit a Request for Service Amendment (RSA) before the amendment is approved.

Name of Participant: \_\_\_\_\_

Medicaid ID #: \_\_\_\_\_

TABS ID #: \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

DDRO: \_\_\_\_\_

### Medicaid Funded Services

Check which service is being reduced in Column A and then the \$ amount that it is being reduced in column B. Check which services are being increased in Column C and the \$ amount in Column D. Totals from the "MA Funded Sum" columns must match.

Column A	Service	Column B	Column C	Service	Column D
<input type="checkbox"/>	Brokerage		<input type="checkbox"/>	Brokerage	
<input type="checkbox"/>	Community Habilitation - Self-Hired		<input type="checkbox"/>	Community Habilitation - Self-Hired	
<input type="checkbox"/>	Community Habilitation - Agency Supported		<input type="checkbox"/>	Community Habilitation - Agency Supported	
<input type="checkbox"/>	Community Habilitation - Direct Provider Purchased		<input type="checkbox"/>	Community Habilitation - Direct Provider Purchased	
<input type="checkbox"/>	Respite - Self-Hired		<input type="checkbox"/>	Respite - Self-Hired	
<input type="checkbox"/>	Respite - Agency Supported		<input type="checkbox"/>	Respite - Agency Supported	
<input type="checkbox"/>	Respite - Direct Provider Purchased		<input type="checkbox"/>	Respite - Direct Provider Purchased	
<input type="checkbox"/>	SEMP - Self-Hired		<input type="checkbox"/>	SEMP - Self-Hired	
<input type="checkbox"/>	SEMP - Agency Supported		<input type="checkbox"/>	SEMP - Agency Supported	
<input type="checkbox"/>	SEMP - Direct Provider Purchased		<input type="checkbox"/>	SEMP - Direct Provider Purchased	
<input type="checkbox"/>	Live-in Caregiver		<input type="checkbox"/>	Live-in Caregiver	
<input type="checkbox"/>	Day Habilitation		<input type="checkbox"/>	Day Habilitation	
<input type="checkbox"/>	Pathway to Employment		<input type="checkbox"/>	Pathway to Employment	
<input type="checkbox"/>	Prevocational Service		<input type="checkbox"/>	Prevocational Service	
<input type="checkbox"/>	IDGS - Camp		<input type="checkbox"/>	IDGS - Camp	
<input type="checkbox"/>	IDGS - Community Classes		<input type="checkbox"/>	IDGS - Community Classes	

<input type="checkbox"/>	IDGS - Coaching/Education	
<input type="checkbox"/>	IDGS - Clinician Consultants	
<input type="checkbox"/>	IDGS - Clinician Direct	
<input type="checkbox"/>	IDGS - Health Clubs/Memberships/Community Participation	
<input type="checkbox"/>	IDGS - Household-Related	
<input type="checkbox"/>	IDGS - Paid Neighbor	
<input type="checkbox"/>	IDGS - Staffing Support	
<input type="checkbox"/>	IDGS - Transition Programs	
<input type="checkbox"/>	IDGS - Transportation	
	MA Funded Sum Total Decrease	

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<input type="checkbox"/>	IDGS - Transportation	
	MA Funded Sum Total Increase	

### NY State Funded Services

Check which service is being reduced in Column E and then the \$ amount that it is being reduced in column F. Check which services are being increased in Column G and the \$ amount in Column H. Totals from the "State Funded Sum" columns must match.

Column E	Service	Column F
<input type="checkbox"/>	Family Reimbursed Respite	
<input type="checkbox"/>	Family Support Services	
<input type="checkbox"/>	Housing Subsidy	
<input type="checkbox"/>	OTPS - Phone Service	
<input type="checkbox"/>	OTPS - Internet	
<input type="checkbox"/>	OTPS - Software	
<input type="checkbox"/>	OTPS – Staff Activity Fees	
<input type="checkbox"/>	OTPS – Staff Advertising/ Recruitment	
<input type="checkbox"/>	OTPS – Staff Training	
<input type="checkbox"/>	OTPS - Transportation	
<input type="checkbox"/>	OTPS - Clothing	
<input type="checkbox"/>	OTPS - Food	
<input type="checkbox"/>	OTPS - Utilities	
<input type="checkbox"/>	OTPS – Other (Independence)	
<input type="checkbox"/>	OTPS – Other (Health and Safety)	
	State Funded Sum Total Decrease	

Column G	Service	Column H
<input type="checkbox"/>	Family Reimbursed Respite	
<input type="checkbox"/>	Family Support Services	
<input type="checkbox"/>	Housing Subsidy	
<input type="checkbox"/>	OTPS - Phone Service	
<input type="checkbox"/>	OTPS - Internet	
<input type="checkbox"/>	OTPS - Software	
<input type="checkbox"/>	OTPS – Staff Activity Fees	
<input type="checkbox"/>	OTPS – Staff Advertising/ Recruitment	
<input type="checkbox"/>	OTPS – Staff Training	
<input type="checkbox"/>	OTPS - Transportation	
<input type="checkbox"/>	OTPS - Clothing	
<input type="checkbox"/>	OTPS - Food	
<input type="checkbox"/>	OTPS - Utilities	
<input type="checkbox"/>	OTPS – Other (Independence)	
<input type="checkbox"/>	OTPS – Other (Health and Safety)	
	State Funded Sum Total Increase	

## Other Changes

Use the space below to describe cost neutral amendments to the Self-Direction Budget that are not reflected above. For example, changes to demographic, designee or provider agency information.

## Signatures

Please sign, date and send to the regional Self-Direction Liaison with supporting information, for example, the Budget.

Participant Confirmation: I am aware that in order for these changes to be carried into my next budget year, these changes must be written into my Self-Direction Budget at the time of my next annual or semiannual review.

Participant/Designee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Broker Name: \_\_\_\_\_

Broker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

FI Staff Name: \_\_\_\_\_

### **This Section to be completed by OPWDD Staff Only:**

*Self-Direction DDRO Liaison Review. If approved, enter the effective date below and sign and date. Forward signed original to the FI, and send copies to the Self-Direction participant, Broker, and MSC.*

**Effective Date:** \_\_\_\_\_ (must be 1st day of month)

*DDRO Self-Direction Liaison Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_