

# MY SUPPORT AND SPENDING PLAN

## ADULT SELF-DIRECTED SERVICES



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

Update 04/01/15

**This Plan Belongs  
to:**

Participant Name:

MID#:

Plan Date:

# MY SUPPORT AND SPENDING PLAN COVER SHEET

|                                       |                |              |             |
|---------------------------------------|----------------|--------------|-------------|
| <b>Personal Information</b>           |                | Initial Plan | Annual Plan |
| Birth date:                           |                | MMCP:        |             |
| Address:                              | City:          | State: ID    | Zip Code:   |
| Community Living Arrangement:         |                |              |             |
| Telephone Number(s):                  |                |              |             |
| Home:                                 | Cellular:      | Other:       |             |
| <b>Legal Guardian (If Applicable)</b> |                |              |             |
| Name:                                 |                |              |             |
| Address:                              | City:          | State:       | Zip Code:   |
| Telephone Number(s)                   |                |              |             |
| Home:                                 | Cellular:      | Other:       |             |
| Primary Care Provider:                |                |              |             |
| Specialist(s):                        | Specialist(s): | Dentist:     |             |

## People Who Helped Create This Plan:

|       |               |
|-------|---------------|
| Name: | Relationship: |

## MY SUPPORT PLAN

|  |                        |
|--|------------------------|
| Goal or Need:  |                        |
| <b>Activities</b>  | <b>How Often?</b>      |
| What activities will I be able to do on my own to reach my goal or meet my need?   |                        |
|  |                        |
|  |                        |
|  |                        |
| <b>Natural Supports</b>  | <b>How Often?</b>      |
| Who could help me reach my goal or meet my need that wouldn't have to be paid?   |                        |
|  |                        |
|  |                        |
|  |                        |
| <b>Paid Supports</b>   | <b>Type of Support</b> |
| Service, Task, or Good Needed<br>Support Key: PS-Personal, ES-Emotional, JS-Job, RS-Relationship, LS-Learning,<br>AE-Adaptive Equipment, SN-Skilled Nursing, TS-Transportation |                        |
|  |                        |
|  |                        |
|  |                        |

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Plan Date:

|   |                        |
|---|------------------------|
| Goal or Need:   |                        |
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|   |                        |
|   |                        |
|   |                        |
| <b>Natural Supports</b><br>Who could help me reach my goal or meet my need that wouldn't have to be paid?   | <b>How Often?</b>      |
|   |                        |
|   |                        |
|   |                        |
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|   |                        |
|   |                        |

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|   |                        |
|   |                        |
|   |                        |
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|   |                        |
|   |                        |
|   |                        |
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|   |                        |
|   |                        |
|   |                        |

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|--|-----------------|
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|  |                 |
|  |                 |
|  |                 |
| Natural Supports<br>Who could help me reach my goal or meet my need that wouldn't have to be paid?   | How Often?      |
|  |                 |
|  |                 |
|  |                 |
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|  |                 |
|  |                 |

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|  |                 |
|  |                 |
|  |                 |

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|   |                 |
|   |                 |
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|   |                 |
|   |                 |
|   |                 |

## MY BACK-UP PLAN

If your health or safety would be in immediate jeopardy or if a natural or paid support listed on any of your Support Plans, did not arrive at the scheduled time to provide the support, a back-up plan must be developed for that support.

For any supports you identify that require a back-up plan, first list the *Goal or Need* associated with the support, then state the support that needs to be provided, followed by three (3) other ways you can obtain the help. Please enter this information in the spaces provided below.

|                                    |
|------------------------------------|
| Goal or Need:                      |
| Support That Needs to Be Provided: |
| Back-Up Plans:                     |
| 1.                                 |
| 2.                                 |
| 3.                                 |
| Goal or Need:                      |
| Support That Needs to Be Provided: |
| Back-Up Plans:                     |
| 1.                                 |
| 2.                                 |
| 3.                                 |
| Goal or Need:                      |
| Support That Needs to Be Provided: |
| Back-Up Plans:                     |
| 1.                                 |
| 2.                                 |
| 3.                                 |

## MY SUPPORT AND SPENDING PLAN AUTHORIZATION

| Service, Task, or Good   | Name of Person, Agency, or Vendor Providing the Support | Number of Hours/Items Per Year | Cost Per Hour/Item | Annual Cost |
|--|---|--------------------------------|--------------------|-------------|
| <b>Personal Support</b><br>To maintain health, safety, and basic quality of life.  |   |                                |                    |             |
| What are the qualifications needed to cover the Personal Support goals:  |   |                                |                    |             |
|  |   |                                | x                  | =           |
|  |   |                                | x                  | =           |
|  |   |                                | x                  | =           |
|  |   |                                |                    | Total = \$  |
| <b>Emotional Support</b><br>To learn and practice behaviors consistent with goals and wishes while minimizing interfering behaviors.   |   |                                |                    |             |
| What are the qualifications needed to cover the Emotional Support goals:   |   |                                |                    |             |
|  |   |                                | x                  | =           |
|  |   |                                | x                  | =           |
|  |   |                                | x                  | =           |
|  |   |                                |                    | Total = \$  |
| <b>Learning Support</b><br>To learn new skills or improve existing skills that relates to identified goals.  |   |                                |                    |             |
| What are the qualifications needed to cover the Learning Support goals:  |   |                                |                    |             |
|  |   |                                | x                  | =           |
|  |   |                                | x                  | =           |
|  |   |                                | x                  | =           |
|  |   |                                |                    | Total = \$  |
| <b>Relationship Support</b><br>To establish and maintain positive relationships with family members, friends, spouse, or others in order to build a natural support network and community. |   |                                |                    |             |
| What are the qualifications needed to cover the Relationship Support goals:  |   |                                |                    |             |
|  |   |                                | x                  | =           |
|  |   |                                | x                  | =           |

Participant Name:

MID#:

Plan Date:

|  |  |  |   |  |   |            |
|--|--|--|---|--|---|------------|
|  |  |  | x |  | = |            |
|  |  |  |   |  |   | Total = \$ |

**Job Support**

To secure and maintain employment or attain job advancement.

What are the qualifications needed to cover the Job Support goals:

|  |  |  |   |  |   |          |
|--|--|--|---|--|---|----------|
|  |  |  | x |  | = |          |
|  |  |  | x |  | = |          |
|  |  |  | x |  | = |          |
|  |  |  |   |  |   | Total \$ |

**Adaptive Equipment**

Equipment that meets a medical or accessibility need and promotes increased independence.

|  |  |  |   |  |   |          |
|--|--|--|---|--|---|----------|
|  |  |  | x |  | = |          |
|  |  |  | x |  | = |          |
|  |  |  | x |  | = |          |
|  |  |  |   |  |   | Total \$ |

**Transportation Support**

To accomplish identified goals through gaining access to community services, activities, and resources.

|  |  |  |   |  |   |          |
|--|--|--|---|--|---|----------|
|  |  |  | x |  | = |          |
|  |  |  | x |  | = |          |
|  |  |  | x |  | = |          |
|  |  |  |   |  |   | Total \$ |

**Skilled Nursing Support:** Intermittent or private duty nursing services within the scope of the Nurse Practice Act provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

|  |  |  |   |  |   |          |
|--|--|--|---|--|---|----------|
|  |  |  | x |  | = |          |
|  |  |  | x |  | = |          |
|  |  |  |   |  |   | Total \$ |

**Total Community Supports and Services (A)**

\$

## MY SUPPORT BROKER AUTHORIZATION

| Required Job Duties   | Hours<br>Per<br>Year | <input type="checkbox"/> | Cost<br>Per<br>Hour | <input type="checkbox"/> | Annual Cost |
|---|----------------------|--------------------------|---------------------|--------------------------|-------------|
| Participate in person-centered planning process.  |                      | X                        |                     | =                        |             |
| Develop a written support and spending plan with the participant, including development of three back-up plans for every identified risk.   |                      | X                        |                     | =                        |             |
| Assist the participant to monitor and review the budget.  |                      | X                        |                     | =                        |             |
| Submit documentation to the Department, as requested, regarding satisfaction with services.   |                      | X                        |                     | =                        |             |
| Participate in Department Quality Assurance measures, as requested.   |                      | X                        |                     | =                        |             |
| Assist the participant to complete annual re-determination process as needed.   |                      | X                        |                     | =                        |             |
| Assist the participant to complete the responsibilities of the programs and assist the participant to meet his or her health and safety needs.  |                      | X                        |                     | =                        |             |
| Complete the Department approved <u>Criminal History Check Waiver Form</u> as requested by the participant and provide counseling to the participant and his or her Circle of Supports regarding the risks of waiving the Criminal History Check. |                      | X                        |                     | =                        |             |
| <b>Required Job Duties Sub Total</b>  |                      |                          |                     | \$                       |             |
| Other Requested Job Duties  | Hours<br>Per<br>Year | <input type="checkbox"/> | Cost<br>Per<br>Hour | <input type="checkbox"/> | Annual Cost |
|   |                      | X                        |                     | =                        |             |
|   |                      | X                        |                     | =                        |             |
|   |                      | X                        |                     | =                        |             |
| <b>Other Requested Job Duties Sub Total</b>   |                      |                          |                     | \$                       |             |
| <b>Required Job Duties + Other Requested Job Duties = Support Broker Total (B)</b>  |                      |                          |                     | \$                       |             |

## FISCAL EMPLOYER AGENT AUTHORIZATION

|  |  |   |    |
|--|--|---|----|
| <b>Total FEA fees (108.00 x 12=) (C)</b>   |  |   | \$ |
| <b>MEDICARE-MEDICAID COORDINATED PLAN</b>  |  |   |    |
| Medicare Medicaid Coordinated Plan- This section is for OT, PT, ST and DME services through MMCP |  |   |    |
|  |  | X | =  |
|  |  | X | =  |
|  |  | X | =  |
| <b>Total \$</b>  |  |   |    |

## FINAL SUPPORT AND SPENDING PLAN AUTHORIZATION

|                                 |  |  |     |
|---------------------------------|--|--|-----|
| Community Supports Total (A)    |  | Plan Dates   |     |
| Support Broker Total (B)        |  | From:  | To: |
| NAME:                           |  | Plan Approved By:<br><br><i>Regional BDDS Care Manager</i> |     |
| ADDRESS:                        |  |  |     |
| PHONE:                          |  |  |     |
| EMAIL:                          |  |  |     |
| Fiscal Employer Agent Total (C) |  | Assessed Annual Medicaid Budget:                           |     |
| Grand Total (D)                 |  | Approved Request Amount:                                   |     |
|                                 |  | MMCP Amount:   |     |
|                                 |  | Remaining Difference:                                      |     |

For Participants enrolled in Medicare-Medicaid Coordinated Plan (MMCP), this signature is required to ensure no duplication or contraindicated services

\_\_\_\_\_  
ICT CARE COORDINATOR SIGNATURE

\_\_\_\_\_  
DATE

## CHOICE AND INFORMED CONSENT STATEMENTS

Instructions: Read, sign, and date the Choice and Informed Consent Statements below.

### Choice Statement:

I have reviewed the services contained in this Support and Spending Plan, and I choose to accept this plan and understand my responsibilities under the Self-Directed Community Supports option of the Developmental Disabilities waiver.

|                                       |       |
|---------------------------------------|-------|
| Participant's Signature:              | Date: |
| Guardian's Signature (if applicable): | Date: |

### Informed Consent Statement for Self-Directed Community Supports Option:

I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an Intermediate Care Facility for Intellectually Disabled. I understand that I may at any time, choose facility admission.

|                                       |       |
|---------------------------------------|-------|
| Participant's Signature:              | Date: |
| Guardian's Signature (if applicable): | Date: |