MY SUPPORT AND SPENDING PLAN

ADULT SELF-DIRECTED SERVICES

IDAHO DEPARTMENT OF HEALTH & WELFARE

Update 07/27/17

This Plan Belongs to:

MY SUPPORT AND SPENDING PLAN COVER SHEET

Personal Information			Initial Plan ☐ Annual Plan ☐	
Birth date:			MMCP: ☐	
Address:	City:		State: ID	Zip Code:
Community Living Arrangement:				
Telephone Number(s):				
Home:	Cellular:		Other:	
Legal Guardian (If Applicable)				
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:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

Participant Name: MID#: Plan Date:

MY SUPPORT PLAN

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

Participant Name: **MID#:** **Plan Date:**

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

Paid Supports Service, Task, or Good Needed Support Key: PS-Personal, ES-Emotional, JS-Job, RS-Relationship, LS-Learning, AE-Adaptive Equipment, SN-Skilled Nursing, TS-Transportation	Type of Support

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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
Personal Support To maintain health, safety, and basic quality of life.						
What are the qualifications needed to cover the Personal Support goals:						
			x		=	
			x		=	
			x		=	
			Total = $			
Emotional Support 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 = $			
Learning Support 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 = $			
Relationship Support 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		=	

			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 Per Year		Cost Per Hour		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 Criminal History Check Waiver Form 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		=	
Required Job Duties Sub Total					$
Other Requested Job Duties	**Hours Per Year**		**Cost Per Hour**		**Annual Cost**
		X		=	
		X		=	
		X		=	
Other Requested Job Duties Sub Total					$
Required Job Duties + Other Requested Job Duties = Support Broker Total (B)					$

FISCAL EMPLOYER AGENT AUTHORIZATION

Fiscal Employer Agent Name	Cost per Month	x	Months per Year	=	Annual Cost

MEDICARE-MEDICAID COORDINATED PLAN

Medicare Medicaid Coordinated Plan- This section if for OT, PT, ST and DME services through MMCP

			x		=	
			x		=	
			x		=	
			Total $			

FINAL SUPPORT AND SPENDING PLAN AUTHORIZATION

Community Supports Total (A)		Plan Dates	
Support Broker Total (B)		From:	To:
NAME:		Plan Approved By:	
ADDRESS:			
PHONE:		*Regional BDDS Care Manager*	
EMAIL:		Assessed Annual Medicaid Budget:	
Fiscal Employer Agent Total (C)			
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: