

My Support & Spending Plan



This Plan Belongs To:

DEVELOPING YOUR SUPPORT AND SPENDING PLAN

Your goal is to submit a Support and Spending Plan which reflects your personal goals and needs and assures that you are able to live safely and successfully in the community within your allocated budget. There are several steps to developing a Support and Spending Plan. Below is a brief overview of each of the steps involved in completing this process. Detailed instructions for filling out each form listed in the steps below are also on the page preceding that form in the Support and Spending Plan template.

- **Step 1.** First, you should have already completed your My Voice My Choice Workbook. Have your workbook available before you begin writing your Support and Spending Plan.
- **Step 2.** Create your My Support Plan pages. To create your My Support Plan pages, you will need to refer back to the worksheets in your My Voice My Choice Workbook. The worksheets will help you decide on goals that will allow you to get the things you want and need. Keep in mind that there is no one correct way to write a goal. Goals can be written as broad as 'explore employment opportunities' or as specific as 'learn how to use my QUEST card'.
 - Your My Support Plans will also identify whether someone will be providing support to you at no cost or whether Medicaid will be paying for the support. In many cases you may be able to do things yourself to accomplish your goal or it may be possible for you to get help for free from community organizations and natural supports. The more support you can find at no cost to you, the more money you will have available to put towards developing other goals or to save for a 'rainy day'.
- **Step 3.** Review your My Health and Safety Plan in your *My Voice My Choice Workbook*. If you listed health and/or safety issues at home, work, or in the community you must also create a My Support Plan page to go along with these health and/or safety issues. This will ensure supports are in place which addresses each of the identified risks.
- **Step 4.** Develop Back-Up Plans. To decide which supports require a Back-Up Plan you must review all of your My Support Plan pages. If your health or safety would be in immediate jeopardy if a natural or paid support listed on a My Support Plan did not arrive at the scheduled time to provide the support, a back-up plan must be developed for that support. A back-up plan identifies three (3) other ways you could go about getting the help you need should a critical support not happen. Use the Back-Up Plan form to create back-up plans for critical natural or paid supports listed on all of your My Support Plan pages.
- **Step 5.** Complete your, My Support Broker Worksheet. You will transfer the Support Broker Total from this page to your My Spending Plan Summary.
- **Step 6.** Complete your My Spending Plan Worksheet. Review the paid supports section of each of your My Support Plans. You will need to list each service, task, or good that you are paying for in the section of the My Spending Plan Worksheet that corresponds to the type of support checked for the particular service, task, or good. This sheet is also used to identify who will provide the support, how often, and at what cost.

- **Step 7.** Fill out your My Spending Plan Summary. You will transfer the total associated with each type of support listed on your My Spending Plan Worksheets and My Support Broker Worksheet to this page.
- **Step 8.** Complete the Support and Spending Plan Authorization Page. This is where you will transfer every paid support listed on your My Spending Plan Worksheets into the support category with the corresponding title. The total amount of money you are going to spend for services, tasks, or goods in a particular support category is also listed on this page.
- **Step 9.** Read, sign, and date the Choice and Informed Consent Statement. This form states you agree with the Support and Spending Plan you are submitting, accept your responsibilities under the Self-Directed Community Supports Waiver option, and choose waiver services over institutional placement.

NOTE: For your convenience we have included ten (10) My Support Plan pages and three (3) Back-up Plan pages with this template. If you need more pages of a particular form than have been included, you will need to use your computer to cut and paste additional blank pages into the document. You can access the entire Support and Spending Plan document at the following website: www.healthandwelfare.idaho.gov.

SUPPORT AND SPENDING PLAN COVER SHEET INSTRUCTIONS:

- **Step 1.** Check either the Initial Plan or Annual Plan box. Only check the Initial Plan box if this is the first Support and Spending Plan you have completed as part of the Self-Directed Community Supports Waiver option.
- **Step 2.** Complete Personal Information, Guardian (if applicable), and Primary Health Care Providers in the applicable section of the cover sheet.
- **Step 3.** List the names of all individuals who were involved in helping develop the Support and Spending Plan in the section, People Who Helped Create This Plan. This list should also include those individuals who may not have attended the person-centered planning meeting(s), but were involved in helping develop your plan.

MY SUPPORT PLAN INSTRUCTIONS:

- **Step 1.** Complete Participant's Name and Medicaid ID Number lines at the top of the page.
- **Step 2.** Goal or Need. List the goal or need you want to achieve or accomplish in the upcoming plan year. There is no one correct way to write a goal. For example, you can have a goal "I want to get a job" or "I want to work in an office".
- **Step 3.** Activities. List the activities and how often you are able to do the activity on your own, to reach your goal or meet your needs.
- **Step 4.** Natural Supports. Identify people you would not need to pay that would help you reach your goal or meet your need. Identify how often these natural supports will be able to provide this help. For example, given the goal of "work in an office" perhaps you have someone that helps you fill out applications.
- **Step 5.** Paid Supports. Complete the boxes as follows:
 - List the service, task, or good needed to reach the goal or meet the need.
 - Indicate the type of support being provided by the service, task, or good by placing a checkmark (✓) in the box corresponding to the support (example: Personal Support, Job Support, etc.). Only checkmark one (1) type of support. Use the following definitions to determine which type of support best describes the service, task, or good being purchased:
 - **PERSONAL:** Helps you maintain health, safety, and basic quality of life.
 - **JOB:** Helps you secure and maintain employment or attain job advancement.
 - **TRANSPORTATION:** Helps you accomplish identified goals through gaining access to community services, activities, and resources.
 - **LEARNING:** Helps you learn new skills or improve existing skills that relate to identified goals.
 - **RELATIONSHIP:** Helps you establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community.
 - **EMOTIONAL:** Helps you learn and practice behaviors consistent with goals and wishes, while minimizing interfering behaviors.
 - **ADAPTIVE EQUIPMENT:** Equipment that meets a medical or accessibility need and promotes your increased independence.
 - **SKILLED NURSING:** Intermittent or private duty nursing services which are within the scope of the Nurse Practice Act, and are provided by a licensed professional nurse (RN) or licensed practical nurse (LPN) under the supervision of an RN, licensed to practice in Idaho.

MY SUPPORT PLAN

Participant's Name: _____

Medicaid ID Number: _____

Goal or Need:

Activities

What Activities Will I Be Able to Do Myself to Reach My Goal or Meet My Need?	How Often Do I Need to Do These Activities?

Natural Supports

Who Could Help Me Reach My Goal or Meet My Need That Wouldn't Have to Be Paid?	How Often Will They Provide The Support?

Paid Supports

Service, Task, or Good Needed	Type of Support
	<input checked="" type="checkbox"/> Check Only One Box Per Service, Task, or Good <input type="checkbox"/> Personal <input type="checkbox"/> Emotional <input type="checkbox"/> Job <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Transportation <input type="checkbox"/> Relationship <input type="checkbox"/> Learning <input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Mileage Reimbursement
	<input type="checkbox"/> Personal <input type="checkbox"/> Emotional <input type="checkbox"/> Job <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Transportation <input type="checkbox"/> Relationship <input type="checkbox"/> Learning <input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Mileage Reimbursement
	<input type="checkbox"/> Personal <input type="checkbox"/> Emotional <input type="checkbox"/> Job <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Transportation <input type="checkbox"/> Relationship <input type="checkbox"/> Learning <input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Mileage Reimbursement
	<input type="checkbox"/> Personal <input type="checkbox"/> Emotional <input type="checkbox"/> Job <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Transportation <input type="checkbox"/> Relationship <input type="checkbox"/> Learning <input type="checkbox"/> Adaptive Equipment

IMPORTANT: If your health or safety would be in immediate jeopardy, if a natural or paid support listed on this My Support Plan did not arrive at the scheduled time to provide the support, a back-up plan must be developed for that support. A back-up plan identifies three (3) other ways you could go about getting the help you need should a critical support not happen. Use the Back-Up Plan form to create back-up plans.

MY BACK-UP PLAN

Participant's Name: _____

Medicaid ID Number: _____

If your health or safety would be in immediate jeopardy, if a natural or paid support listed on any of your My 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 BROKER WORKSHEET INSTRUCTIONS:

- **Step 1.** Complete Participant's Name and Medicaid ID Number lines at top of page.
- **Step 2.** Required Job Duties. Review each of the Required Job Duties listed on the My Support Broker Worksheet. The required job duty of person-centered planning participation asks you to provide details about what you want your Support Broker to do as part of this requirement. List the specific activities in the appropriate box.
- **Step 3.** Other Requested Job Duties. You may want your Support Broker to assist you with completing a number of other tasks associated with self-directed services. List each of these duties separately under the section titled Other Requested Job Duties.
- **Step 4.** Number of Hours Needed, Per Year. For each of the Required Job Duties and Other Requested Job Duties, enter the maximum number of hours you will employ your Support Broker to provide each of these supports during the upcoming Plan Year.
- **Step 5.** Cost Per Hour. Enter the hourly rate you will pay your Support Broker during the upcoming plan year for each of their job duties. This hourly rate cannot exceed \$18.72/hour. Keep in mind that this hourly rate cannot change from job duty to job duty. You must pay the same hourly rate for all of the support provided by your Support Broker.
- **IMPORTANT REMINDER:** You will need to add an additional 9.95% to the hourly rate you want to pay your Support Broker, before putting the hourly rate in the Cost per Hour section. This additional 9.95% is the employer's share of taxes you are responsible for paying to the Federal Government as an employer under the Self-Directed Community Supports Waiver option. To figure out the Cost per Hour for Support Broker services with the 9.95% added on, just multiply the hourly rate you want to pay your Support Broker by 1.0995.
 - Example: If you decide to pay your Support Broker \$18.72/hour, your cost per hour for Support Broker services would be \$20.58.
$$\$18.72 \times 1.0995 = \$20.58$$
- **Step 6.** Annual Cost. Multiply the number of hours needed per year by the cost per Hour to calculate the Annual Cost of each job duty listed.
- **Step 7.** Support Broker Total. Add together the annual cost of all listed job duties to calculate your Support Broker total. Write this total amount on the line provided on the lower right of the worksheet.

MY SUPPORT BROKER WORKSHEET

Participant's Name: _____

Medicaid ID Number: _____

Required Job Duties	Number of Hours Needed, Per Year		Cost Per Hour		Annual Cost
Person-Centered Planning Participation, to Include:		X		=	
Development of Written Support and Spending Plan.		X		=	
Assist with Monitoring and Review of Budget.		X		=	
Quality Assurance Activities. (As Required by the Department of Health and Welfare.)		X		=	
Assisting with Annual Re-determination Process.		X		=	
Criminal History Check Waiver Process (example: complete waiver form, education and counseling to participant and circle of support, assist with detailing rationale for waiver and identifying how health and safety will be protected).		X		=	

Other Requested Job Duties (Give Details of Duties)

		X		=	
		X		=	
		X		=	
		X		=	
		X		=	

Support Broker Total = \$ _____

MY SPENDING PLAN WORKSHEET INSTRUCTIONS:

- **Step 1.** Complete Participant's Name and Medicaid ID Number lines at top of page.
- **Step 2.** Paid Supports section. For each service, task, or good listed under the Paid Supports section of your My Support Plan, list that service, task, or good in the section that corresponds with the Type of Support checked () for that particular service, task, or good on the My Support Plan.
- **Step 3.** Name of Person, Agency, or Vendor Providing the Support. Enter the name of the person, agency, or vendor who will be providing the identified service, task, or good.
- **Step 4.** Number of Hours/Items Needed Per Year. Enter the maximum number of hours or items needed of that service, task, or good during the upcoming plan year.
- **Step 5.** Cost Per Hour/Items. List in this section the hourly, or per item cost for the service, task, or good.
 - Important: If you are hiring a person to provide hourly services, you will need to add an additional 9.95% to the hourly wage you want to pay your service provider before putting the hourly cost in this column. The additional 9.95% is the employer's share of taxes you are responsible for paying to the Federal Government, as an employer under the Self-Directed Community Supports Waiver option.
 - Example: If you decide to pay your Support Worker \$10.00/hour, your cost per hour for that worker's services would be **\$11.00 > \$10. x 1.0995 = \$11.00.**
 - Note: The amount on the Employment agreement will be the \$10.00/hour and is the employee's wages before their individual taxes are taken out.
- **Step 6.** Annual Cost. Multiply the total number of hours or items by the hourly, or per item cost to calculate the annual cost of the service, task or good.

Repeat Steps 6 - 10 for every paid service, task, or good listed on all of your My Support Plan pages. Calculate the total for each type of support (example: Personal, Job, etc.) by adding together the annual cost(s) of all of the service(s), task(s), or good(s) listed.

MY SPENDING PLAN WORKSHEET

Participant's Name: _____

Medicaid ID Number: _____

Personal Support: Helps you maintain health, safety, and basic quality of life.

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed Per Year		Cost Per Hour/Item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	

Total = \$ _____

Emotional Support: Helps you learn and practice behaviors consistent with goals and wishes while minimizing interfering behaviors.

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed Per Year		Cost Per Hour/Item		Annual Cost
			x		=	
			x		=	
			x		=	

Total = \$ _____

MY SPENDING PLAN WORKSHEET

Participant's Name: _____

Medicaid ID Number: _____

Job Support: Helps you secure and maintain employment or attain job advancement.

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed Per Year		Cost Per Hour/Item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total = \$ _____

Transportation Support: Helps you accomplish identified goals through gaining access to community services, activities, and resources.

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed Per Year		Cost Per Hour/Item/Mile <i>(Please specify)</i>		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total = \$ _____

MY SPENDING PLAN WORKSHEET

Participant's Name: _____

Medicaid ID Number: _____

Learning Support: Helps you learn new skills or improve existing skills that relate to identified goals.

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed Per Year		Cost Per Hour/Item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	
			x		=	

Total = \$ _____

Relationship Support: Helps you establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community.

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed per Year		Cost Per Hour/Item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total = \$ _____

MY SPENDING PLAN WORKSHEET

Participant's Name: _____

Medicaid ID Number: _____

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

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed per Year		Cost Per Hour/Item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total = \$ _____

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

Service, Task, or Good	Name of Person, Agency, or Vendor Providing the Support	Number of Hours/Items Needed Per Year		Cost Per Hour/Item		Annual Cost
			x		=	
			x		=	
			x		=	
			x		=	

Total = \$ _____

MY SPENDING PLAN SUMMARY INSTRUCTIONS:

- **Step 1.** Complete Participant's Name and Medicaid ID Number lines at top of page.
- **Step 2.** Refer to the My Support Broker Worksheet. Transfer the Support Broker total to the My Spending Plan Summary sheet.
- **Step 3.** Refer to your My Spending Plan Worksheet pages. Transfer the total from each individual section of the My Spending Plan Worksheets to the My Spending Plan Summary sheet. (Example: totals for Personal Support, Job Support, etc.)
- **Step 4.** Add together the annual amounts for Personal Support, Job Support, Transportation Support, Learning Support, Relationship Support, Emotional Support, Skilled Nursing Support, and Adaptive Equipment, to calculate your Community Support Total.
- **Step 5.** Indicate the total annual cost for Fiscal Employer Agent services.
- **Step 6.** Calculate the Grand Total of all supports and services by adding together the Support Broker Total, Community Supports Total and the Fiscal Employer Agent Total.

MY SPENDING PLAN SUMMARY

Participant's Name: _____

Medicaid ID Number: _____

- **Support Broker Total** = \$ _____
 - Personal Support \$ _____
 - Job Support \$ _____
 - Transportation \$ _____
 - Learning Support \$ _____
 - Relationship \$ _____
 - Emotional Support \$ _____
 - Skilled Nursing Support \$ _____
 - Adaptive Equipment \$ _____

- **Community Supports Total** = \$ _____
 - Fiscal Employer Agent \$ _____

- **Grand Total** = \$ _____

SUPPORT AND SPENDING PLAN AUTHORIZATION INSTRUCTIONS:

- **Step 1.** Complete Participant's Name and Medicaid ID Number lines at top of page.
- **Step 2.** Community Supports Total. Enter the Community Supports Total from your My Spending Plan Summary page to the Community Supports Total line.
- **Step 3.** Fiscal Employer Agent. Enter the Fiscal Employer Agent Total from your My Spending Plan Summary page to the Fiscal Employer Agent line.
- **Step 4.** Grand Total. Add together the Community Supports Total and the Fiscal Employer Agent (FEA) to calculate the Grand Total. Enter this dollar amount on the Grand Total line.
- **Step 5.** Support Broker Total. Enter the Support Broker total from your My Support Broker Worksheet on the Support Broker Total line. Then enter the Support Broker's name and address on the following lines where indicated.
- **Step 6.** In the gray shaded box on the upper right hand side of the page, enter the start date of your Support and Spending Plan and the annual Medicaid budget you were given, at the time eligibility was determined. Refer to your eligibility approval letter for this information.
- **Step 7.** Transfer every service, task, or good listed on your My Spending Plan Worksheets into the support section with the corresponding title.
- **Step 8.** Transfer the total from each of the support sections of your My Spending Plan Worksheets onto the Total line with the corresponding title.

SUPPORT AND SPENDING PLAN AUTHORIZATION

Participant's Name: _____ Region: _____

Medicaid ID Number: _____

Community Supports Total \$ _____

Fiscal Employer Agent \$ _____

Grand Total \$ _____

SUPPORT BROKER TOTAL: \$ _____

NAME: _____

ADDRESS: _____

PHONE: _____

Personal Support:

(Services, Tasks, and Goods)

Job Support:

(Services, Tasks, and Goods)

Transportation Support:

(Services, Tasks, and Goods)

Plan Start Date:
 From _____ To _____ DOB: _____

Plan Approved By:

 Regional Medicaid Services Signature

Assessed Annual Medicaid Budget
 \$ _____

Approved Request Amount:
 \$ _____

Remaining Difference: \$ _____

Total= \$ _____

Total= \$ _____

Learning Support:
(Services, Tasks, and Goods)

Total= \$ _____

Relationship Support:
(Services, Tasks, and Goods)

Total= \$ _____

Emotional Support:
(Services, Tasks, and Goods)

Total= \$ _____

Skilled Nursing Support:
(Services, Tasks, and Goods)

Total= \$ _____

Adaptive Equipment:
(Services, Tasks, and Goods)

Total= \$ _____

Total= \$_____

CHOICE AND INFORMED CONSENT STATEMENT

Participant's Name: _____

Medicaid ID Number: _____

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 Waiver option of the Developmental Disabilities waiver.

Participant's Signature

Date

Guardian Signature (if applicable)

Date

Informed Consent Statement:

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 Developmentally Disabled)/Mentally Retarded. I understand that I may at any time, choose facility admission.

Participant's Signature

Date

Guardian Signature (If Applicable)

Date