RAMSEY COUNTY
Community Human Services

Consumer Support Grant Plan Period
from **to**

Name	**PMI #**	**DOB**
Parent/Guardian	**Phone #**	
Street Address		
City	**State** ---	**Zip**
Email Address		
Type of Service Plan ---		
County Case Manager/Representative		
CSG Funds (monthly)	**FSG** No	**Total Annual Budget**
FMS Provider Chosen	**Contact Name**	
FMS Phone #	**FMS Fax #**	

Self Description: Please describe yourself, your strengths and needs, likes and dislikes, and how your disability or age impacts your life.

Health and Safety Concerns: Identify any health, supervision and safety concerns that you think are important for your plan to address.

Support and Expenditure Plan

Please complete the Support and Expenditure Plan by identifying the supports, goods and services that are directly attributable to your disability, are over and above normal costs, helps you remain at home, are <u>not covered by other funding sources</u>, and will address your health and safety needs.

Staffing and Training (examples: PPOM, staffing, Respite)				
Expense	**Describe how this relates to the functional limitation.**	**Cost per month**	**Monthly FSE fees**	**Total Yearly Cost**
			Total Annual Cost:	$ 0

Job Descriptions for Staff listed above:

Goods & Services (examples: Sensory Items, Personal Care Items)				
Expense	**Describe how this relates to the functional limitation.**	**Monthly/One time cost**	**FSE fees**	**Total Yearly Cost**
			Total Annual Cost:	$ 0

Environmental Modifications (Examples: Vehicle mods, widening doors, fences)				
Expense	**Describe how this relates to the functional limitation.**	**Monthly/One time cost**	**FSE fees**	**Total Yearly Cost**
			Total Annual Cost:	$ 0

Other				
Expense	**Describe how this relates to the functional limitation.**	**Monthly or one time cost**	**FSE fees**	**Total Yearly Cost**
			Total Annual Cost:	$ 0

YEARLY GRANT AMOUNT: _____

TOTAL ESTIMATED YEARLY EXPENSES: _____

BALANCE REMAINING: _____

Signatures	
☐	I/we agree that this plan addresses my wellbeing.
☐	I/we understand that this plan is in effect unless and until any proposed changes are discussed and approved with my social worker or CSG Coordinator.
☐	I/we understand that expenditures must be within the budget and identified in this approved support and expenditure plan.
☐	I/we understand I am required to notify the county of any changes within 10 days that may affect my service needs or eligibility for CSG.
☐	I/we understand that records of time worked, reimbursed expenses, as well as receipts/bills for other expenditures, must be retained for two years.

Client/Responsible Party	Date
Case Manager/CSG Coordinator	Date