State Aid and County Mill Funding Guidelines and Forms

Version date: October 1, 2025

Introduction

*State Aid Funding is allocated for the fiscal year beginning July 1st through June 30th. It is allocated on an annual basis and subject to change; therefore, all allocations are subject to the availability of funds.

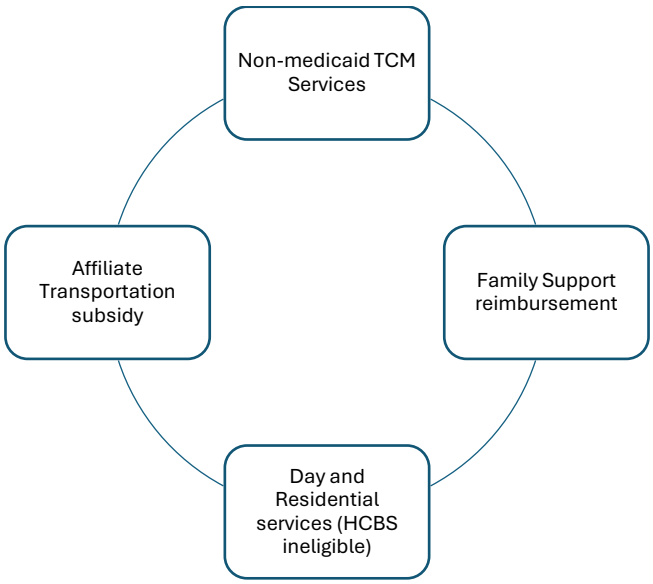
*County Mill Funding is allocated for the calendar year beginning January 1st through December 31st. It is allocated on an annual basis and subject to change; therefore, all allocations are subject to the availability of funds.

*Funding requests are reviewed monthly and checks are processed on the 15th of every month.

*The availability of funds is subject to monthly monitoring and changes will be made if necessary to stay within our allocation of funds.

Funding Goals:

1. Provide some level of support to families while their child with an intellectual or developmental disability waits for Home and Community Based Services Waiver funding.
   - This is accomplished by providing financial assistance to providers of case management services so the child can access those services when the family has no other way of paying for it.
2. Provide some level of support to those who are not eligible for the Home and Community Based Services Waiver funding due to their age or level of functioning but qualify as having an intellectual or developmental disability.
   - This is accomplished by providing financial assistance to providers of value-based daytime activities and daily living support, respite, or disability-related personal needs and camps when people have no other way of paying for it.
3. Provide some level of support to enhance services for people receiving supports from a community-based service provider through increase training for staff, expanding program options, increase wage rates, increase benefits, or to help cover costs not reimbursable for the provision of transportation for people receiving services.
   - This is accomplished by providing financial assistance to community-based service providers who deliver services to citizens with intellectual or developmental disabilities residing in Butler County.



Non-medicaid Targeted Case Management (TCM) Services

Maximum: 40 units or 10 hours per person per year @ $18.75 per unit or $75.00 per hour

- The TCM provider must be an affiliate of the CDDO of Butler County and hold a current license to provide TCM services with KDADS for Butler County.
- The person must be determined eligible for the I/DD system and 18 years of age or younger.
- The person must not be eligible for Medicaid (if the person is not eligible as a result of a lapse in the re-eval process, they will not be eligible for this service in the interim).
- The person will only be allowed a maximum of 40 units or 10 hours each year. This will be tracked on a monthly basis, and any units submitted over the cap will not be paid.
- The provider will be reimbursed at 1 unit = $18.75 or 1 hour = $75.00.
- The TCM provider (one form submission per provider per month) will complete the appropriate funding request form along with including copies of supporting documentation (TCM services provided) to the CDDO for the month.

Family Support Reimbursement

Maximum: $500 per year

- This financial assistance can be for the reimbursement of any of the following or a combination of the following: disability-related camps, personal needs including diapers/wipes/pull-ups, or respite.
- The child must be 18 years of age or younger.
- These items cannot be reimbursable by another founding source the child qualifies for.
- If the child is offered access to any of the HCBS waiver(s), they will no longer be eligible for this reimbursement.
- This assistance is limited to a maximum of $500.00 per year.
- The appropriate form along with copies of receipts or timesheets will be submitted to the CDDO either by the family or the case manager.

Day and Residential Services (HCBS ineligible)

- For any new request, the person must be 18 years of age or older who has been determined eligible for the I/DD system but does not meet the eligibility criteria for HCBS I/DD waiver(s) via the MFEI tool.
- The appropriate form will be completed by the case manager and reviewed by the CDDO. They will be placed on our internal waiting list until additional funding becomes available.
- People currently receiving day and/or residential services under this plan will be grand-fathered in under the old guidelines as indicated on the CDDO Funding Plan.
- The CDDO will complete the Day and/or Residential Services Approved Funding Plan and send to the case manager and/or service provider to gather signatures. This will reflect what service(s), frequency, and reimbursement rate that will be allowed.

Affiliate Transportation Subsidy

Maximum: $21 per person per month per Day and/or Residential Services provided

- The Day and/or Residential provider must be an affiliate of the CDDO of Butler County and hold a current license to provide day and/or residential services with KDADS for Butler County.
- This subsidy is to help cover costs not reimbursed by fees charged to the person for the provision of transportation for people currently receiving day and/or residential services from the provider requesting funds under this plan.
- The day and/or residential provider will ensure the person has received day and/or residential services for the month the subsidy is being requested and submit the appropriate form and documentation to the CDDO for review.

Non-Medicaid TCM Monthly Billing Form

Provider Name:
Date submitted to CDDO:
Month and Year TCM services were provided:

1 unit = 15 minutes = $18.75
4 units = 1 hour = $75.00
Maximum cap per person per year is 40 units or 10 hours

Case Notes are attached for the following people:

Name	Age	TCM Name	Total Units	Total $ requested

Name of provider representative submitting this form/attachments:
Signature of provider representative:
Date:

Family Support Reimbursement Form

Applicant's Name: **Age:**
Name of person submitting this form: **Date submitted to the CDDO:**

Indicate who the check for reimbursement is to be made out to and mailed –
Parent/Guardian/Legal Representative Name(s):
Mailing address:
City, State, Zip:

Reimbursement is being requested for the following categories and amounts –
Maximum cap is $500 per year per child

Category	Mark if receipts and/or timesheets are attached	Total amount $
Personal needs including diapers/wipes/pull ups		
Respite		
Disability-related camp(s)		

Explanation of need:

If the CDDO needs additional information, who should we contact:
Name:
Email:
Phone:

Name of person submitting this form:
Signature: **Date:**

Day and/or Residential Services (HCBS ineligible) Funding Request

Person's Name: **Age:**
Date determined ineligible by MFEI assessment:
TCM Name: **TCM Agency:**

What service(s) are being requested?

Service Type	Days/Week requested	# of days/week X 52 weeks
Day		
Residential		

Please describe the need in detail:

What resources are currently available for the person:

If these resources were no longer available, what barriers would it present for the person:

Please include a copy of the person's current PCSP.

TCM signature: **Date:**

Day and/or Residential Services Approved Funding Plan

Recipient Name:

Funding approval date range:

Funding Plan:

Type of Service	Frequency	Provider	Unit Cost	Frequency X Unit Cost per week

Funding is allocated based on need and availability of funds. By signing below, I am indicating that I acknowledge the funding is subject to change based on availability of funds and nothing in this funding plan creates any entitlement to services. This funding cannot be transferred when moving out of Butler County.

Recipient signature:

	Date:

Legal representative signature:

	Date:

Case Manager signature:

	Date:

CDDO signature:

	Date:

Special Notes by CDDO:

Affiliate Transportation Subsidy Monthly Request Form

Provider Name:

Mailing Address:

City, State, Zip:

***Please attach a list of person's served for the month along with a mark indicating if day and/or residential services were delivered. It is the responsibility of the provider to submit this form and supporting documentation (list) to the CDDO each month.**

Please complete the box below:

Service Type	Month service was delivered	Total # people served	Reimbursement	Total $ Amount (Total # people X reimbursement)
Day			$21/per person	
Residential			$21/per person	
			Total	

Name of person submitting this form:

Signature: **Date:**