

SLS Individual Rate Determination Worksheet

6. Rate to the Supported Living Services Provider Name of Supported Living Services Provider: _____ Enter the estimated cost of the Supported Living Services portion of the Supported Living Arrangement, if available from the proposed SLS vendor. (Do not include costs of anything which is the consumer's responsibility, ie: rent, food) originally proposed: _____	\$
7. Day Services II Describe the actual day services that the consumer has chosen for the supported living arrangement: _____ Only indicate cost if a day program is separate from the supported living services. If day services are to be provided as part of SLS, or funded by Department of Rehabilitation indicate \$0.00. (indicate '0' if SLS will provide the chosen day support)	\$
8. Transportation II Describe the mode of transportation the consumer will use in the supported living arrangement. (indicate '0' if SLS will provide the chosen transportation) _____	\$
9. Other Services II What other services would be funded by the Regional Center while the consumer is living in the supported living arrangement, specify hours and specific service? (indicate '0' if SLS will provide the chosen service/support) _____	\$
10. Estimated total of Regional Center - funded services not included within Supported Living Services Total the costs of lines seven through nine.	\$
11. Determination of the cost of the plan meets the conditions of the regulations. Add lines six and 10 and subtract the total from line five to determine if these calculations meet the regulatory requirements. If line 11 is a negative number, then this calculation of the cost of the proposed Supported Living Arrangement is not acceptable and must be revised.	\$
Bring this sheet for review at the ID team meeting. Team must approve SLS Agency, prior to authorization of ongoing SLS services.	

Amount from line five \$ _____. The maximum amount available to the Supported Living Agency for services is \$ _____ per month.
(Line 5 minus Line 10)

The negotiated rate, if different, is \$ ____ per month. (The negotiated rate must be less than or equal to the amount on the previous line.) The supported living agency has agreed to this negotiated rate. The regional center () will () will not pay the IHSS rate of \$ ____ for ____ hours until IHSS is approved by DPSS.

 Service Coordinator, Date Supervisor, Date CmSD Specialist, Date

Based on the SLS Agency Assessment and schedule submitted, the hours of service are broken down as follows:

24 hours one on one direct care equals 744 hours a month.
 130 day program hours, ____ IHSS hrs at the \$ ____ an hour rate
 ____ Overnight AWAKE average of \$ ____.
 ____ hours of Habilitation SLS rate of \$ ____.
 ____ hours of Personal Support SLS rate of \$ ____.

Consumer:
UCI:
Service Coordinator: