



**WORK (Work Opportunities Reward Kansans)  
Individualized Budget Form for Allocation Funds  
Self-Directed Form**

Indicate type of change for WORK individualized budget, (Examples include: Initial Start Date, Revision Date, Annual Re-Assessment, etc.) and the month and year the change is to take effect. Examples and rows can be added as needed.

|                                  |  |
|----------------------------------|--|
| <b>Initial Start Date</b>        |  |
| <b>Annual Re-assessment 2008</b> |  |
| <b>Revision Date 2009</b>        |  |
|                                  |  |

**A) CONSUMER INFORMATION**

|             |                     |
|-------------|---------------------|
| Name:       | Medicaid ID:        |
| Address:    | Phone:              |
| City & Zip: | Monthly Allocation: |

**B) FISCAL MANAGEMENT**

Fiscal management services are optional and are paid from the allocation funds. The current provider of this service is KATCO and they are required to set up separate accounts for the PAS services and any variable expenditure.

| Vendor | Description | Calculation<br>Monthly allocation X 8% | Cost |
|--------|-------------|--|------|
|        |             |  |      |

**C) ALTERNATIVE PERSONAL SERVICES (Services in place of PAS hours)**

Provide a brief description below of the service you plan to use alternative services funds and the estimated cost. Alternative personal services are things that you can purchase to provide support in place of personal assistance hours? The use of these funds should be reflected by a reduction of allowed personal assistance hours on the Individualized Budget Form. (e.g. meals on wheels). Expenditures must be approved before use of the funds by KHPA WORK Program Manager.

| Vendor | Description |
|--------|-------------|
| 1)     |             |
| 2)     |             |
| 3)     |             |

**D) PERSONAL ASSISTANCE SERVICES (KATCO is available to assist with the estimate of withholding for employees)**

| Name | Address – SS# | Hourly Pay | X Total Hours per Month | = Monthly Pay | + Payroll Deductions | Workmen’s Compensation Costs | = Total Cost per Month |
|------|---------------|------------|-------------------------|---------------|----------------------|------------------------------|------------------------|
| 1)   |               |            |                         |               |                      |                              |                        |
| 2)   |               |            |                         |               |                      |                              |                        |
| 3)   |               |            |                         |               |                      |                              |                        |
| 4)   |               |            |                         |               |                      |                              |                        |
|      |               |            | Hours                   |               |                      | TOTAL                        | \$                     |

**E) CALCULATION ESTIMATE**

|                                      |            |
|--------------------------------------|------------|
| <b>Allocation</b>                    | <b>\$-</b> |
| <b>Fiscal Management</b>             | <b>\$-</b> |
| <b>Alternative Personal Services</b> | <b>\$-</b> |
| <b>Personal Assistance Services</b>  | <b>\$-</b> |
| <b>Carry-Over Funds</b>              | <b>\$</b>  |

**F) CARRY-OVER FUNDS**

**Please list and explain how you will use any remaining funds from allocation. If you have unspent funds they will be moved to a savings account to be used only as approved by the KHPA WORK Program Manager.**

Note: These funds are to be used in ways that will increase independence, decrease reliance on PAS services, or assist to recruit or retain quality attendant care. Please provide an explanation in the description box. These funds can also be used to purchase emergency/safety equipment such as smoke or carbon monoxide detectors.

| Vendor | Description and Cost |
|--------|----------------------|
| 1)     |                      |
| 2)     |                      |
| 3)     |                      |

I understand that the Allocation funds are to be used to fund activities necessary to support my independence. Variable expenses not used for Personal Assistant Services or Fiscal management fees are to be moved to the savings account. The variable expenses will be used only for supports that are listed and approved on the Plan for Independence. If my eligibility for WORK ends and there are still remaining funds in the accounts I agree to return the funds to the Kansas Health Policy Authority.

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Signature

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Date

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Approval signature of WORK Program Manager

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Date