

## Amount Implementation Meeting (AIM) Worksheet - APD 2015-01

Discussion on iBudget Amount			
Date:	Date of Enrollment:		
Individual:	Field Office:		
Legal Rep:	_ Region:		<del></del> -
Attendees:	_ PIN:		<del></del>
WSC:	Date of Birth:		<del></del>
Algorithm Amt:	 Proposed iBudget CP:		
	_ '		
Please identify Significant Additional Needs that justify funding to exceed the algori	ithm amount.		
I have met with my Waiver Support Coordinator to discuss my iBudget.			
Individual or Legal Representative (Signature)			Date:
Individual or Legal Representative Printed Name			
For Regional Office Use Only			
Waiver Unit Staff Member Notes: *Attach a page if space here is no	ot sufficient.		
Total of services required to meet Significant Additional Needs			
Total of all services:	<u>-</u>	APPROVED	
Final Recommended Amount:	<del>_</del>		
Signature of ROM:		NOT APPROVED	Date:

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Region:					Date Submitted:		
iBudget Cost Plan Begin/E	nd Dates From:		To			-	
Individual's Name: Legal Rep. Name:				PIN:	i	Budget Amount:	
		Requeste	ed Annualized	Services			
SERVICE	BEGIN DATE	END DATE	RATE	UNITS (Number only)	AMOUNTS	ANNUALIZED UNITS	ANNUALIZED AMOUNTS
					\$ - \$ -		\$ - \$ -
					\$ - \$ -		\$ - \$ -
					\$ -		\$ -
					\$ -		\$ -
					\$ -		\$ -
					\$ - \$ -		\$ - \$ -
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					\$ -		\$ -
				TOTAL:	\$ -		\$ -
Region Office Note							
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Amount Implementation Meet	ing Worksheet					iBudge	t Florida

Proposed Annualized iBudget Services (To be used if Significant Additional Needs exceed the Algorithm Amount)

SERVICE	BEGIN DATE	END DATE	RATE	CURRENT UNITS (Number only)	AMOUNTS	ANNUALIZED UNITS	ANNUALIZED AMOUNTS
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					\$ -		\$ -
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Recommended Annualized iBudget Services (To be used by regional office if all proposed annualized services are not considered medically necessary

SERVICE	BEGIN DATE	END DATE	RATE	CURRENT UNITS (Number only)	AMOUNTS	ANNUALIZED UNITS	ANNUALIZED AMOUNTS
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		_		TOTAL:	\$ -	_	\$ -

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