

**HOME AND COMMUNITY BASED SERVICES
ADULT RESIDENTIAL CARE CALCULATION**

Consumer Name: _____ Medicaid #: _____ A Bed _____
 Facility Name: _____ PCF _____ B Bed _____
 AFH _____ C Bed _____

(A) Room & Board (R&B) The amount for R&B is set by DPHHS, but collected from the consumer by the facility.
 (B) Service Package The basic service amount established by DPHHS.
 (C) Support Services Support service rate is based upon individual needs & established by the case management team for DPHHS. If the need is met or the facility does not provide the service, enter 0. The facility must provide the service listed below.

	LOC Score		LOC Score
Bathing	<input type="text"/>	Housekeeping	<input type="text"/>
Personal Hygiene	<input type="text"/>	Money Management	<input type="text"/>
Dressing	<input type="text"/>	Socialization	<input type="text"/>
Toileting	<input type="text"/>	Transportation	<input type="text"/>
Medication Management	<input type="text"/>	Communication	<input type="text"/>
Medical Management	<input type="text"/>	Behavior Management	<input type="text"/>
Mobility	<input type="text"/>	Impaired Judgment	<input type="text"/>
Transfers	<input type="text"/>	Memory Cueing	<input type="text"/>
Eating	<input type="text"/>	Time Management	<input type="text"/>
Diet	<input type="text"/>	Other	<input type="text"/>
Exercise	<input type="text"/>	Other	<input type="text"/>
Total LOC Score	<input type="text"/>	x \$	<input type="text"/>

SCORING KEY

0 = Independent - includes assist from family or others or need is met.

1 = Minimal Assist - set up help, prompting.

2 = Direct Assist - with active participation of individual to complete task.

3 = Extensive Assist - with limited participation of individual to complete task.

4 = Total Dependence - with no participation of individual to complete task.

(D) (A+B+C)
 (E) Facility Private Pay Rate
(F) Total to facility is the lesser of D or E
 (See instructions on back of form for maximum limit)

The following outlines the responsibility of payment to the facility:

Daily Rate Computation Effective Date _____

(A1) Room & Board
 (A2) Consumer Contribution (see instructions on back)
 (A3) Other _____

(G) Subtotal of consumer responsibilities: (A1+A2+A3) **Daily Rate**

(H) Daily Rate: (F-G) Divided by 30 Days

(I) Medicaid Responsibility Daily rate is billable day _____ through the end of the month

Incurment Section

(A4) Incurment used for AR services divided by (H) Daily Rate - _____
 Day incurment is met

(J) Total Consumer Responsibility: (G + A4)

Provider Signature: _____ Date _____
 CMT Signature: _____ Date _____