



Connecticut Department of Developmental Services

Residential CLA/CRS Supports

Level of Need (LON) Rate Transition Plan

**Agency Receiving Reduction in Funding**

**Budget Plan**

**Provider:**

**DDS Region:**

**Transition Meeting Date:**

**Executive Director/Principal of the Entity:**

**Summary of Budget Plan:**

**Specific Budget Areas to be addressed:**

**Administrative & General Areas:**

Narrative:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current FY2015 Budget | FY2016 Budget Decrease | Annualized Decrease |
| A&G |  |  |  |
|  |  |  |  |

**Organizational and Programmatic Areas:**

Narrative:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current FY2015 Budget | FY2016 Budget Decrease | Annualized Decrease |
|  |  |  |  |
|  |  |  |  |

**Staff Salaries/ Benefits:**

Narrative:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current FY2015 Budget | FY2016 Budget Decrease | Annualized Decrease |
| Salaries/Wages |  |  |  |
| Benefits |  |  |  |

**Clinical Staff :**

Narrative:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current FY2015 Budget | FY2016 Budget Decrease | Annualized Decrease |
| Staff Nurse |  |  |  |
| Nurse Consultant |  |  |  |
| Staff Behaviorist |  |  |  |
| Behavioral Consultant |  |  |  |

**Decrease # of Opportune Vacancies:**

Narrative:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Program | Current FY2015 # of Opportune Vacancies | Projected FY2016 # of Opportune Vacancies | FY2016 Budget Increase | Annualized Increase |
| CLA |  |  |  |  |
| CRS |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Increase/Decrease Number of Consumers in 24 hour congregate settings:**

Narrative:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Program | Current Number of FY2015 Program Participants | Projected Number of FY2016 Program Participants | Net Addition or reduction of Program Participants in FY2016 | Annualized Increase/ decrease due to changes in the number of program participants |
| CLA |  |  |  |  |
| CRS |  |  |  |  |
| IHS |  |  |  |  |
| CCH |  |  |  |  |
| Shared Living |  |  |  |  |

**Increase/Decrease House Hours:**

Narrative:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Program | Current Number of FY2015 House Hours | Projected Number of FY2016 House Hours | Net Addition or reduction of House Hours in FY2016 | Annualized Increase/ decrease due to changes in the number of program participants |
| Identify House |  |  |  |  |
| Identify House |  |  |  |  |
| Identify House |  |  |  |  |
| Identify House |  |  |  |  |

**Increase/Decrease Staffing Ratio:**

Narrative:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Program | Current Number of FY2015 Program Participants | Current FY2015 Staffing Ratio Percentage | Projected Number of FY2016 Program Participants | Net Addition or reduction of Program Participants | Projected FY2016 Staffing Ratio Percentage | Annual Effect on Budget due to changes in staff ratios |
| Identify House |  |  |  |  |  |  |
| Identify House |  |  |  |  |  |  |
| Identify House |  |  |  |  |  |  |
| Identify House |  |  |  |  |  |  |

**Assistive Technology:**

Narrative:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Identify Current Assistive Technology used in the house | Identify Proposed Assistive Technology to be used in the house | FY2016 Projected Cost | FY2016 Projected # of hours Assistive Technology will enhance  program hours | FY2016 Budget Projected Salary Reduction  Due to the Assistive Technology |
| Identify House |  |  |  |  |  |
| Identify House |  |  |  |  |  |

**Other:**

Narrative:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current FY2015 Budget | FY2016 Budget Reduction/Revenue Enhancement | Annualized Reduction/Revenue Enhancement |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
|  |

Total proposed Annualized Revenue Enhancements

Describe the Communication Plan the agency will use to inform the individuals, their families and DDS staff of this transition plan:

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Signature of DDS Regional Resource Administrator or designee\*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Provider\*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_