



## State Supported Living Services Support Plan

### Individual's Information

Name:	Date of Birth:
Home Address:	
Phone:	Email:
Living situation: <input type="checkbox"/> Group Home <input type="checkbox"/> Host Home <input type="checkbox"/> Discharge from ICF/nursing home <input type="checkbox"/> Discharge from Hospital <input type="checkbox"/> Living independently <input type="checkbox"/> Family Home <input type="checkbox"/> Experiencing homelessness <input type="checkbox"/> Other: _____	

### List all others with whom the individual resides:

Name	Relationship

Name of Authorized Representative and/or Legal Guardian:	
<input type="checkbox"/> Authorized Representative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> N/A	Phone:
Developmental Disability Determination Date:	

### Support Plan

<input type="checkbox"/> Initial <input type="checkbox"/> Annual <input type="checkbox"/> Revision	<b>Staffing Date:</b>
Start Date:	End Date:

### Support Categories that will be authorized (choose all that apply):

<input type="checkbox"/> Supports for individuals waiting for HCBS waiver enrollment <input type="checkbox"/> Supports for individuals experiencing temporary hardships <input type="checkbox"/> Supporting independence in the community <input type="checkbox"/> On-going State SLS supports
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## Support Plan

Explain what the individual wants to achieve by utilizing State SLS services and supports:

Explain how State SLS Services and Supports will help the individual achieve the identified outcome(s):

Describe how the need for a higher level of care will be alleviated,

- Address all health or safety issues,
- Indicate if the person is at risk of becoming homeless.
- Identify if the individual is at risk of needing a more restrictive setting.

Other supports that have been attempted:

- Natural supports
- Community/third party resources (Food banks, LEAP, SNAP benefits, etc.)
- Other insurance
- Other Medicaid services
- Other

Explain why other sources of supports, including HCBS waivers, cannot meet the individual's needs:



### Individual seeking Services Roles and Responsibilities

Individual has been informed of their roles and responsibilities for participation in the State SLS program.

I agree to participate in the coordination of my services and will be responsible to:

- Give accurate information to my case manager.
- Assist in promoting my own independence.
- Cooperate with my providers and case management agency.
- Notify my case manager of changes in my support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) placements.
- Notify my case manager if I enroll in a Home and Community Based waiver.
- Notify my case manager of any changes in my care needs and/or problems with services.

### Case Manager Roles and Responsibilities

Individual has been informed of the State SLS Case Manager's roles and responsibilities.

The Case Manager agrees to:

- Coordinate needed services.
- Communicate with service providers regarding service delivery, and concerns.
- Review and revise services, as necessary.
- Notify clients regarding any change in services.
- Notify clients when services are denied, suspended, terminated, or reduced.
- Document, report, and resolve client complaints and concerns.
- Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.

### Statement of Agreement

Individual/Guardian indicates that he/she agrees with the information in the Support Plan and agrees to receive services accordingly.

OR

Individual/Guardian acknowledges that they are choosing not to sign the Support Plan agreement.

Signatures		
Individual I certify, to the best of my knowledge, all information on this support plan is true and complete.		
Signature:	Print Name:	Date:
<input type="checkbox"/> Authorized Representative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> N/A I certify, to the best of my knowledge, all information on this support plan is true and complete.		
Signature:	Print Name:	Date:
Case Manager I certify, to the best of my knowledge, all information on this support plan is true and complete.		
Signature:	Print Name:	Date:

Individuals Who Assisted in Developing the Support Plan		
Name (Please Print)	Title	Relationship to State SLS Participant

Please retain a copy of this in the individual's file to make available upon request by the Department.