

Ramsey County CDCS Annual Community Support Plan

Personal Information

Name of person receiving services: Date of Birth:	Personal Master Index Number (PMIN): (eight digit Medical Assistance #)	Phone: Home () Work () Cell ()
Address:		
Email Address:		
Waiver Type: <input type="checkbox"/> MR/RC <input type="checkbox"/> CAC <input type="checkbox"/> CADI <input type="checkbox"/> TBI-NF <input type="checkbox"/> TBI-NB <input type="checkbox"/> EW <input type="checkbox"/> AC		
Parent/Legal Representative/Responsible Party (if any):		
Address:		
Phone: ()	Email Address:	
County of Residence:	County of Financial Responsibility (CFR):	
Social Worker/County Representative:		Phone: ()
Address:		
Email Address:		Fax: ()

Fiscal Support Entity: (Person or agency that bills and reimburses)	Contact Name:
Address:	Phone: ()
Fax: ()	Email Address:
Common Law Employer: (person or agency with choice that hires & handles payroll. May be the same as fiscal sector support representative)	Contact Name:
Address:	Phone: ()
Fax: ()	Email Address:

Flexible Case Manager (if any)	Phone: ()	FAX: ()
Address:		Email Address:

Annual Community Support Plan For: _____

When developing your Annual Community Support Plan, think about and describe yourself, your strengths and needs, likes and dislikes, and how your disability or age impacts your 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.

Refer to the guidebook in completing this form.

Remember, all goods and services must be directly related to the disability and/or condition and based on the goals you detail in this Community Support Plan.

This Plan covers the time period from: ____/____/____ to ____/____/____
(month/day/year) (month/day/year)

1. What do you want to do?

2. What unpaid and paid supports will you need?

A. PERSONAL ASSISTANCE:

(Supports for personal care, Respite Care, Homemaker, etc.)

Provider Qualifications:

Training:

B. TREATMENT AND TRAINING:

(Specialized health care, Habilitative Services, Day services/programs, Training and Education, etc. Refer to the guidebook for a more complete list.)

Provider Qualifications:

Training:

C. Environmental Modifications and Provisions:

(Assistive Technology, Home and Vehicle Modifications, Environmental supports such as snow removal, lawn care or heavy cleaning, supplies and equipment, special diets, adaptive clothing.)

Provider Qualifications:

D. SELF-DIRECTION SUPPORT ACTIVITIES:

(Flexible Case Management, payroll costs, newspaper ads, etc. Refer to the guidebook for a more complete list.)

Provider Qualifications:

Training:

3. How will the supports you listed in question #2 help you do what you want to do? (Describe intended outcomes -refer to the guidebook)

Monitoring

Your Community Support Plan must include who (paid and unpaid) is responsible for monitoring.

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)

- Me (Consumer)
- Parent/Responsible Party
- Flexible Case manager
- Licensed Agency
- Other: _____ (Indicate who.)

* For what positions, if any, do you want criminal background check completed?

* All licensed agencies are required to complete criminal background checks, and most Agency with Choice Providers will require them.

A written agreement is in place stating duties and responsibilities of:

(Check all that apply)

- Fiscal Agent
- Agency with Choice
- Flexible Case Manager

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.

The guide will include questions to help you think about your health and safety plan. Revise the plan as necessary. The Health and Safety Plan must be completed in detail highlighting how all health and safety issues will be met.

Date: ____/____/____
Month/ Day/ Year

Revisions to the Health and Safety Plan:

**Date of Revision: ____/____/____
Month/ day/ year**

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**Date of Revision: ____/____/____
Month/ day/ year**

What I Will Do In Case...

What will you do in case there is an emergency, such as, staff not showing up for their shift, sudden illness of the primary caregiver, staff is late returning. The guide will include questions to help you think about your Emergency plan.

Complete this emergency plan and update as necessary. Date: ____/____/____

Who do you call?

Alternate person

Name:		
Home phone:		
Work phone:		
Cell phone		

Revisions to the Emergency Plan:

Date of Revision: ____/____/____
Month/ day/ year

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Date of Revision: ____/____/____
Month/ day/ year

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Date of Revision: ____/____/____
Month/ day/ year

