

FAMILY-DIRECTED SERVICES SUPPORT AND SPENDING PLAN



IDAHO DEPARTMENT OF
HEALTH & WELFARE

CHILD'S NAME:

MID#:

DATE:

SUPPORT AND SPENDING PLAN COVER SHEET

Personal Information Plan

Initial Plan Annual

Community Living Arrangement:

Date of Birth:

Address:

City:

State: ID

Zip Code:

Telephone Number(s): Home: ()

Cellular: ()

Other: ()

Parent(s) Name:

Address:

City:

State:

Zip Code:

Telephone Number(s): Home: ()

Cellular: ()

Other: ()

Legal Guardian (if not Parent) Name:

Address:

City:

State:

Zip Code:

Telephone Number(s) Home: ()

Cellular: ()

Other: ()

Primary Care Provider:

Healthy Connections: Yes No

Specialist(s):

Dentist:

PEOPLE WHO HELPED CREATE THIS PLAN

Name:	Parent or legal Guardian
Name:	Relationship to Child:
Name : ADDRESS: PHONE(S):	Support Broker

SUPPORT PLAN

Goal or Need:

Activities

What activities will my child be able to do themselves to reach goal or meet need?

How Often?

Natural Supports

Who could help my child reach goal or meet need that wouldn't have to be paid?

How Often?

Medicaid Paid Supports

Service, Task, or Good Needed

Type of Support
KEY →

One per Service, Task, or Good

- P: Personal
- E: Emotional
- J: Job
- R: Relationship
- L: Learning
- AE: Adaptive Equipment
- SN: Skilled Nursing
- T: Transportation
- MR: Mileage Reimbursement

		One per Service, Task, or Good P: Personal E: Emotional J: Job R: Relationship L: Learning AE: Adaptive Equipment SN: Skilled Nursing T: Transportation MR: Mileage Reimbursement

Steps to Independence: What can be done to develop more independence?

PLEASE REPRODUCE AS NECESSARY - ONE PAGE FOR EACH GOAL

BACK-UP PLAN

If your child's health or safety would be in immediate jeopardy if a natural or paid support listed on any of your child's Support Plans, was temporarily unavailable or did not arrive at the scheduled time, 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 Plan:
1.
2.
3.
Goal or Need:
Support that needs to be provided:
Back-Up Plan:
1.
2.
3.
Goal or Need:
Support that needs to be provided:
Back-Up Plan:
1.
2.
3.

SUPPORT AND SPENDING PLAN AUTHORIZATION

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
Personal Support						
To maintain health, safety and basic quality of life.						
			X		=	
			X		=	
			X		=	
			X		=	
				Total = \$		
Emotional Support						
To learn and practice behaviors consistent with goals and wishes while minimizing interfering behaviors.						
			X		=	
			X		=	
			X		=	
			X		=	
				Total = \$		
Learning Support						
To learn new skills or improve existing skills that relate to identified goals.						
			X		=	
			X		=	
			X		=	
			X		=	
				Total = \$		
Relationship Support						
To establish and maintain positive relationships with immediate family members, friends, spouse, or others in order to build a natural support network and community.						
			X		=	
			X		=	
			X		=	
			X		=	
				TOTAL = \$		
				PAGE 1 TOTAL: \$		

CHILD'S NAME:

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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
Job Support To secure and maintain employment or attain job advancement.				
			X	=
			X	=
			X	=
			Total = \$	
Adaptive Equipment Equipment that meets a medical or accessibility need and promotes increased independence.				
			X	=
			X	=
			X	=
			X	=
			Total = \$	
Transportation Support To accomplish identified goals through gaining access to community services, activities, and resources.				
			X	=
			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	=
			X	=
			Total = \$	
		TOTAL PAGE 1:		
		TOTAL PAGE 2:		
		TOTAL SUPPORTS AND SERVICES: (A)		

CHILD'S NAME:

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SUPPORT BROKER AUTHORIZATION

Required Job Duties	Hours Per Year		Cost Per Hour		Annual Cost
Participate in the family-centered planning process.		X		=	
Develop a written <u>Support and Spending Plan</u> , including the development of 3 back-up plans for every identified risk.		X		=	
Assist the parent 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 parent to complete annual re-determination process as needed.		X		=	
Assist the parent to complete the responsibilities of the programs and meet the child's health and safety needs.		x		=	
Complete the Department approved <u>Criminal History Check Waiver Form</u> for CSWs as requested by the parent and provide counseling to the parent regarding the risks of waiving the Criminal History and Background Check.		x		=	
Required Job Duties Subtotal \$ _____					
Other Requested Job Duties	Hours Per Year		Cost Per Hour		Annual Cost
		X		=	
		X		=	
		X		=	
		X		=	
Other Requested Job Duties Subtotal \$ _____					
(B) REQUIRED JOB DUTIES + REQUESTED JOB DUTIES = SUPPORT BROKER TOTAL \$ _____					

CHILD'S NAME:

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FISCAL EMPLOYER AGENT AUTHORIZATION

Number of months in which FEA will complete Payroll transactions	
Number of months in which FEA will pay for Goods	
Total Number of months FEA services will be used	
108.00 x ____ (months)	
TOTAL FEA FEES	(C)

PLAN AUTHORIZATION SUMMARY

SUPPORTS TOTAL (A) \$ _____
 SUPPORT BROKER TOTAL (B) \$ _____
 FISCAL EMPLOYER AGENT TOTAL (C) \$ _____

 GRAND TOTAL \$ _____

TO BE COMPLETED BY FACS CASE COORDINATOR ONLY

PLAN DATES: FROM _____ TO _____

PLAN APPROVED BY: _____
FACS CASE COORDINATOR

ASSESSED ANNUAL MEDICAID BUDGET: \$ _____

APPROVED REQUEST AMOUNT: \$ _____

REMAINING DIFFERENCE: \$ _____

CHOICE AND INFORMED CONSENT STATEMENT

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 Family-Directed Services option.

Parent or Legal Guardian Signature

Date

Complete if funded by the DD Waiver

Informed Consent Statement for Family-Directed Community Services Option:

I have been informed of and understand my choice of waiver services. I choose to receive Family-Directed Community Supports, rather than to accept placement for my child (or ward) in an Intermediate Care Facility for the Intellectually Disabled. I understand that I may, at any time, choose facility admission for my child.

Parent or Legal Guardian Signature

Date