
Developmental Disabilities Services

PRO-RATED STAFF TRAINING



PROCEDURES

- New forms put into place in March of 2010 replace all previous instructions related to direct care shared staff
- Forms must be used by group homes, apartments or in any living situation where shared staff are used to provide direct care



IMPORTANT....



- If transportation is included as a service, you must explain how transportation will be used in the PCSP narrative



- Staff fringe benefits are not required to be justified if 25% or less – however, if they are over 25%, the fringe calculation worksheet must be submitted

Fringe benefits cannot exceed 32%

Supportive Living Worksheet Scenario

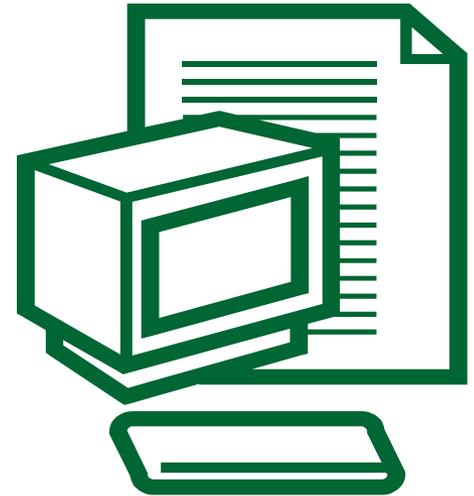
- Group Home has 10 Persons
- Residential Staff

Scheduled	Days	Hours
DM	Monday-Friday	12pm to 8am
JT	Monday-Friday	4pm to 12am
KC	Monday-Thursday	12am to 8am
NK	Saturday/Sunday	8am to 12pm
MG	Saturday/Sunday	7am to 11pm
SL	Fri, Sat. & Sun	12am to 8am

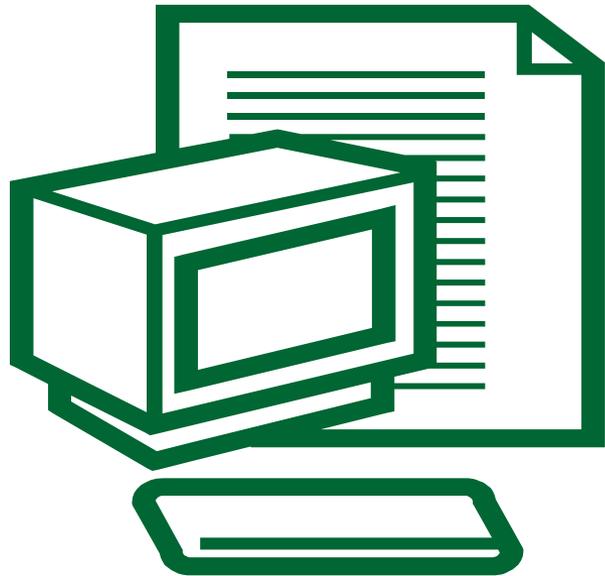
- All 10 persons utilize the residential staff for their care

Entry to Pro-Rated Direct Care Staff and Fringe Worksheet

- Enter the name of each worker in “Staff Name” column
- Next, enter the days or hours worked per week for each worker in the “Schedule” column
- Enter the days or hours each position works in the “Hours/Days Per Week” column
- Enter the number of weeks worked per year in the “Weeks Per Year” column
- Enter the hourly or daily rate for each worker in the “Rate” column
- Enter your fringe benefit rate % in the “Fringe %” column
- At the bottom of the page, enter the number of persons served by shared staff



Calculations on Pro-Rated Direct Care Staff and Fringe Worksheet



- The “Salary” column will automatically calculate cost of each position and display total at the bottom
- The total column will calculate the Salary + Fringe amount
- The amount per individual will automatically calculate and display

Supportive Living Total Costs sheet....

The **Amount Per Individual** total figure from the Supportive Living Pro-Rated Direct Care Staff and Fringe Worksheet is transferred to the **Total (Supportive Living)** line on the Total Supportive Living Costs page of the spreadsheet

Note the areas shaded in yellow...

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
ACS WAIVER SERVICES
TOTAL SUPPORTIVE LIVING COSTS

Individual's Name

Medicaid Number

PLAN DATES	
BEGIN DATE	END DATE

DAYS OF SERVICE PER MONT	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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TYPE OF SERVICE	SPECIFIC INFORMATION	DAILY HOURLY	DAYS HOURS	ANNUAL SALARY	FRINGE %	FRINGE AMOUNT	TOTAL SALARY
PRO-RATED STAFF							
SUPPORTIVE LIVING ONE ON ONE STAFF							
<i>SUBTOTAL (Supportive Living One On One Staff)</i>							

DIRECT CARE SUPERVISION	MONTHS		RATE	\$100.00
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TRANSPORTATION	MILES		RATE	\$0.42
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TOTAL (Supportive Living)				
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INDIRECT COSTS	Indirect Cost Percentage	20.00%		
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DAYS PER YEAR	
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SUPPORTIVE LIVING PLAN TOTAL	DAILY RATE			
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RESPIRE CARE				
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NOTE: The yellow shaded cells turn to a white background once you enter data

Enter data on SL Total Costs Page

- Enter individual's name and Medicaid number
 - Enter beginning/ending plan dates
 - Enter days of service per month
 - Enter any one-on-one staff name, salary, days/hours and fringe percentage
 - Enter direct care supervision months and rate
 - Enter miles of transportation (if applicable)
 - Enter and respite salary and days/hours and fringe percentage (if applicable)
 - The supportive living daily rate and total amount will calculate
-

ARKANSAS DEPARTMENT OF HUMAN SERVICES
 DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
 ACS WAIVER SERVICES
 TOTAL SUPPORTIVE LIVING COSTS

JOE DOE

Individual's Name

1234567-899

Medicaid Number

PLAN DATES	
BEGIN DATE	END DATE
06/11/10	06/10/11

DAYS OF SERVICE PER MON Jan 31 Feb 28 Mar 31 Apr 30 May 31 Jun 30 Jul 31 Aug 31 Sep 30 Oct 31 Nov 30 Dec 31

TYPE OF SERVICE	SPECIFIC INFORMATION	DAILY HOURLY	DAYS HOURS	ANNUAL SALARY	FRINGE %	FRINGE AMOUNT	TOTAL SALARY
PRO-RATED STAFF				\$8,143.20		\$2,035.80	\$10,179.00
SUPPORTIVE LIVING ONE ON ONE STAFF	ZT	\$10.00	520.00	\$5,200.00	25.00%	\$1,300.00	\$6,500.00
<i>SUBTOTAL (Supportive Living One On One Staff)</i>			520.00	\$5,200.00		\$1,300.00	\$6,500.00
DIRECT CARE SUPERVISION			MONTHS	12	RATE	\$100.00	\$1,200.00
TRANSPORTATION			MILES	4,450	RATE	\$0.42	\$1,869.00
TOTAL (Supportive Living)			520.00	\$13,343.20		\$3,335.80	\$19,748.00
INDIRECT COSTS			Indirect Cost Percentage	20.00%			\$4,549.60
			DAYS PER YEAR	365			
SUPPORTIVE LIVING PLAN TOTAL			DAILY RATE	\$66.57			\$24,297.60
RESPIRE CARE		\$10.00	240.00	\$2,400.00	25.00%	\$600.00	\$3,000.00

To get figures into ACS 703 (PCSP) forms....



- Enter the number of days and the Supportive Living Plan Total amount on the “Annual Salary and Fringe and/or Annual Rate” area on the Supportive Living Array Worksheet on the Supportive Living line in the Total Requested column (**Black** arrow on slide 15)
- Enter the dollar amount on the “ACS Waiver Plan Budget Sheet” (**Blue** arrow on slide 16)

To get figures into ACS 703 (PCSP) forms....

- If there is respite on the Supportive Living Pro-Rated Direct Care Staff and Fringe Worksheet, enter days and dollar amount to Supportive Living Array Worksheet in the Respite Care line in the Total Requested column (**Red** arrow on Slide 15)
- Enter the dollar amount on the ACS Waiver Plan Budget Sheet (**Green** arrow on Slide 16)



Supportive Living Array Worksheet (ACS 703)

ARKANSAS DEPARTMENT OF HUMAN SERVICES
 DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES
 ACS WAIVER PLAN SUPPORTED LIVING ARRAY WORKSHEET (EXCEL)

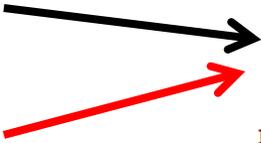
Joe Doe
 Individual's Name

1234567-899
 Medicaid #

Total Number of Days in Plan of Care Year Service is Requested: 365 Total Days DDS Approved _____

Supported Living Array includes supportive living and respite care. Salary and fringe are calculated as one rate. Fringe cannot exceed 32%. Any fringe 25% or more must be justified. Supported Living Array components cannot exceed the maximum rate for the level of care, i.e. pervasive, extensive or limited. Supportive Living includes direct salaries and fringe for supportive living staff, direct care supervisor, transportation and indirect costs. Note: If staff positions are vacant and filled with a higher or lower salary than submitted, a revision MUST be submitted.

SERVICE COMPONENT	TOTAL REQUESTED				DDS TOTAL APPROVED		
	DAYS		ANNUAL SALARY AND FRINGE AND/OR ANNUAL RATE	BILLING RATE	DAYS	ANNUAL SALARY AND FRINGE AND/OR ANNUAL RATE	BILLING RATE
H2016 Supportive Living	365	Days	\$24,297.60	\$66.57	Days		
S5151 Respite Care	20	Days	\$3,000.00	\$150.00	Days		
A. TOTAL			\$27,297.60				



B. Supported Living Array Daily Rate (R - Days in POC Year Requested) \$74.79 (R - Days in POC Year Approved) _____

Level of Care:
 Pervasive
 Extensive
 Limited

Level of Care

Level of Care

 Provider Designee/Agency Signature

 Date

DDS USE ONLY

 Reviewed by

 Date Reviewed

Budget Sheet (ACS 703)

ACS WAIVER PLAN BUDGET SHEET (EXCEL)

Joe Doe

1234567-899

Individual's Name

Medicaid #

Provider Name and Number	DHCD Check if Applies	Services being Requested Procedure Code/	Total Requested		Begin Date	End Date	DDS Total Approved	
			Units	Amount			Units	Amount
	<input type="checkbox"/>	H2016 Supportive Living	N/A	\$24,297.60	06/11/10	06/10/11	N/A	
	<input type="checkbox"/>	S5151 Respite Care	N/A	\$3,000.00	06/11/10	06/10/11	N/A	
	<input type="checkbox"/>	S5165 U1 Adaptive Equipment	N/A				N/A	
	<input type="checkbox"/>	S5160 Emergency Response System	N/A				N/A	
	<input type="checkbox"/>	S5161 Emergency Response System	N/A				N/A	
	<input type="checkbox"/>	S5162 Emergency Response System	N/A				N/A	
	<input type="checkbox"/>	K0108 Environmental Modifications	N/A				N/A	
	<input type="checkbox"/>	T2028 Specialized Medical Supplies	N/A				N/A	
	<input type="checkbox"/>	T2020 UA Supplemental Support	N/A				N/A	
	<input type="checkbox"/>	T2022 Case Management						
	<input type="checkbox"/>	H2023 Supported Employment						
	<input type="checkbox"/>	T2025 Consultation						
	<input type="checkbox"/>	T2034 U1 UA Crisis Intervention						
	<input type="checkbox"/>	T2022 U2 Transitional Case Management						
	<input type="checkbox"/>	T2020 UA U1 Community Transition Services	N/A				N/A	
TOTAL				\$27,297.60				

Provider Designee/Agency Signature

Date

DDS USE ONLY I have verified totals are within approved limits. I have compared this request to the prior year's POC expenditures. If the request has a significant increase or decrease in the prior year's POC expenditures, the provider has identified and justified in the