

GUIDE TO COMPLETING THE COMMUNITY SUPPORT PLAN (CSP)

The following information will help you complete your CDCS *Person Centered* Community Support Plan.

GETTING STARTED...

To get started with writing this plan **THINK ABOUT** the following:

WHAT WOULD I LIKE TO SEE...

- ...IMPROVED
- ...MAINTAINED
- ...CHANGED



LONG TERM

**Goals/
Outcomes** E.g. area of interest, communication, behaviors, self-care, self-sufficiency.

AND...

SHORT TERM

- WHO
- WHAT
- HOW



Objectives – staff, therapy, goods, modifications, etc.

WILL I MAKE PROGRESS TOWARDS

THESE GOALS/OUTCOMES???

AND...

HOW WILL I KNOW I AM PROGRESSING?



Measure/
Observe

GOALS = DESIRED OUTCOMES

When you get to the Goals sections of the CSP, please read the NEXT section.

All staff (paid and unpaid), services, and goods MUST be tied to a measureable GOAL AND be directly related to the consumer's disability and/or condition. You will be asked to write long term goals and short term objectives that will move you closer to your desired outcomes. For each goal, you will write specific objectives outlining what and who you will need, how you will use the service/good, and finally how you will measure/observe progress.

USE REGULAR LANGUAGE.

Following are examples of how to write clear, concise, and measurable goals and objectives:

GOAL 1:

Goal: I want a job in the community. (Long-Term Goal)

Objective: I will identify 5 places I want to explore employment with & talk to the manager. (Short-Term Goal)

Action Plan: Staff will look with me through the want ads in for jobs of interest to me. Staff will assist me in setting up, transporting, and interview these managers.

Measure/Observe: Staff will document how many jobs and exploration visits were conducted.

I need these services because: (list all services separately)

Staff: I am not able to drive myself or comprehend want ads. I need practice talking with employers about what their organization expects from an employee.

GOAL 2:

Goal: John will learn to walk.(Long-Term Goal)

Objective: John will participate in hippotherapy to strengthen his gait control & balance. (Short-Term Goal)

Action Plan: Staff will take John to hippotherapy once a week. On each shift staff will have John practice walking with the gait trainer for 15 minutes.

Measure/Observe: John will walk using a gait trainer from 25 feet (currently) to 50 feet independently.

I need these services because: (List all services in this section separately)

Hippotherapy - Currently, John is able to walk about 25 feet using a gait trainer. His doctor feels if he can gain strength in balance, gait, and core strength he could start to walk further. Hippotherapy is proven to improve strength in these areas.

GOAL 3

Goal: Joy will have appropriate social skills. (Long Term Goal)

Objective: Joy will increase social skills by engaging in weekly play activity with a peer. (Short Term Goal)

Action Plan: Staff will take Joy to the community center once a week to play with peers. Staff will model and teach turn taking with Joy prior to the community outing. Staff will model necessary steps to the activity and encourage her to try. Staff will praise Joy for each attempt at trying to interact with her peer and displaying appropriate behavior.

Measure/Observe: Joy will interact with a peer for at least 5 minutes when playing. Staff will document the length of time she interacted appropriately with her peer.

I need these services because: (List all services in this section separately)

Staff: Joy is able to play next to a peer but not interact. Staff is needed to help model appropriate social cues.

GOAL 4:

Goal: Diana will be independent with self cares. (Long Term Goal)

Objective: Diana will increase her ability to perform her daily personal cares such as toileting, bathing, and dressing. (Short Term Goal)

Action Plan: Staff will provide assistance to Diana in personal cares. They will provide verbal cues and physical assistance and ask her to help as she is able. Staff will break down tasks so she may better understand what needs to be done. Staff will praise her for each attempt. She will use specific items to help in this area: wipes.

Measure/Observe: Progress will be tracked by parents by interviewing staff.

I need these services because: (List all services in this section separately)

Staff – Diana is currently unable to safely perform her activities of daily living without staff assistance.

Wipes – Diana is still diapered and needs wipes to help clean herself if she has had an accident.

COMPLETING HEALTH & SAFETY

Attach a copy of a current Health & Safety Plan to the CSP OR if you DO NOT have a current plan and are creating a Health and Safety plan from scratch, these are some of the issues that should be addressed:

Are there concerns about?

- Food, such as food allergies, choking, eating non-edible food, following special diets?
- Dressing for weather, being in public
- Street safety, riding safely in vehicles, vulnerability around water, stairs, etc.?
- Mobility, balance issues, difficulty standing for a period of time, using a walker or cane?
- Vulnerability to strangers or being vulnerable to sexual abuse?
- Knowing whom to seek out if lost, being able to provide name, address, and phone number to the appropriate people if lost?
- Medical treatments, taking medication as prescribed, seeking out medical attention for emergency situations? Medical condition that staffs need to be trained in, such as seizures, diabetes, taking medications with harmful side effects?
- Using money and money management.
- Vulnerability to physical, verbal or self-abuse?

In the CSP, describe your concern and how that concern will be addressed to decrease or eliminate your vulnerability. Make sure you write your plan to address the concerns in clear, concise directions for your staff to follow. Health & Safety Plans are great tools to use for staff training.

Example: Tom eats fast and will choke on food if not watched. To avoid choking, only a small portion of food should be on Tom's plate and the food needs to be cut in very small pieces. Tom needs someone to sit close to him throughout the meal to monitor. People who work with Tom need to know the Heimlich maneuver.

Example: Tom will give money to people he doesn't know or will try to buy things he doesn't have enough money for. Before going out, discuss with Tom what he is going to buy and make sure he has enough money with him. Tom needs to be supervised when he has money so we won't give it away.

OTHER HELPFUL TIPS & REMINDERS

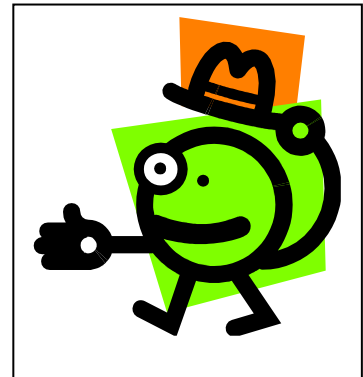
Criteria for Purchased goods/services is as follows and should be for the sole benefit of the participant. Recreational and diversional items are not allowed:

- Used to **maintain** community integration
- **Develop** and **maintain** skills
- **Promote** health and safety
- **Build** community inclusion
- **Assist** personal, social, physical or economic development
- **Increase** independence

Staff must be paid at least minimum wage. There may be a maximum wage that staff can be paid and/or a customary range of pay. Check your county guidelines and provide justification for paying staff more than what may be considered customary.

All items in the plan must be in a cost range that is reasonable, customary, and not covered by any other funding source (e.g. mileage for medical appointments can be covered by medical assistance).

The waiver does NOT cover services during hospital, nursing facility, or ICF stay.



REVIEWING CSP DIRECTIONS:

When reviewing directions electronically, make sure you click on the Review Tab and then Final: Show Markup. This will show comments on the right side panel. You may also hover over highlighted areas and comments will just “popup”. Another way to view the document is to do Review Pane. This will open comments on the left hand side in a larger font.

DIRECTIONS FOR COMPLETING CSP

DHS-6532: This is the e-doc number of this form from DHS. 3-13 is last date updated. You will want to save this to your own computer. Some browsers may not open this document. **Try Internet Explorer.** Search DHS edocs and type in 6532 or go to the following link: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6532-ENG> **You may also obtain a copy of this plan from your case manager.**

Prior to writing the CSP, please read the *Getting Started* part of the instructions. You also may want to SAVE this form to your computer for future use. After you save this document to your computer, you will need to open it again in Adobe Reader. You can download Adobe Reader for FREE at www.adobe.com

Time Period: The plan year usually covers a 12 month span EXCEPT the first year can be less if you are switching to CDCS from a licensed waiver plan. CDCS usually starts on the first of a month.

Name of Person Receiving Services: Include FULL name of consumer.

Date of birth: Include as month/day/year.

PMI #: This is the consumer’s Medical Assistance (MA) number.

Email Address: If applies.

Preferred phone number: Phone number consumer can be reached at.

County of Residence: The county the consumer is currently living in.

County of Financial Responsibility: The county responsible for paying for your services.

Waiver Type: Indicate which waiver/program receiving.

Parent/Legal Representative/Address/Phone/Email: List the person that has the legal power to make decisions regarding consumer. Following, include legal representative's address, city, state, zip code, and phone number and email.

Lead Agency/County Representative: This is typically the county that is in charge of administering/approving the plan.

Contact Name: List the name of the lead agency’s contact (e.g. county case manager) that you will be working with and their contact information.

Fiscal Support Entity(FSE): This is the agency that pays your bills for all your services, goods, and usually payroll (except licensed homecare services)

Contact Name: List the name of the FSE contact person you will be working with and all their contact information.

Support Planner Agency (SP): Provide Agency Name (if applies). You may choose to hire a SP to assist in writing the plan, interviewing/hire staff, find resources, etc. SP’s are OPTIONAL, but available if you would like more assistance to write or manage the plan. It is highly recommended you use a SP the at least the first year of writing the plan.

Contact Name: Individual Support Planner’s name. and contact information.

Employment Model: Indicate which model you are using:

*Agency with Choice – FSE is the employer and processes payroll and purchase of goods. (Most use this model)

*Payroll Model – Consumer is employer but FSE processes payroll and purchase of goods.

*Fiscal Conduit – Consumer is employer AND processes own payroll. FSE processes bills submitted for purchase of goods.

DIRECTIONS CONTINUED...

Additional Contacts: List all “team members” including paid and **unpaid** persons that help to plan for needed services. These include primary doctor, specialists, school AND IEP manager. **Informal or unpaid staff is also important team members to list in this section (e.g. boyfriend, neighbor, relative, etc).** If handwriting plan, you may attach additional pages.

Doctor Name AND Phone Number: **REQUIRED ON ALL PLANS!**

Click **ADD CONTACT** button to add more contacts.

What did you do AND How Did it go?:

For **NEW/FIRST year plan:** Write NA (not applicable)

For **Renewals:** List each goal AND objective individually. Describe what services you used to improve/change this goal. What worked well or didn't? What changes do you need to make? Why will you discontinue this goal? There must be at least ONE goal and there is no maximum number of goals. Most plans have 1-4 primary goal areas (Long Term) that the plan focuses on with multiple measurable objectives (Short Term)/ strategies in each Expenditure Category (Personal Assistance, Treatment & Training, Environmental Modifications and Provisions, Self Direction Support Activities).

What was changed or improved? Indicate what was changed or improved in working towards each goal/objective.

Do you plan to work on this goal in next year's plan? Answer which statement applies most.

Click **ADD GOAL** (e.g. Goal 2, Goal 3, etc.) button to add the remaining goals/objectives.

Are there any support/services you needed that were not available? Please list any services that would have helped to meet goals/objectives but were not available or an option. E.g. Items on the "unallowed" list.

Strengths: List skills or qualities consumer is good at. **Other examples:** Participant can push his/her own wheelchair; running/climbing; good sense of humor; very good with technology.

Needs: Tasks/skills the consumer needs help with. **Other examples:** brushing teeth; social skills, medical needs, etc.

Likes: Items/activities/etc. that consumer enjoys. **Other examples:** cherry pie, county western music, horses, car rides, going to the mall, etc.

Dislikes: Things participant does not like. **Other examples:** Loud noises, crowds, change in routine, food that is crunchy, getting haircuts, going to the dentist, etc.

Describe disability/health condition and how impacts life. Describe SPECIFICALLY how consumer's daily life is impacted because of their disability/condition. The more detail the better here. **Examples:** Because of my cerebral palsy, I am unable to dress myself independently or go for long walks. OR Because of my autism I am unable to transition from one activity to another very quickly so I need visuals to help direct me to the next task at hand.

Why did you choose the CDCS option? Identify the consumer's preferences for services and why a self-directed option was chosen, including services and supports needed to achieve employment goals (if applicable).

List your diagnosis/ conditions: List any diagnosis/conditions diagnosed by a professional.

Personal assistance: This category is about helping the participant with daily care for themselves (e.g. bathing, grooming, toileting, transfers, etc.). It may also include respite opportunities for primary care givers to take a break. The supports in this area typically do not require a professional license, certification or other professional credentialing and are “hands on.” **Paid Parent of Minor/Spouse MUST go in this category.**

DIRECTIONS CONTINUED...

Additional examples: Hire a friend to clean the bathroom and kitchen, hire someone to assist the consumer to get ready for work or school, hire someone to provide redirection to prevent certain behaviors.

Type of Service: List the type of service needed. **Examples:** Paid Parent of a Minor, staff, caregiver relief, house cleaning, camp as respite.

Rate of Pay or Cost: List the rate/cost of the service for the basic unit. **Examples:** dollars/hour, dollars per day, or one time cost.

Total # of Hours/Units per week: List the number of hours per week. **Note:** Paid Parent of Minors/Spouses may not EXCEED 40 hours/week.

Number of weeks: 52 weeks for full year. Shortened plan year or seasonal changes will affect number of weeks.

Do payroll taxes apply? Indicate whether payroll taxes need to be taken out. If you are listing hourly staff, then payroll taxes probably apply (EXCEPTION: Payroll Model or Fiscal Conduit Model). Ask your FSE if you are not sure.

Grand Total: The form is programmed to do the math for you. It will multiply the "Rate of Pay or Cost" by Total number of hours and weeks. Example: \$13.93 X 20hrs/week X 30 weeks = \$8,358.00. The TOTAL for this category will be automatically copied to the total budget amount towards the end of the plan.

Add Service: Click the button to ADD more services in this area.

What are the goals and outcomes: List each of the Goals that apply to the Personal Assistance Category. Be sure to include SPECIFIC short term objectives including how they will be implemented and measured within this plan year. **SEE GOAL & OBJECTIVE WRITING (incl. examples on Pg. 2-3).**

Also identify any unpaid staff that are assisting consumer. E.g. Friend, relative, neighbor. There should be *paid and unpaid* supports in plan.

I would like the agency/person responsible for providing this service to have the following qualities, skills, training: Include such things as age (e.g. over 18), personal qualities (e.g. reliable), skills, specialized training (e.g. CPR), licenses (e.g. driver's license), certifications, or physical requirements (e.g. can lift 50 lbs.) **AND who** will provide this training (e.g. Parents will train staff on Child's Community Support Plan, Health & Safety Plan, etc.

I need these services because: Give rationale about why he needs these particular services/goods that are beyond what a typical child or adult responsibility.

Do you plan to use a paid parent of minor/spouse as staff: Indicate whether parent(s) or spouse will be paid.

Paid Parent or Spouse Schedule: Include the typical staffing schedule here. Hours **must not** exceed 40 hours per week. For recipients who are students, school year and summer schedules may vary. **Two** lines are provided to indicate variable schedule.) Based on your typical day, either use specific hours 7 a.m. – 9 a.m. or 2 hours in the a.m.

Job Duties for Paid Parent of Minor or Spouse: List job duties that are specifically related to disability/condition **AND** are **BEYOND** typical age appropriate parenting or care. You may either list job duties in plan or attach a job description. Job descriptions for other staff **MUST** be on file with FSE, but it is not necessary to include them in this plan.

DIRECTIONS CONTINUED...

Treatment And Treatment: Treatment And Treatment: THIS THE SECTION WHERE YOU LIST STAFF THAT ARE EITHER PAID OR UNPAID TO WORK ON GOALS WITH THE PARTICIPANT. For services that require an Alternative Treatment Form, be sure to list the agency and /or professional along with information about their licensure and/or credentials.

Habilitation refers to therapeutic activities, monitoring, supervision, training, or guided assistance to a person.

If using any licensed services (e.g. in home family support, licensed respite, vocational/work services, they must go in this section. Be sure to include the correct licensed rate. For qualification state they are following all requirements for 245d providers

Additional examples: Counseling services, behavioral services, and cognitive or other therapy

Type of Service: List the name of the service needed. Examples: support staff, alternative therapy, adapted sports, habilitation activities/materials, training for staff or consumer; day programs. Indicate whether payroll taxes need to be taken out. If you are listing hourly staff, then payroll taxes probably apply. Ask your FSE if you are not sure.

Rate of Pay: List the cost of the service for the basic unit. Examples: dollars/hour, dollars per day, or one time cost.

Total # of Hours/Units per week: List the number of hours per week AND the number of weeks per year.

Number of weeks: 52 weeks for full year. Shortened plan year or seasonal changes will affect number of weeks.

Do payroll taxes apply? Indicate whether payroll taxes need to be taken out. If you are listing hourly staff, then payroll taxes probably apply. If you are paying for an item, program, or therapy, payroll taxes would not apply. Ask your FSE if you are not sure.

Total: Form is programmed to do the math for you. It will multiply the “Rate of Pay or Cost” by Total number of hours. Example: \$60 X 1hrs/week X 42 weeks = \$2,520.00. The TOTAL for this category will be automatically copied to the total budget amount towards the end of the plan.

Add Service: Click the button to ADD more services.

List each of the Goals that apply to the Treatment & Training Category. Be sure to include SPECIFIC short term objectives including how they will be implemented and measured within this plan year. **SEE GOAL & OBJECTIVE WRITING (incl. examples on Pg. 2-3).**

What are the goals and outcomes: List each of the Goals that apply to the Treatment & Training Category. Be sure to include SPECIFIC outcomes including how they will be implemented and measured.

For licensed services ONLY state: An Individual Program Plan will be developed and followed according to respective state and federal licensing and certification standards. Further assessments will be conducted as needed. Providers will implement and make recommendations for any modification to CSP.

I would like the agency/person responsible for providing this service to have the following qualities, skills, training: The supports in this area **usually** require the person or entity performing the service to be professionally licensed, credentialed or otherwise certified. Please include this information in this section. For support staff you may also include such things as age, personal qualities (e.g. reliable), skills, specialized training (e.g. CPR), licenses (e.g. driver’s license) AND **who** will provide this training (e.g. Parents will train staff on Childs Community Support Plan, Health & Safety Plan, etc.

DIRECTIONS CONTINUED...

All alternative therapy requests such as music, hippo, art therapy, etc. will only be approved with an **Alternative Therapy Form** (DHS #5788) completed by a Minnesota MA enrolled physician (MHCP). You may get a copy on DHS website in edocs section or ask your case manager for a copy of the form.

I need these services because: Give rationale about why he needs these particular services/goods that are beyond what a typical child at this age or adult would be responsible for. **TIP:** It is helpful to list each item and service separately and how this relates to the child's needs because of his disability/condition.

Environmental modifications and provisions: This category includes supports, services and goods provided to the consumer to maintain a physical environment that assists the consumer to live and participate in the community, or that are required to maintain health and well-being.

Additional examples: Adaptive clothing, home delivered meals (if unable to prepare food)

Type of Service: List the name of the service needed. **BE SPECIFIC** and **ITEMIZE** individually! Examples: Weighted blankets, wipes/diapers, replacement bedding.

Cost: List the individual price of each item.

Quantity: Number of each particular item.

Number of weeks/month: 52 weeks for full year. Shortened plan year or seasonal changes will affect number of weeks.

Grand Total: Form is programmed to do the math for you. It will multiply the "Cost" by quantity and number of weeks. Example: Wipes = \$56.25 X 1 box X 4 months = \$225.00. The TOTAL for this category will be automatically copied to the total budget amount towards the end of the plan.

Add Service: Click the button to ADD more services.

What are the goals and outcomes: List each of the Goals that apply to the Environmental Modifications & Provisions Category. Be sure to include SPECIFIC short term objectives including how they will be implemented and measured within this plan year. **SEE GOAL & OBJECTIVE WRITING (incl. examples on Pg. 2-3).**

I would like the agency/person responsible for providing this service to have the following qualities, skills, training: If staffing such as house cleaning, consider experience, licensure. For items you may state: *Vendor of choice but follow safety standards in their industry.* For environmental modifications: *Contractor must be licensed and enrolled with DHS.*

I need these services because: **I need these services because:** Give rationale about why he needs these particular services/goods as it relates to the disability/condition and how it will support his needs. All goods and service items should be items needed beyond what would be considered a typical child or adult responsibility/need/want. For example, every child needs a toothbrush so this would NOT be an allowed item. However, an electronic tooth brush would be allowed if an occupational therapist recommended it because he has sensory issues and this will help him get the input he needs to get his teeth brushed. It is helpful to list each item, service individually and describe how this item relates to the child's needs because of his disability/condition.

Note: List all sensory items separately and their cost either in budget section or in body of the plan. This way FSE knows which items in particular have been approved when receipts come in for payment.

Paid Parent of Minors and spouses are not eligible to receive mileage reimbursement.

Self-Direction Support Activities: This category includes services, supports, and expenses incurred for administering or assisting the consumer or their representative in administering CDCS. For example: Fiscal Support Entity and Support Planner services. Some employer-related expenses such as health benefits, if offered by the consumer to support staff. Also included are record keeping costs such as printer cartridges, fax machine, etc.

DIRECTIONS CONTINUED...

FSE Fee: All FSE's require a monthly fee for their administrative expenses. The cost will differ depending on the employment model you are using. Some FSE's also charge a transaction based fee for processing payroll. You can find out their fees by going to the DHS website at: <http://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fiscal-support-entities.jsp>

Support Planner Fee: Hiring a Support Planner is optional. Support Planners charge varying fees. You can find out their fees by visiting MNHelp.net: https://www.minnesotahelp.net/Public/pui_results.aspx?SearchID=6E5C957E-7F15-4835-A278-7EF89E37AF63 A Support Planner is recommended for the first year of writing a plan.

Ads for hiring staffing and costs for keeping records for the CDCS waiver are allowable expenses in this area.

Payroll Taxes: You will need to ask the FSE what their percentage of payroll taxes are based on which model they are using and put that number in. Payroll wages will already have been carried over from the 4 expenditure budgets completed earlier. The taxes X total wages will automatically be calculated and added to the Grand Total.

Grand Total: Form is programmed to do the math for you. The TOTAL for this category will be automatically copied to the total budget amount towards the end of the plan.

Add Service: Click the button to ADD more services

Qualifications: See sample. Good description of qualifications. Minimally, SP must be certified with MN DHS AND FSEs must be enrolled with DHS and passed the "Readiness Review." FSE's should also follow Dept. of Labor Rules and Regulations.

MA Home Care Services: If you are receiving licensed home care services, list them here. The cost of these services **MUST** be included in the overall CDCS budget even though they get billed separately.

Provider Number: Ask the provider for this number.

Rate per unit or visit: List the rate/cost of the service for the basic unit. Examples: 15 minute rate, daily rate. Ask the providers what their rate is.

Total # of Hours/Units per week: List the number of hours per week AND the number of weeks per year.

Number of Weeks: 52 weeks for full year. Shortened plan year or seasonal changes will affect number of weeks.

Total Cost to Plan: This will automatically be calculated based on rate X number of hours/units/week X number of weeks.

Add Provider: Click on this button to add more providers.

This is the annual amount for the plan. Your case manager will provide this amount. This amount may be prorated in some cases.

Total of the 4 Expense Categories are automatically carried forward from each individual section.

Grand Total: Auto-calculated total of the 4 Expense Categories above. These funds have been assigned to a particular expense.

Unused Budget Amount: This amount has not yet been assigned to a particular expense and may be used in the future to add new services, goods, or increase an existing expense. An Addendum form must be completed and approved by your case manager in order to use these remaining funds. Some counties request that you assign all funds to a particular expense category and make changes during the plan year. Ask your case manager about what their county prefers.

Monitor health and safety and how often: Typically includes parents/ guardians and/or staff and how often will vary depending on the consumer. Suggest indicating person consumer lives with and checking Other and Specifying - Daily .

DIRECTIONS CONTINUED...

Monitor expenditures? This is typically the parent/guardian and the FSE.

Responsible assuring provider qualifications/training: Because this is a consumer directed option, parents or legal guardians and representatives are responsible for assuring provider qualifications are met. For licensed services, the licensed provider would help assure qualifications are being met.

It is important that your Health & Safety Plan be kept up to date. This should be used as a tool to train anyone working with the consumer. **You may bypass this section if you have an up to date Risk Management Plan or Health & Safety Plan on file with your case manager.**

If you are creating a Health and Safety form from scratch SEE COMPLETING HEALTH & SAFETY SECTION ON PG. 3 of **GUIDE TO COMPLETING CSP.**

What Will I Do in Case: List 2 emergency contacts: At least one of the emergency contacts should be someone other than the parent/guardian. Your county may also require you to complete an additional backup emergency plan.

Please review and sign on the next page. Your lead agency may or may not require you to sign a participation agreement specific to your county.

Signatures: Consumer or Parent/Legal Representative MUST sign and DATE this plan prior to any services beginning.

This form does allow for **Electronic Signatures**. You will need to create your own customer ID on your computer. Please check with your case manager regarding whether their county will accept an electronic signature or whether they still require a handwritten signature.

Habilitative Component: For DD Waivers ONLY there must be at least one habilitative service in the plan in either a paid or unpaid capacity. A goal and service in the Treatment and Training section of the plan should fulfill this requirement. If the only service is Paid Parent of Minor/Spouse please indicate how and what habilitation is occurring in an unpaid capacity (e.g. Child is improving his ADL's with assistance of Mom (in an unpaid capacity) in brushing his teeth.

Health & Safety Plan reviewed: This must be checked in order for the plan to move forward.

Plan approved: Lead Agency checks this when the plan is approved.

Lead Agency Representative Signature: Case Manager signature.

Lead Agency Representative/Care Manager: Whoever gives approval in the lead agency to move forward with the plan.

Print Form: If you have not saved this document to your computer, please do so now. That way you will be able to make changes to this document instead of starting over.