NEW BEGINNINGS ENTERPRISES, INC
COMMUNITY DEVELOPMENTAL DISABILITY ORGANIZATION

CDDO MEDICAID INELIGIBLE TCM FUNDING PLAN

Recipient Name:	Date of Birth:
Social Security Number:	Medicaid Number:
Effective Date:	

Date of Request	Funding Source	Provider	Date Services Started

Date of BASIS	Date of Eligibility	Date Choice Form Signed
TIER		

The recipient below acknowledges these funds are made available through a contract between the CDDO and the State of Kansas. As such, the amounts and service are subject to change based on availability of funds and nothing in this funding plan creates any entitlement to services. This funding option can only be provided in accordance with NBE CDDO policy 104.2. Hours cannot exceed 2.5 (10 units) per month.

Recipient:_____ Date:_____

Guardian:_____ Date:_____

Target Case Manager:_____ Date:_____

CDDO AGENCY REVIEW:

APPROVED		**CDDO-**
DISAPPROVED		