Appendix B:

Service and Support Plan (SSP) Template

Mi Via Service and Support Plan

INSTRUCTIONS

The new Service and Support Plan (SSP) is organized by four (4) categories of services:

1. Living Supports
2. Community Membership Supports
3. Health and Wellness Supports
4. Other Supports

There are also sections for:

5. Environmental Modifications
6. Emergency Back-up Plan
7. Consultant/Support Guide Services
8. SSP Preparation Information

You do not need to fill out every portion of every section. The questions that must be answered are marked "*mandatory*." However, if the question does not apply to you, just put "not applicable" or "n/a" in the space provided and move on.

The SSP can be written out by hand, or the consultant can use the Word version of the form to type in the answers. However, in order for the SSP to be submitted to the Third Party Assessor (TPA), all information must be entered into the FOCoS*online* SSP by the consultant.

Mi Via Overview

The Mi Via Home and Community Based Services Waiver is a program that supports eligible New Mexicans with intellectual/developmental disabilities (I/DD) to live safely in their communities and prevent institutionalization. Mi Via is a self-directed waiver that allows participants to choose service vendors or hire, fire, supervise, and manage employees of their choosing with support from a designated representative (if applicable) and consultant.

Based on assessed need and the participant's qualifying disability, the participant develops a service and support plan through person centered planning that outlines the services and supports the participant needs in order to live independently in their own home or community.

The services and supports purchased from Mi Via are in addition to natural and other paid supports and are intended to increase independence or be a substitute to human assistance.

The use of restraints, restrictive interventions and seclusion is not permitted in the delivery of Mi Via Waiver services.

My Mi Via Service and Support Plan

Q1. What do I want to have happen as a result of my participation in the Mi Via Program at home, at work and in the community related to my health, friends and relationships?

Mandatory

Q2. What strengths do I have?

Mandatory

Personal Plan Facilitation

Do you want to use an additional person centered planning activity to help you develop your SSP? Mi Via Personal Plan Facilitation service can be used for this purpose. Examples of person-centered planning tools are MAP, PATH, Eco-mapping, etc. This type of activity can help you identify your personal goals/needs, what resources you currently have and what else you may need. This is an optional service.

You can use this information to decide how the Mi Via program can be used to help you address your needs and reach your goals. You can also use this activity to help you plan for other parts of your life not covered by the Mi Via program.

Q3. If you currently have a PATH or MAP or similar information, do you want to use it as part of your SSP planning?

❑ Yes ❑ No

Q4. Do you want to use Mi Via Plan Facilitation service as part of your SSP planning?

❑ Yes ❑ No

If you choose yes, please stop this process and ask your consultant for a list of Personal Plan Facilitation Providers.

1. Living Supports

Living Supports Definition: Individually determined supports that help you stay in your own home and community. These supports can provide needed assistance with activities of daily living, home management, supports for health and safety as well as independent living skills. Supports can be provided using three (3) different models and are to occur in a participant's private residence, not in a home owned by their provider agency:

- Homemaker/Direct Support Services
- Home Health Aide
- In-Home Living Supports

How can Mi Via support you to live independently in your own home? Please identify any supports needed to successfully and safely complete daily activities or build skills in the areas listed below:

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week)**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Month)**
Eating				
Dressing				
Bathing				
Transfers				
Toileting				
Heavy Housework				
Light Housework				
Cooking				
Grocery Shopping				
Taking Medication				
Routine Communications				

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week)**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Month)**
Banking				
Managing bills				
Miscellaneous finance				
Working with Vendors/Employees				
Scheduling Appointments				
Managing other benefits				
Exterior Supports(gardening, yard maintenance)				
Total Hours per Week/Month				

Based on your physical or cognitive needs and qualifying condition, please identify the services needed to address your Living Supports.

Available Living Support Services

(Totals should be from Mi Via column ONLY from above)

Living Support Service	Hours/Days per Month
Homemaker/Direct Support	**Hours per Month:**
Home Health Aide	**Hours per Month:**
In-Home Living Supports	**Days per Month:**
Total Hours per Month	
Total Days per Month	

Details of Living Supports:

Living Support	Projected Amount, Frequency and Duration	Expected Outcome	What is the DD or MF Qualifying Condition that results in the need for this service?	How does this support meet your clinical, medical, functional or habilitative needs related to your qualifying condition?

Q5. Do any of your Mi Via paid Living Support providers live in the same home with you?

❑ Yes ❑ No

Q6 . Are any of your paid Mi Via Living Support providers your spouse (a Legally Responsible Individual (LRI)?

❑ Yes ❑ No

Q7 . Has your LRI been approved by DOH to be a paid Mi Via Living Support provider for you?

❑ Yes ❑ No ❑ Currently Requesting ❑ N/A

If yes, or currently requesting please provide the LRI's planned work schedule (*mandatory)*:

Work Schedule for (name of LRI):						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Q8. How will I measure if my Living Support services are working well for me and meet my identified needs?

Mandatory

2. Community Membership Supports

Community Membership Supports Definition: These supports help you participate in community life in order to enhance relationships with others, work or participate in activities that are meaningful to you. These supports include:

- Community Direct Support
- Employment Supports
- Customized Community Group Supports

The Mi Via Program supports participants to become involved in the community.

Q9. How do you want to be involved in your community?

Mandatory

Q10. Are you interested in exploring what your interests or opportunities might be in the community?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q11. Are you currently involved in any community activities such as, clubs, bowling league, scouting or other?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q12. Do you have any interest in volunteering in areas such as, community projects, charitable organizations or other special events in the community?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q13. Do you know how or where to access community activities or volunteer opportunities you are interested in?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q14. Do you need transportation to participate in community or volunteer activities?
❑ Yes ❑ No

If yes, please explain.

Mandatory

Q15. Are you currently employed?
❑ Yes ❑ No

If yes, please explain.

Mandatory

If you are currently employed, please answer the following questions:

Where do you work?

How many hours do you work?

How long have you been employed?

Do you enjoy your employment?

What would make your employment better?

Do you feel included in your work environment?

❑ Yes ❑ No

If no, please explain.

Mandatory

Are there other employment opportunities (ie. another job or career) you would like to pursue?

❑ Yes ❑ No

If yes, please explain.

Based on your answers above, please list the areas where you need support to participate in activities in the community or build skills related to community membership.

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week)**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Month)**
Employment				
Volunteering				
Educational				
Leisure/Recreational *Does not include Related Goods				
Building Relationships				
Interpreter				
Translator/Interpreter				
Total Hours per Week/Month				

Based on your physical or cognitive needs and qualifying condition, please identify the services needed to address your Community Membership Supports.

Available Community Membership Services
(Totals should be from Mi Via column ONLY from above)

Community Membership Service	Hours per Month
Community Direct Support	
Employment Supports	
Customized Community Group Supports	
Total Hours per Month	

Details of Community Membership Supports:

Community Membership Support	Projected Amount, Frequency and Duration	Expected Outcome	What is the DD or MF Qualifying Condition that results in the need for this service?	How does this support meet your clinical, medical, functional or habilitative needs related to your qualifying condition?

Community Membership Support	Projected Amount, Frequency and Duration	Expected Outcome	What is the DD or MF Qualifying Condition that results in the need for this service?	How does this support meet your clinical, medical, functional or habilitative needs related to your qualifying condition?

Q16. Do any of your paid Mi Via Community Membership Support providers live in the same home with you?

❑ Yes ❑ No

Q17. Are any of your paid Mi Via Community Membership Support providers a Legally Responsible Individual (LRI) for you such as your parent or guardian (for minors) or spouse?

❑ Yes ❑ No

Q18. Has your LRI been approved by DOH to be a paid Mi Via Community Membership Support provider for you?

❑ Yes ❑ No ❑ Currently Requesting ❑ N/A

If yes, or currently requesting please provide the LRI's planned work schedule (*mandatory)*:

Work Schedule for (name of LRI):						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Q19. How will I measure if my Community Membership Support services are working well for me and meet my identified needs?

Mandatory

3. Health and Wellness Supports

Health and Wellness Supports Definition: These supports are made available in Mi Via to assist you with medically related or behavioral health needs that are not covered by your health plan and will enhance your ability to remain in your home and community. These supports are generally provided by a licensed professional and include:

- Skilled Therapy for Adults - Occupational, Physical and Speech Therapy
- Behavior Support Consultation
- Nutritional Counseling

- Private Duty Nursing for Adults
- Specialized Therapies

Use the answers to these questions to think about how Mi Via can support you to be healthy and well.

Q20. What do I want to have happen as a result of my participation in the Mi Via Program related to my health and wellness needs?

Mandatory

Q21. What will I need to address any health or safety concerns?

Mandatory

Q22. Do you have any health concerns that have not been addressed? (Be sure to consider medical/health issues, eating and nutrition concerns, and behaviors that might not be safe or helpful in your life.)

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q23. Has a health professional recommended a special nutritional plan or special diet for you?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q24. Has a health professional recommended that you take nutritional supplements?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q25. Do you need reminders to eat?
❑ Yes ❑ No

If yes, please explain.

Mandatory

Q26. Do you have health and wellness needs in addition to the services provided through your regular Medicaid coverage?
❑ Yes ❑ No

If yes, please explain.

Mandatory

Q27. Do you need additional health and safety supports from Mi Via, which are not covered by Medicaid insurance to be independent?
❑ Yes ❑ No

If yes, please explain.

Mandatory

Q28. Do you need support from Mi Via to be physically active?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Skilled Services

Q29. Do you need the services of a licensed nurse, therapist, and/or nutritional counselor?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q30. Do you have a need for any other specialized service(s) to address your health and wellness needs?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Available Health and Wellness Supports

Based on your physical or cognitive needs and qualifying condition, please identify the services needed to address your Health and Wellness Supports.

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week)**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Month)**
OT for Adults				
PT for Adults				
SLP for Adults				
Behavior Support Consultation				
Nutritional Counseling				
Private Duty Nursing for Adults				
Acupuncture				
Biofeedback				
Chiropractic				
Hippotherapy				

Activity/Services	Non-Mi Via Paid Supports (Hours per Week)	Unpaid Supports (Hours per Week)	Mi Via Supports (Hours per Week)	Total Hours (Hours per Month)
Massage Therapy				
Naprapathy				
Native American Healers				
Play Therapy				
Cognitive Rehabilitation Therapy				
Total Hours per Week/Month				

Details of Health and Wellness Supports

Health and Wellness Support	Projected Amount, Frequency and Duration	Expected Outcome	What is the DD or MF Qualifying Condition that results in the need for this service?	How does this support meet your clinical, medical, functional or habilitative needs related to your qualifying condition?

Health and Wellness Support	Projected Amount, Frequency and Duration	Expected Outcome	What is the DD or MF Qualifying Condition that results in the need for this service?	How does this support meet your clinical, medical, functional or habilitative needs related to your qualifying condition?

Q31. Are any of your paid Mi Via Health and Wellness Support providers a Legally Responsible Individual (LRI) for you such as your parent or guardian (for minors) or spouse?

❑ Yes ❑ No

Q32. Has your LRI been approved by DOH to be a paid Mi Via Health and Wellness Support provider for you?

❑ Yes ❑ No ❑ Currently Requesting ❑ N/A

If yes, or currently requesting please provide the LRI's planned work schedule (*mandatory)*:

Work Schedule for (name of LRI):						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Q33. How will I measure if my Health and Wellness Support services are working well for me and meet my identified needs?

Mandatory

4. Other Supports

Other Supports Definition: These supports are available to enhance or enable you to receive other services on your plan, or to decrease the need for more direct services, thereby increasing your independence. In Mi Via these supports include:

- Transportation
- Emergency Response Services
- Related Goods
- Respite (To give the unpaid, primary care giver time away from his/her duties)
  - If requesting Respite, please provide the name of the unpaid primary caregiver utilizing the Respite and their relationship to you: ____

a. **Based on your physical or cognitive needs and qualifying condition, please identify the transportation, emergency response and respite needed to address your Other Supports.**

Activity/Services	**Non-Mi Via Paid Supports**	**Unpaid Supports**	**Mi Via Supports**	**Total Hours/ Miles/Trips**
Transportation by MILE	Miles per Month:	Miles per Month:	Miles per Month:	Miles per Month:
Transportation by TRIP	Trips per Month:	Trips per Month:	Trips per Month:	Trips per Month:
Transportation by HOUR	Hours per Month:	Hours per Month:	Hours per Month:	Hours per Month:
Emergency Response Services	Hours (“ONE” in FOCoS) per Month:	Hours (“ONE” in FOCoS) per Month:	Hours (“ONE” in FOCoS) per Month:	Hours (“ONE” in FOCoS) per Month:
Respite Care	Hours per Month:	Hours per Month:	Hours per Month:	Hours per Month:

Detail of Other Supports

Other Support	**Projected Amount, Frequency and Duration**	**Expected Outcome**	**What is the DD or MF Qualifying Condition that results in the need for this support**	**How does this support meet your clinical, medical, functional or habilitative needs related to your qualifying condition?**
Transportation				
Emergency Response				
Respite				

Q34 . Are any of your paid Mi Via Transportation providers your spouse (a Legally Responsible Individual (LRI)?

❑ Yes ❑ No

Q35. Has your LRI been approved by DOH to be a paid Mi Via Transportation provider for you?

❑ Yes ❑ No ❑ Currently Requesting ❑ N/A

If yes, or currently requesting please provide the LRI's planned work schedule (*mandatory)*:

Work Schedule for (name of LRI):						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Q36. Are any of your paid Mi Via Respite providers a Legally Responsible Individual (LRI) for you such as your parent or guardian (for minors) or your spouse?

❑ Yes ❑ No

Q37. Has your LRI been approved by DOH to be a paid Mi Via Respite provider for you?

❑ Yes ❑ No ❑ Currently Requesting ❑ N/A

If yes, or currently requesting please provide the LRI's planned work schedule (*mandatory)*:

Work Schedule for (name of LRI):						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

b. **Based on your physical or cognitive needs and qualifying condition, please identify the Related Goods needed to address your Other Supports.**

Related goods must the following requirements:

- Must be responsive to your qualifying condition; and
- Meet your clinical, functional, medical, or habilitative needs; and
- Supports you to remain in the community and reduce the risk for institutionalization; and
- Promote your personal safety and health; and
- Afford you greater independence; and
- Decrease your need for other Medicaid services; and
- Accommodate you to manage your household; or
- Facilitate your activities of daily living.

Related Goods	**Projected Amount, Frequency & Duration**	**Expected Outcome**	**What is the DD or MF Qualifying Condition that results in the need for this support.**	**Describe how this good meets the above listed requirements?**

Related Goods	Projected Amount, Frequency & Duration	Expected Outcome	What is the DD or MF Qualifying Condition that results in the need for this support.	Describe how this good meets the above listed requirements?

Q38. How will I measure if each of the Other Support services identified above are working well for me and meet my identified needs?

Mandatory

5. Environmental Modifications

Q39. Have you had any ‘home modifications’ for accessibility or safety purposes funded by a New Mexico Medicaid Waiver Program in the past five (5) years?

Examples: Ramps, Grab Bars, Doorway / Hallway Modifications, Bathroom Modification

❑ Yes ❑ No

If yes, please explain.

Mandatory

If yes, please provide the following information.

Item/Modification	Date Completed	Cost	Paid By	Contractor
Total Cost of all Environmental Modifications to Date:				

Q40. Are there any environmental modifications covered under Mi Via that you need? (Please refer to Mi Via regulations)

Indicated items will be subject to review / approval

❑ Yes ❑ No

If yes, please explain.

Mandatory

If you have had environmental modifications in the last five (5) years but need additional environmental modifications done, please contact your consultant to see if funds are still available. Each participant may be eligible to receive up to $5,000 every five (5) years for environmental modifications.

6. Emergency/Backup Plan

Please print this section so that you can keep it easily available for your employees and other people who help you.

IF THERE IS AN EMERGENCY PLEASE CALL 911

Q41. If regularly scheduled employees or service providers are unable to report to work I will contact the following:

(Mandatory: You must list at least one alternate provider.)

Service	Name (First Last)	Address, City, State, Zip	Times Available	Phone

Relative(s) *(Mandatory: You must list parent(s) (required for minors), spouse (required if applicable) or at least one relative, or mark "n/a".)*

Name	Relationship to Participant	Address, City, State, Zip	Phone	Email

Participant Name: ____

Consultant/Support Guide *(Mandatory: You must list at least one consultant.)*

Name	Address, City, State, Zip	Phone	Email

Physician or Primary Care Provider *(Mandatory: You must list at least one health care provider.)*

Name	Type of service provided	Address, City, State, Zip	Phone	Email

Other people you rely on *(Mandatory: You must list legal guardian or Power of Attorney (if applicable)*

Name	**Relationship to Participant**	**Address, City, State, Zip**	**Phone**	**Email**

Consultant Acknowledgement

Mandatory

CONSULTANT MUST ACKNOWLEDGE:
I have provided the participant with a copy of the SSP Emergency Back-Up Plan Acknowledgement Form, and I have reviewed the form with him/her. I confirm that the participant has completed the form in its entirety. A copy of the completed form will be kept by the participant and in the consultant's file.

7. Consultant/Support Guide Services

Please answer the following questions. The answers may help you understand how much assistance you may need from your Consultant/Support Guide or others to participate in the Mi Via Program. The answers will also help you understand how much help you or your Employer of Record may need from your Consultant/Support Guide or others to be a successful employer.

Q42. Do you need assistance putting your Mi Via plan into action?
❑ Yes ❑ No

If yes, please explain.

Mandatory

Q43. Do you have access to a fax?
❑ Yes ❑ No

If no, please explain.

Mandatory

Q44. Do you know how to use a fax?
❑ Yes ❑ No

If no, please explain.

Mandatory

Q45. Do you have access to the Internet?

☐ Yes ☐ No

If no, please explain.

Mandatory

Q46. Do you need support using the Internet?

☐ Yes ☐ No

If yes, please select all that apply:

☐ Screen Reader ☐ Computer Adaptations

☐ Computer Instruction ☐ Other *(Please explain)*

If you checked any of the boxes above please provide additional information.

Mandatory

Q47. Do you need assistance with any of the following program administration activities?

☐ Processing timesheets ☐ Processing invoices

☐ Identifying other resources ☐ Managing program budget

☐ Operating a fax machine ☐ Operating a computer

☐ Finding related goods

If you checked any of the boxes above please provide additional information.

Mandatory

Q48. Do you need help with any of your employer responsibilities and/or the management of your Mi Via program and budget?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q49. Do you need assistance with any of the following employer responsibilities?

- ☐ Scheduling employees
- ☐ Resolving employee conflicts
- ☐ Encouraging good performance
- ☐ Disciplinary actions
- ☐ Interviewing/Hiring employees
- ☐ Supervising employees
- ☐ Developing Interview Questions
- ☐ Checking reference

Participant Name: ____

If you checked any of the above boxes please provide additional information.

Mandatory

Q50. Your consultant will be contacting you by phone monthly and will conduct four (4) in-person visits with you per year. Do you want more contact?

❑ Yes ❑ No

If yes, please explain.

Mandatory

Q51. Based on your physical or cognitive needs and qualifying condition, what type and level of support will you need from your Consultant/Support Guide?

Mandatory: If using Support Guide services, please indicate your expectation of the service

Q52. How will I measure if my Consultant/Support Guide services are working well for me and meet my identified needs?

Mandatory: If using Support Guide services, please indicate your expectation of the service

Q53. Please describe the plan/agreement you have for Consultant/Support Guide service.

Mandatory

<u>8. Person’s participating in the development of the SSP</u>

(Mandatory – you must list at least one consultant)

Developed By:	**Title/Relationship to Participant** ***(required)*****/Participant (*****required*****)**	**Date(s) of Entry**

Mi Via Service and Support Plan Emergency Back-Up Plan Acknowledgement Form

Participant's Name:__________________
Print Name Of Person Completing Form:_______________________________
Instructions for Consultants: Please review these questions carefully with the participant as part of the process of developing the SSP. Please ensure that the participant initials each box. Provide a copy of the completed form to the participant and keep a copy for your records.

IMPORTANT: The SSP cannot be submitted through FOCoS*online* until you have checked the on-line acknowledgement box that confirms that you have completed this form with the participant.

Participant Initials	Acknowledgements
	I will talk with backup service providers about employment, pay, availability and my personal care needs before an emergency comes up.
	I understand I may only get my essential needs met in an emergency. I will keep a current list of my needs and tasks that must be performed in a given day because they are essential to my health and safety on the back of this page.
	EMERGENCY CONTACTS: If I feel my health and safety is at risk or in harm's way, I will contact all of the people who are listed on my emergency back-up plan to see if they can provide assistance. I will also contact emergency personnel, if appropriate.
	I have developed and posted a list of emergency contacts (an emergency call list) that my service providers can easily refer to if necessary.
	If I am a child (under age 18) and I or my parent, caregiver or other support person believes that I am at risk of harm for abuse, neglect or exploitation, I know that I or my support person should contact **Child Protective Services at 1-800-797-3260 and/or the Department of Health/Division of Health Improvement at 1-800-445-6242** and report to my Consultant Agency within 24 hours.
	If I am an adult (age 18 or older) and I or my guardian, caregiver, employee or anyone else believes that I am at risk of harm for abuse, neglect, or exploitation they should contact the **Department of Health/Division of Health Improvement (DHI) at 1-800-445-6242** and report to my Consultant Agency within 24 hours.

Person Completing Form Signature:____________________________
Date:________________