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| LogoSmCDCS Annual Community Support PlanCLIENT DRIVENSUPPORT |
| Date: |       | to |       |

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| PERSONAL INFORMATION |

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| --- | --- | --- | --- | --- |
| **Client Name:** | **PMI #:**       | **Phone:** | **Home:** |       |
|       | *(8 digit Medical Assistance #)* |  | **Work:** |       |
|  |  | **Case #:**       |  | **Cell:** |       |
| **Date of Birth:** |       | *(10 digit Dakota County case #)* |  |  |  |
| **Address:** |       |
| **Email:** |       |
| **Waiver Type:** | [ ]  AC [ ]  CAC [ ]  CADI [ ]  DD [ ]  EW [ ]  BI-NF [ ]  BI-NB |
| **County of Residence:** |       | **County of Financial Responsibility (CFR):** Dakota |

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| **Parent/Legal Representative/Responsible Party *(if any)*:** |       |
| **Address:** |       |
| **Phone:** | **Home:** |       | **Email:** |
|  | **Work:** |       |       |
|  | **Cell:** |       |  |

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| **Social Worker/Public Health Nurse:** | **Phone:** |       |
|       | **Fax:** |       |
| **Address:** |       |
|  |       |
| **Email:** |       |

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| **Fiscal Management Service Provider:** *(Agency that bills and reimburses)* | **Contact Name:** |
|       |
| **Address:**  |       |
| **Phone:** |       | **Fax:** |       |
| **Email:** |       |

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| **Common Law Employer(s):** *(Person or agency that hires &*  | **Contact Name:** |
| *handles payroll. May be the same as the Fiscal Management Service)* |       |
|  |  |
| **Address:**  |       |
| **Phone:** |       | **Fax:** |       |
| **Email:** |       |

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| **Support Planner, if any:** |
|       |
| **Address:**  |       |
| **Phone:** |       | **Fax:** |       |
| **Email:** |       |

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| **Annual Community Support Plan for:** |       |

***You may want to refer to the “Dakota County Guide To Completing the Annual Community Support Plan” when completing this form.***

When developing the Annual Community Support Plan, think about and describe the individual, his or her strengths and needs, likes and dislikes, and how the disability/condition impacts his or her life. Some people find these questions easy to answer and can do so without assistance. Others have found it helpful to participate in a facilitated person-centered planning process. Information about planning processes is included at the end of the guidebook. Remember all goods and services must be directly related to the disability and/or condition and based on the intended outcomes described in this Community Support Plan.

**Brief Description** *(Age, disability/condition, how disability impacts life)*

**Brief Summary of Last Plan Year’s Progress** *(Describe the accomplishments or progress made on things you wanted to do or achieve.)*

1. **What do you want to do? What are the measurable goals you are working on?**
2. **What unpaid and paid support will you need?**

1. **PERSONAL ASSISTANCE** *(Support for personal care, relief of caregiver, etc. use term “support staff” instead of “PCA” unless they are actually a PCA from an agency who pays them. Use the term “Paid Parent of a Minor” if applicable, etc.)*

**PROVIDER QUALIFICATIONS:**

**TRAINING:**

1. **TREATMENT AND TRAINING** *(Support/services for training, therapy, etc.)*

**PROVIDER QUALIFICATIONS:**

**TRAINING:**

1. **ENVIRONMENTAL MODIFICATIONS AND PROVISIONS** *(Supplies, equipment, modifications, special diets, chore services, mileage, etc.)*

**PROVIDER QUALIFICATIONS:**

1. **SELF DIRECTION SUPPORT ACTIVITIES** *(Support Planner, Fiscal Support Entity fees, payroll costs, newspaper ads, etc.)*

**PROVIDER QUALIFICATIONS:**

**TRAINING:**

**How will the supports you listed in question #2 help you do what you want to do? What is the disability need to support this being paid through CDCS?** *(Describe the intended outcomes here.)*

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| **MONITORING** |

*Your Community Support Plan must include who is responsible for monitoring. They may be paid or unpaid.*

**Indicate who will monitor Health and Safety along with the County. How often?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Who | Daily | Monthly | Quarterly | Other |
|       | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  | [ ]  |       |

**Indicate who will monitor expenditures along with the county. How often?**

|  |  |  |  |
| --- | --- | --- | --- |
| Who | Monthly | Quarterly | Other |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |
|       | [ ]  | [ ]  |       |

**Who will be responsible for assuring the provider qualifications and training of the support people:** *(Check all that apply)*

[ ]  Individual

[ ]  Parent/Spouse/Responsible Party

[ ]  Support Planner

[ ]  Licensed Agency

[ ]  Other:       *(Indicate who)*

For what positions, if any, do you want criminal background checks completed? Names of support staff that need Criminal Background Studies.

*\*All licensed agencies are required to complete criminal background checks.*

**A written agreement is in place stating duties and responsibilities of** (check all that apply):

[ ]  Fiscal Management Services

[ ]  A contract with your Support Planner

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| **HEALTH AND SAFETY PLAN** |

*How will your health and safety needs be met? Think about what supports and services are needed along with what skills and knowledge staff may need. If you have a formal plan from a Provider? If not, consider if you were not available, how to help in severe weather, a fire, a fall, lost in community, safety issues you are teaching.*

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| Revision to Health and Safety Plan: | Date:       |

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| **WHAT WILL I DO IN CASE . . .** |

*What will you do in case there is an emergency, such as staff not showing up for their shift, primary caregiver is ill, staff is late returning. The Guide includes questions to help you think about your Emergency Plan. Update the plan as necessary.*

|  |  |  |
| --- | --- | --- |
|  | Emergency Contact | Alternate person |
| Name: |       |       |
| Home phone: |       |       |
| Work phone: |       |       |
| Cell Phone: |       |       |

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| Revision to Emergency Plan: | Date:       |

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| LogoSmCDCS Annual Community Support PlanCLIENT DRIVENSUPPORT |
| Date: |       | to |       |
| Client Name: |       |

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| --- | --- | --- |
|  |  |       |
| Client/Responsible Party/Guardian Signature |  | Date |
|  |  |       |
| Social Worker/Public Health Nurse Signature |  | Date |