New Mexico Developmental Disabilities Supports Division

HCBS Medicaid Waiver Programs Expense Tool for Fiscal Year 2017

12 Month Reporting Period

12 Month Period Start	
12 Month Period End	

Provider and Contact Information

Provider Name	
Provider IRS Tax Status	
Provider Medicaid ID #	
HCBS Program Name (if different)	
HCBS Program Address	
City, State, Zip	
County	
Contact Name	
Contact Position	
Contact Email	
Contact Phone	

Revenue

	Provider Total $	Developmental Disabilities Waiver $	Medically Fragile Waiver $	Mi Via Waiver $	HCBS Program Total $	Notes/Comments
Revenue from HSD: Medicaid					$ -	
Revenue from Other State Agency					$ -	
Other Revenue					$ -	
Total Revenue						

Personnel

	Provider Total FTEs	Developmental Disabilities FTEs	Medically Fragile FTEs	Mi Via FTEs	HCBS Program FTEs	Notes/Comments
Employee FTEs					-	
Employee FTEs Vacant					-	

	Provider Hours Per Employee	Developmental Disabilities Waiver Hours Per Employee	Medically Fragile Waiver Hours Per Employee	Mi Via Waiver Hours Per Employee	HCBS Program Total Hours Per Employee	Notes/Comments
Holiday Hours					$ -	
Vacation Hours					$ -	
Sick Hours					$ -	
Training Hours					$ -	
Total Paid Non-Working Hours						

	Provider Total $	Developmental Disabilities Waiver $	Medically Fragile Waiver $	Mi Via Waiver $	HCBS Program Total $	Notes/Comments
Direct Service Salaries					$ -	
Administrative Salaries					$ -	
Personnel Taxes					$ -	
Workers' Compensation					$ -	
Healthcare					$ -	
Retirement					$ -	
Other Fringe Benefits					$ -	
Total Personnel Expenses						

Other Expenses

	Provider Total $	Developmental Disabilities Waiver $	Medically Fragile Waiver $	Mi Via Waiver $	HCBS Program Total $	Notes/Comments
Mileage					$ -	
Occupancy/Facility					$ -	
Supplies					$ -	

Equipment					$ -	
Liability Insurance					$ -	
Translation/Interpretation/Accommodation Services					$ -	
HCBS Subcontractor					$ -	
Training					$ -	
Transportation					$ -	
Travel					$ -	
Depreciation					$ -	
Gross Receipts Tax					$ -	
Other Operating Expenses					$ -	
Indirect (from Parent Organization)					$ -	
Total Other Expenses					$ -	
Total Expenses						

Attestation

By entering my name, staff title and electronically signing my name below, I attest that the information contained in this worksheet and any of its accompanying financial statements/files are both accurate and complete to the best of my knowledge, and I am authorized to attest and submit this information on behalf of my provider agency.

Authorized Attestation Name:	
Attestation Staff Title:	
Electronic Signature (Retype Name):	
Date of Attestation:	