



SERVICE AND SUPPORT PLAN, BUDGET AND WORKSHEETS

1-866-786-4999 (toll-free) • www.MiViaNM.org

Name (First) _____ (Middle) _____ (Last) _____

Date of Birth _____ Medicaid Card ID # _____

Physical Address _____ City _____ Zip _____

Mailing Address (if different) _____ City _____ Zip _____

Phone (home) _____ Phone (work) _____ Phone (cell) _____

Phone (message) _____ Name of person to leave message with _____

Email _____

Name of Parent/Guardian/Other _____ Role _____

Physical Address _____

Mailing Address (if different) _____

Phone (home) _____ Phone (work) _____ Phone (cell) _____

Current Medicaid Provider Molina Presbyterian Lovelace Fee for Service

Persons contributing to this plan (names, roles and/or relationships):

Consultant Name _____ Phone _____ Email _____

SIGNATURES

As the Participant, I was involved in the development of this Service and Support Plan. My signature indicates my approval of the services, supports and/or items described in the plan.

Participant _____ Date _____

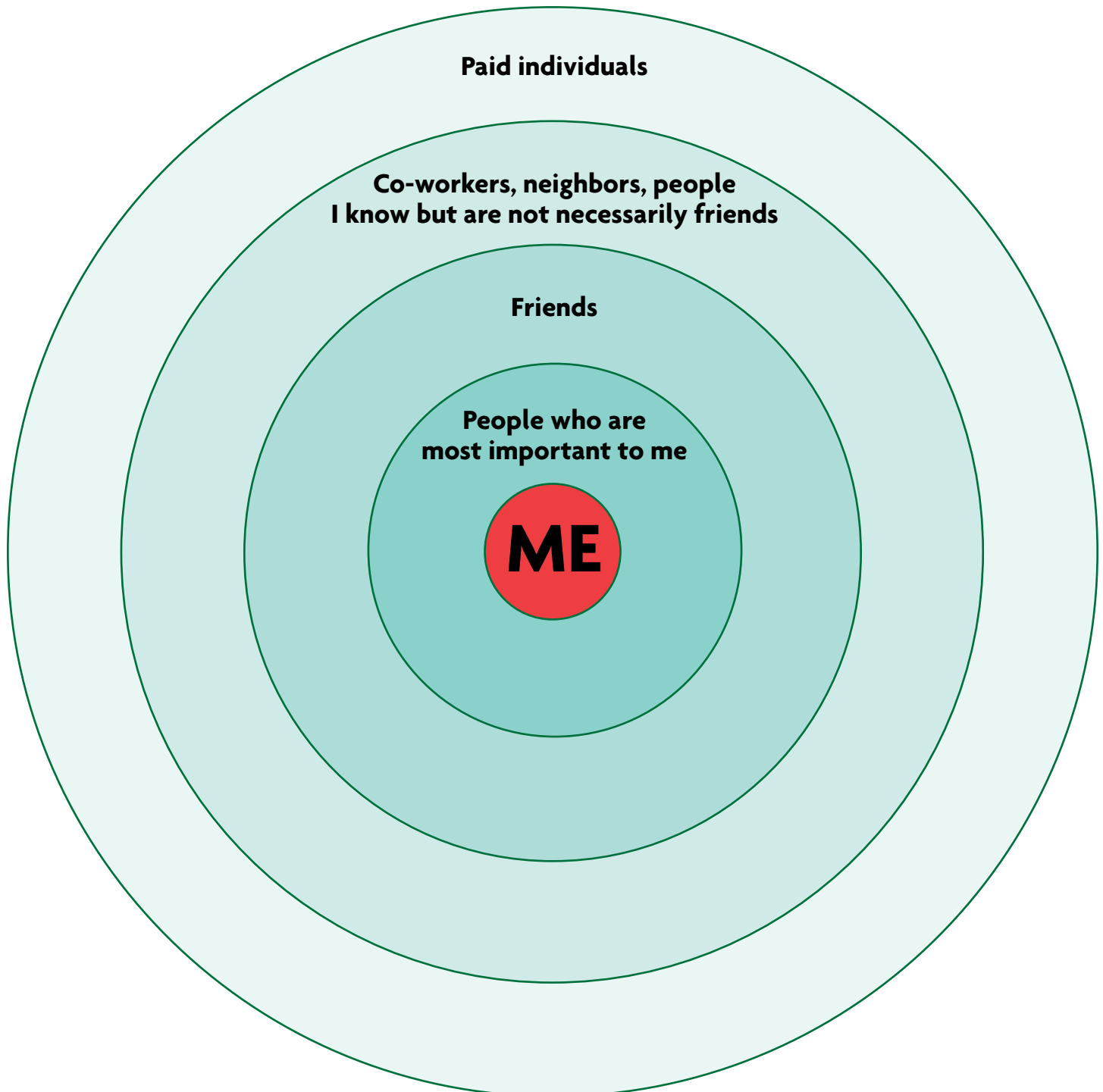
Guardian and/or Representative (if applicable) _____ Date _____

Consultant _____ Date _____

SECTION 1 • CHARTING MY PERSONAL RELATIONSHIPS

Everyone counts on a variety of support from other people to get through the day. The people you count on become especially important when there are major changes in your life.

Imagine yourself in the center of the circles below. Fill in the names of people you can count on and who are a part of your support system.





SECTION 2 • PREPARING FOR MY SERVICE AND SUPPORT PLAN

If I were planning a “good day” for me, it would look like ...

A “bad day” for me might be ...

What is important in my life now and in the future?

What is working well in my life?

What are my strengths and accomplishments?



SECTION 2 • PREPARING FOR MY SERVICE AND SUPPORT PLAN *continued*

What are my needs and concerns?

What are my health concerns? (Be sure to consider medical issues, eating and nutrition concerns, and behaviors that might not be safe or helpful in your life.)

Do I need any Assistive Technology, Environmental Modifications or Durable Medical Equipment? If so, what?

Do I, or someone who works with me, want/need additional resources or training? If yes, what?

Who are the people who might help me? (List them below and how they may help. If necessary, refer to the circle chart in Section 1.)



SECTION 3 • PULLING IT ALL TOGETHER • A Snapshot of Your Life

In this section, describe what your life looks like right now as well as what you want it to look like. List how you spend your time in each area. Include hobbies, interests, activities, memberships and individuals who are part of each area. **What do I want my life to look like? What changes would I like to make in any of these areas?** How do I want to spend my time? What would I like to keep the same? What makes me happy? Who would I like to have more/less involved in these areas?

MY LIFE NOW	WHAT I WANT
Home/Family	Home/Family
Recreation/Fun/Relaxation	Recreation/Fun/Relaxation
Community Involvement/Social	Community Involvement/Social
School/Learning/Coaching	School/Learning/Coaching
Work/Volunteer Activities/Work Coaching	Work/Volunteer Activities/Work Coaching



SECTION 3 • PULLING IT ALL TOGETHER *continued*

As you look at the following questions, think about what you wrote on the previous pages. What is most important to me? What strengths do I have that will help me to self-direct my services? Who from my personal relationships chart might be available to help me? What concerns need to be addressed? How do I want to spend my time?

What do I want to happen as a result of my plan?

How will I know if my plan is working well?

How will I address any health concerns or safety concerns?

How often do I want my consultant to contact me?



SECTION 4 • EMERGENCY BACKUP PLAN

Participant Name _____ Legal Representative/Guardian (if applicable)

An **Emergency Backup Plan** helps in an emergency or if your scheduled employees cannot provide your care, services or supports. This plan is part of the Service and Support Plan (SSP) and is modified, when necessary. At a minimum, your Consultant will check with you four (4) times per year to see how Mi Via is working for you.

If there is an emergency, call 911 right away.

1. **Backup:** If regularly scheduled employees/service providers cannot provide my care, services and supports, I will call/contact one of the individuals listed below.

Please list below whom you will call if your current employee/service provider fails to report for his/her shift or task. (Examples: friends, family, past personal care providers, church members, other volunteers.)

Service	Name	Days/Times Not Available	Phone

A. ______(initial) I will talk with backup service providers about employment, pay, their availability and my personal care needs before an emergency comes up. (Initial for Participant or Representative/Guardian to indicate agreement.)



Service and Support Plan, Budget and Worksheets

SECTION 5 • ACTION PLAN

Participant Name _____ **Date** _____

1. Develop your Action Plan by reviewing the information from the previous pages, including what you would like to happen as a result of your plan, any needs and concerns, and the people in your life who might be able to help you self-direct your services.
2. Make choices about the services, supports and goods you feel would address the needs described in your plan.
3. Remember that service and support choices should be linked to needs identified in the plan, but not limited to medical or clinical needs.
4. Use letters A, B, C, etc., for each “What I want to happen...” and number each service, support or good you choose as action #s.

_____ **What I want to happen** _____

_____ **What I see as obstacles to this happening** _____

Action #	What Services, Supports or Goods Will Help to Make It Happen?	How and Why Will This Help Me?	Who Helps Make This Happen? (e.g. provider, friend, etc.)	Start Date/ End Date	How Often, How Long and How Many?	Mi Via \$? Y/N
1						
2						
3						
4						



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SECTION 5 • ACTION PLAN *continued*

Participant Name _____ Date _____

_____ What I want to happen _____

What I see as obstacles to this happening _____

Action #	What Services, Supports or Goods Will Help to Make It Happen?	How and Why Will This Help Me?	Who Helps Make This Happen? (e.g. provider, friend, etc.)	Start Date/ End Date	How Often, How Long and How Many?	Mi Via \$? Y/N

_____ What I want to happen _____

What I see as obstacles to this happening _____

Action #	What Services, Supports or Goods Will Help to Make It Happen?	How and Why Will This Help Me?	Who Helps Make This Happen? (e.g. provider, friend, etc.)	Start Date/ End Date	How Often, How Long and How Many?	Mi Via \$? Y/N

Please copy and repeat pages as needed, and handwrite page numbers



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SECTION 6 • PARTICIPANT PURCHASING WORKSHEET

Use this worksheet to help you estimate the cost of services, supports and items you would like to purchase with Mi Via funds. This worksheet could help you prioritize and decide exactly how you want to spend your Mi Via budget. See shaded examples and instructions below.

Participant Name _____ **Mi Via** Budget Amount \$ _____

Projected Budget Start Date _____ Budget Expiration Date _____ Plan Development Date _____

#	Waiver Service Category	A	B	C	D	E	F	G	H	I
	Service, Support or Good to be Purchased	Negotiated Rate or Cost per Unit	Withhold Employee Taxes? Yes/No	Cost to Budget per Unit (including taxes)	Unit (per hr, ¼ hour, month, etc.)	# Units (per week or month or budget)	How Long? (# weeks or months)	Total Units in Budget (E x F)	Total Cost (C x G)	How much is left over from your Mi Via Budget? Amt _____
X 1	Example Category (Hiring an Employee)	\$10.00	Yes	\$11.10	Hour	35 hours per week	24 weeks	840 hours	\$9,324.00	
X 2	Example Category (Service/Agency)	\$15.00	No	\$15.00	¼ Hour	4 per week	24 weeks	96 ¼ hours	\$1,440.00	
X 3	Example Category (Good or Item)	\$50.88	No	\$54.44	Item	1 per budget	n/a	1	\$54.44	

Please copy and repeat pages as needed, and handwrite page numbers