

RATE DEVELOPMENT - INDIVIDUAL COSTS ASSOCIATED WITH RESIDENCY

DS 6024 (REV 10/2016)

A. FACILITY TYPE

Enhanced Behavioral Supports Home Community Crisis Home Other _____

B. CONTACT INFORMATION

| | | |
|-----------------|--------|----------|
| Consumer Name: | | UCI # |
| Vendor Name: | | Vendor # |
| Vendor Address: | | |
| City: | State: | Zip: |

C. CATEGORIES AND DESCRIPTIONS OF COSTS

| | Unit Cost | Total Monthly Cost | Notes |
|--|-----------|--------------------|-------|
| 1. Salaries and Wages | | | |
| a. Total Wages – Hourly Direct Care Staff | | | |
| 1) Direct Care Staff | | | |
| 2) Behaviorist | | | |
| 3) Relief Time/Staff | | | |
| 4) Other Costs: Describe in Notes | | | |
| Total Salaries and Wages Costs | | \$ | |
| 2. Payroll Taxes, Workers Compensation, and Fringe Benefits | | | |
| a. Payroll Taxes | | | |
| b. Workers Compensation | | | |
| c. Benefit Allowance: Medical, Dental, etc. | | | |
| d. Other Costs: Describe in Notes | | | |
| Total Taxes and Benefits Costs | | \$ | |
| Total Personnel Costs (Combine Totals from Section 1 and 2 above) | | \$ | |
| 3. Program Costs – Per Consumer | | | |
| a. Snacks/Food | | | |
| b. Combined Utilities - Additional | | | |
| c. Consultant (Non-Behaviorist) | | | |
| d. Training | | | |
| e. Transportation: Vehicle, Maintenance, Fuel (not DP/School) | | | |
| f. Other Costs: Repairs and Maintenance - Additional | | | |
| g. Office Supplies - Additional | | | |
| h. Other Costs: Outside Activities Expenses | | | |
| i. Other Costs: Activity Supplies | | | |
| j. Other Costs: Describe in Notes | | | |
| Total Program Costs | | \$ | |
| TOTAL INDIVIDUAL COSTS | | \$ | |

D. SIGNATURES

| | |
|---|-------|
| Vendor Signature: | Date: |
| Print Name: | |
| Regional Center Representative Signature: | Date: |
| Print Name: | |