



**ARKANSAS DEPARTMENT OF HUMAN SERVICES**  
**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 MONTH:	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
----------------------------	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----

TYPE OF SERVICE	SPECIFIC INFORMATION	DAILY HOURLY	DAYS HOURS	ANNUAL SALARY	FRINGE %	FRINGE AMOUNT	TOTAL SALARY
<b>PRO-RATED STAFF</b>							
<b>SUPPORTIVE LIVING ONE ON ONE STAFF</b>							
<i>SUBTOTAL (Supportive Living One On One Staff)</i>							
<b>DIRECT CARE SUPERVISION</b>		MONTHS			RATE	\$100.00	
<b>TRANSPORTATION</b>		MILES			RATE	\$0.42	
<b>TOTAL (Supportive Living)</b>							
<b>INDIRECT COSTS</b>		<i>Indirect Cost Percentage</i>		20.00%			
		<i>DAYS PER YEAR</i>					
<b>SUPPORTIVE LIVING PLAN TOTAL</b>		<i>DAILY RATE</i>					
<b>RESPIRE CARE</b>							