



Connecticut Department of Developmental Services

Residential CLA/CRS Supports

Level of Need (LON) Rate Transition Plan

**Agency Receiving Increased 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 Increase | Annualized Increase |
| A&G |  |  |  |
|  |  |  |  |

**Organizational and Programmatic Areas:**

Narrative:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current FY2015 Budget | FY2016 Budget Increase | Annualized Increase |
|  |  |  |  |
|  |  |  |  |

**Staff Salaries/ Benefits:**

Narrative:

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

**Clinical Staff Enhancements:**

Narrative:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Current FY2015 Budget | FY2016 Budget Increase | Annualized Increase |
| 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 enhanceprogram hours | FY2016 Budget Projected Salary ReductionDue 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.

Signature of DDS Regional Resource Administrator or designee\*:

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

Signature of Provider\*:

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