Supports Waiver Individual Service Plan (ISP)

Instructions

The Supports Waiver ISP is organized by four (4) categories of services:

1. Personal Care Services
2. Community Membership Supports
3. Health and Wellness Supports
4. Other Supports: Assistive Technology, Vehicle Modification, and Non-Medical Transportation
5. Environmental Modifications
6. Emergency Back-up Plan
7. Consultant/ Support Guide Services
8. ISP Preparation Information
9. Emergency Backup Acknowledgement

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 ISP can be written out by hand, or the Community Supports Coordinator (CSC) can type in the answers in the word version of the form. For the Participant Directed Service Delivery Model, the all of the information must be submitted into the FoCoS*online* system. For the Agency Based Services Delivery Model, the information must be submitted to the Third-Party Assessor by the Community Support Coordinator.

Supports Waiver Overview

The Supports Waiver is a Home and Community Based Services (HCBS) Waiver program that supports eligible New Mexicans with intellectual developmental disabilities (I/DD), to live safely in their communities. It is designed to provide an option for support to individuals who are on the Developmental Disabilities (DD) Waiver Waitlist waiting for an allocation to the DD or Mi Via Waivers.

Supports Waiver services are intended to complement unpaid supports that are provided to individuals by family and others.

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

The services and supports in the Supports Waiver 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 Supports Waiver.

My Supports Waiver Plan

QI. What do I want to have happen as a result of my participation in the Supports Waiver Program at home, at work and in the community related to my health, friends and relationships? (*Mandatory)*

Q2. What are my strengths? (*Mandatory)*

Q3. What is important in my life now and in the future? (*Mandatory)*

Q4. What is working well in my life? (*Mandatory)*

Q5. Who are the people that are in my circle of support? (*Mandatory)*

Q6. Will you be using the Agency Based Service Delivery Model or the Participant Directed Service Delivery Model? *(Mandatory,* Check one)

☐ Agency Based Service Delivery Model ☐ Participant Based Service Delivery Model

1. Personal Care Services

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 (ADLs), home management, supports for health and safety. Supports are to occur in a participant's private residence, not in a home owned by their provider agency:

- Personal Care Services

How can the Supports Waiver 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/ Service	**Paid Supports (other than Supports Waiver)** **Hours Per Week**	**Unpaid Supports** **Hours per Week**	**Supports Waiver Supports** **Hours per Week**	**Supports Waiver Supports Service Instructions**	**Total Hours** **Hours per Week**
ADLS					
Eating					
Dressing					
Transfers					
Toileting Maintenance Continence					

Activity/ Service	**Paid Supports (other than Supports Waiver)** **Hours Per Week**	**Unpaid Supports** **Hours per Week**	**Supports Waiver Supports** **Hours per Week**	**Supports Waiver Supports Service Instructions**	**Total Hours** **Hours per Week**
iADLS					
Personal Hygiene					
Light Housework					
Meal Preparation					
Grocery Shopping					
Laundry					
Routine Communications					
Money Management					
Banking					
Miscellaneous Finance					
Working with Vendors/Employees					
Scheduling Appointments					
Total Hours Per Week					

Based on your physical or cognitive needs and qualifying condition, please identify the services needed to address your Personal Care Services.

(Totals should be from Supports Waiver column ONLY from above)

Personal Care Services	Hours per Month
Personal Care Services	
Total Hours per Month	

Details of Personal Care Services

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

Q5. Do any of your Supports Waiver paid Personal Care Services providers live in the same home with you?

☐ Yes ☐ No

Q6. Are any of you Supports Waiver paid Personal Care Services providers a relative or legal guardian?

☐ Yes ☐ No

Q7. Has your relative or legal guardian been approved by the Department of Health (DOH) to be a paid Supports Waiver Personal Care provider for you?

☐ Yes ☐ No ☐ Currently Requesting ☐ N/A

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

Work Schedule for (name of Relative or Legal Guardian)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Q8. If you are under 21, are you receiving Personal Care Services through EPSDT?

☐ Yes ☐ No

Q9. How will I measure if my Personal Care Services are working well for me and meet my identified needs?

Q10. Do you need your Personal Care Direct Support Personnel to have training on wheelchair tie downs, lifting, and transferring, meal preparations, or housekeeping skills? Please specify the trainings needed.

Q11. What else do you need your Personal Care employees to know about you?
(Mandatory)

2. 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:

- Supported Employment
- Customized Community Supports Group
- Customized Community Supports Individual

The Supports Waiver program supports participants to become involved in the community.

Q12. How do you want to be involved in your community? (*Mandatory)*

Q13. Are you interested in exploring what your interests or opportunities might be in the community? (*Mandatory)*

☐ Yes ☐ No If yes, please explain **(*Mandatory)***:

Q14. Do you have any interest in volunteering in areas such as: community projects, charitable organizations or other special events in the community?

If yes, please explain **(*Mandatory)***:

Q15. Do you know how or where to access community activities or volunteer opportunities you are interested in?

If yes, please explain **(*Mandatory)***:

Q16. Do you need transportation to participate in the community or volunteer activities including Supported Employment?

If yes, please explain **(*Mandatory)***:

Q17. Are you currently employed or are you interested in employment?

☐ 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 (i.e. another job or career) you would like to pursue?
  - ☐ Yes ☐ No

    If yes, please explain **(*Mandatory)***:

Q18. Do you know how or when to access employment resources and supports in your community? (*Mandatory)*

Q19 If you are not employed, are you interested in exploring new experiences that could lead to a volunteer position or work, or to more involvement in the community? (*Mandatory)*

Activity/ Service	**Paid Supports (other than Supports Waiver)** **Hours Per Week**	**Unpaid Supports** **Hours per Week**	**Supports Waiver Supports** **Hours per Week**	**Supports Waiver Supports Service Instructions**	**Total Hours** **Hours per Week**
Employment					
Volunteering					
Educational					
Leisure/ Recreational * Does not include Related Goods					
Building Relationships					
Translator/ Interpreter					
Total Hours per Week					

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 Supports Waiver column ONLY from above)

Community Membership Service	**Hours per Month**
Customized Community Supports Individual	
Supported Employment	
Customized Community Supports Group	
Total Hours per Month	

Details of Community Membership Supports

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

Q20. Do any of your paid Supports Waiver Community Membership Support providers live in the same home with you?

☐ Yes ☐ No

Q21. Are any of you paid Supports Waiver Customized Community Supports Individual (CCS-I) a relative or legal guardian?

☐ Yes ☐ No

Q22. Has your relative or legal guardian been approved by DOH to be a paid Supports Waiver Customized Community Supports Individual (CCSI) provider for you?

☐ Yes ☐ No ☐ Currently Requesting ☐ N/A

If yes, or currently requesting, please provide the relative or legal guardian's planned work schedule ***(Mandatory):***

Work Schedule for (name of Relative or Legal Guardian)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Q23. How will I measure if my Community Membership Support services are working well for me and meet my identified needs? ***(Mandatory)***

Q24. Do you need your Community Membership Support Employees to have training on wheelchair tie downs or lifting and transferring? Please specify the trainings needed.

Q25. What else do you need your Community Membership Support Employees to know about you?

3. Health and Wellness Supports

Definition: Provide information about health, medical, dental, behavioral, and environmental concerns to consider during ISP planning that impact your health and safety. Please include what is being done to address these concerns. Supports to address these concerns may be outside of Supports Waiver Services. Please include all paid supports other than the Supports Waiver, non-paid supports and Supports Waiver supports.

Use the answers to these questions to think about how the Supports Waiver and other identified services can support you to be healthy and well.

Q26. What do I want to have happen as a result of my participation in the Supports Waiver Program, related to my health and wellness needs? ***(Mandatory)***

Q27. What Managed Care Organization (MCO) do you receive your Medicaid through? What is the name and contact information of your Care Coordinator? ***(Mandatory)***

Q28. Have you had a Comprehensive Needs Assessment (CNA) done this year? What is your level of Care Coordination? ***(Mandatory)***

Q29. Do you have a regular doctor or medical practitioner? Have you seen them in the past year? ***(Mandatory)***

Q30. Do you have a regular dentist? Have you seen them in the past year? ***(Mandatory)***

Q31. What are my health, medical, and dental issues? What will I need to address any health or safety concerns? ***(Mandatory)***

Please see the table below. List any identified health and safety issues in the column below. Information from the Centennial Care Comprehensive Needs Assessment (CNA) or any other applicable assessments should be here.

Mandatory

Health and Safety Area	History	Supports Instructions for Support Waiver Services	Other related Services and Supports
Allergies -Food Specific			
Allergies			
Ambulation – including fall risk			
Aspiration			
Bowel Obstruction			
Deydration			
GERD			

Q32. 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 to your life).

☐ Yes ☐ No

If yes, please explain ***(Mandatory):***

Q33. Has a health professional recommended a special nutritional plan, a special diet, or meal plan for you?

☐ Yes ☐ No

If yes, please explain ***(Mandatory):***

Q34. Has a health professional recommended that you take nutritional supplements?

☐ Yes ☐ No

If yes, please explain ***(Mandatory):***

Q35. Do you need reminders to eat?

☐ Yes ☐ No

If yes, please explain ***(Mandatory):***

Q36. Do you need support from Supports Waiver to be physically active?

☐ Yes ☐ No

If yes, please explain ***(Mandatory):***

4. Behavior Support Consultation

Based on your physical or cognitive needs and qualifying condition, please identify the Behavior Support Consultation services needed.

Activity/ Service	Paid Supports (other than Supports Waiver) Hours Per Week	Unpaid Supports Hours per Week	Supports Waiver Supports Hours per Week	Supports Waiver Supports Service Instructions	Total Hours Hours per Week
Behavior Support Consultation					

Details of Behavior Support Consultation

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

Q37. How will I measure if my Behavior Support Consultation services are working well for me and meet my identified needs? *(Mandatory)*

Q38. What else do you need your Behavior Support Consultant to know about you? *(Mandatory)*

5. Other Supports: Assistive Technology, Vehicle Modification and Non-Medical Transportation

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 the Supports Waiver, these include:

- Non-medical Transportation
- Assistive Technology
- Vehicle Modification
- Respite (To give the unpaid, primary caregiver time away from their duties).
    - If requesting Respite, please provide the name of the unpaid primary caregiver utilizing the Respite and their relationship to you:

_____

Q39. Have you had any Assistive Technology or Vehicle Modifications for accessibility or safety purposes, funded by the Supports Waiver Program in the past five (5) years? ***If you have utilized Assistive Technology or Vehicle Modifications in the last five (5) years, please contact your Community Support Coordinator (CSC) to see if funds are still available.***

Based on your physical or cognitive needs and qualifying condition, please identify the non-medical transportation, assistive technology, vehicle modification and respite needed to address Other Supports.

Activity/ Service	Paid Supports (other than Supports Waiver)	Unpaid Supports	Supports Waiver Supports	Supports Waiver Supports Service Instructions	Total Hours
Transportation by MILE.	Miles per month:	Miles per month:	Miles per month:	Miles per month:	Hours per month:
Transportation through passes or ride share.					
Transportation by hourly driver.	Hours per month:	Hours per month:	Hours per month:	Hours per month:	Hours per month:
Assistive Technology					
Respite Care	Hours per month:	Hours per month:	Hours per month:	Hours per month:	Hours per month:
Vehicle Modification					

Details of Other Supports

Other Support	Projected Amount, Frequency, and Duration	Expected Outcome	What is the DD Qualifying Condition that results in the need for service?	How does this support meet your clinical, medical, functional, or habilitative needs related to your qualifying condition?
Non – Medical Transportation				
Assistive Technology				
Respite				
Vehicle Modification				

Q40. Any of your paid Supports Waiver Non-Medical Transportation providers relatives or legal guardians?

☐ Yes ☐ No

Q41. Has your relative or legal guardian been approved by DOH to be a paid Supports Waiver non-medical Transportation provider for you?

☐ Yes ☐ No ☐ Currently Requesting

If yes, or currently requesting, please provide the Relative or Legal Guardians planned work schedule ***(Mandatory):***

Work Schedule for (name of Relative or Legal Guardian)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Q42. Do you have information about medical transportation through your Managed Care Organization (MCO) in the event that medical transportation is needed?

Q43. Are any of your paid Supports Waiver Respite providers a relative or legal guardian?

☐ Yes ☐ No

Q44. Has your relative or legal guardian been approved by DOH to be a paid Supports Waiver Respite provider for you?

☐ Yes ☐ No ☐ Currently Requesting

If yes, or currently requesting, please provide the Relative or Legal Guardians planned work schedule ***(Mandatory):***

Work Schedule for (name of Relative or Legal Guardian)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Q45. How will I measure if each of the Other Support services identified above are working well for me and meet my identified needs? (Mandatory)

6. Environmental Modifications

Q46. 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):***

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

Q47. Are there any environmental modifications covered under the Supports Waiver that you need? (Please refer to the Supports Waiver 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 Community Supports Coordinator to see if funds are still available.

6. Emergency/ Backup Plan

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

IF THERE IS AN EMERGENCY PLEASE CALL 911

Q48. If regularly scheduled employees or service providers are unable to report to work I will contact the following:

Each service requested and approved must have at least one alternative provider. If an agency is being accessed for a service, then the agency must be listed as a back-up provider for that service.

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

Relative(s) (*Mandatory: You must list at least one relative, or mark "N/A")*

Relationship to Participant	**Name (First, Last)**	**Address (City, State, Zip)**	**Phone**	**Email**
Parent(s): (Required if Participant is a minor)				
Legal Guardian: (if applicable)				
Spouse: (if applicable)				
Other:				

Community Support Coordinator (CSC) (*Mandatory: You must list at least one Community Support Coordinator)*

Name (First, Last)	**Address (City, State, Zip)**	**Phone**	**Email**

Employer of Record (EOR) (*Mandatory)*

Name (First, Last)	**Address (City, State, Zip)**	**Phone**	**Email**

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

Name of Provider (First, Last)	Type of Service Provided	Address (City, State, Zip)	Phone	Email

Other People You Can Rely On

Name (First, Last)	Relationship to Participant	Address (City, State, Zip)	Phone	Email

Community Support Coordinator (CSC) Acknowledgement

(Mandatory)

COMMUNITY SUPPORT COORDINATOR MUST ACKNOWLEDGE:

I have provided the Participant with a copy of the ISP, Emergency Back-Up Plan Acknowledgement Form, and I have reviewed the form with them. I confirm that the participant has completed the form in it's entirety. A copy of the completed form will be kept by the Participant and in the Community Support Coordinator (CSC) file.

Community Support Coordinator Name: _____

Community Support Coordinator Signature: _____

Date: _____

7. Community Support Coordinator

Please answer the following questions. The answers help you understand how much assistance you may need from your Community Supports Coordinator or others to participate in the Supports Waiver.

If you are accessing the Participant – Directed Service Delivery Model, the answers will also help you understand how much help you or your Employer of Record (EOR) may need from your Community Supports Coordinator, or others, to be a successful employer.

Q49. Do you need assistance putting your Supports Waiver plan into action?

☐ Yes ☐ No

If yes, please explain ***(Mandatory):***

Q50. For Participant Directed Service Delivery Model: Do you have access to a fax?

☐ Yes ☐ No

If no, please explain ***(Mandatory):***

Q51. For Participant Directed Service Delivery Model: Do you know how to use a fax?

☐ Yes ☐ No

If no, please explain ***(Mandatory):***

Q52. Do you have access to the Internet?

☐ Yes ☐ No

If no, please explain ***(Mandatory):***

Q53. Do you need support using the Internet?

☐ Yes ☐ No

If yes, please select all that apply:

☐ Screen Reader
☐ Computer Adaptations
☐ Computer Instructions
☐ Other *(Please explain):*

If you checked any of the boxes above, please provide additional information ***(Mandatory):***

Q54. For Participant Directed Service Delivery Model: Do you need assistance with any of the following program administration?

- ☐ Processing timesheets
- ☐ Identifying other resources
- ☐ Operating a fax machine
- ☐ Operating a computer
- ☐ Finding related goods
- ☐ Processing invoices
- ☐ Managing program budget

If you checked any of the boxes above, please provide additional information ***(Mandatory):***

Q55. For Participant Directed Service Delivery Model: Do you need help with any of your employer responsibilities and/or managements of your Supports Waiver program and budget?

☐ Yes ☐ No

If yes, please explain ***(Mandatory):***

Q56. For Participant Directed Service Delivery Model: Do you need assistance with any of the following employer responsibilities?

- ☐ Scheduling employees
- ☐ Encouraging good performance
- ☐ Interviewing/hiring employees
- ☐ Resolving employee conflicts
- ☐ Disciplinary actions
- ☐ Supervising employees
- ☐ Developing interview questions
- ☐ Checking references

If you checked any of the boxes above, please provide additional information ***(Mandatory):***

Q57. Your Community Support Coordinator will be contacting you by phone monthly and will conduct four (4) in-person visits with you per year. Do you want more contact?

If yes, please explain ***(Mandatory):***

Q58. Based on your physical or cognitive needs and qualifying condition, what type and level of support will you need from your Community Support Coordinator?

Please indicate your expectation of the service ***(Mandatory):***

Q59. How will I measure if my Community Support Coordinator services are working well for me, and if they are meeting my identified needs?

Please indicate your expectation of the service ***(Mandatory):***

Q60. Please describe the plan/agreement you have for Community Support Coordinator service *(Mandatory)*.

8. Person's Participating in the Development of the ISP

(*Mandatory- you must list at least one Community Support Coordinator)*

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

Supports Waiver Individual Service Plan Back-Up Plan Acknowledgement Form

Participant's Name: _____

Print Name of Person Completing Form: _____

Instructions for Community Support Coordinators:
Please review these questions carefully with the participant as part of the process of developing the ISP. 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 ISP cannot be submitted through FOCoSonline or through the TPA 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 during the day and night because they are essential to my health and safety.
	Emergency Contacts: If l 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 help. 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 needed. The list includes contacts identified in the ISP, fire, police, doctor, utility company, crisis hotline and the nearest hospital. I have developed and made service providers, employees and vendors aware of my emergency back-up plan and where my emergency "Go Bag" or written list of equipment and medication necessary in an evacuation are.

Participant Initials	Acknowledgements
	Abuse, Neglect and Exploitation (7 NMAC 1.4) The Division of Health Improvement's (DHI), Incident Management Bureau's (IMB) role is to ensure the health and safety of waiver participants and to ensure compliance with state and federal regulations by community-based providers. Common warning signs and indicators of abuse, neglect and exploitation may include: • Changes in normal patterns occur seemingly without explanation (sleeping pattern, eating pattern, toileting); • Sudden and unexplained changes in behavior; • Unexplained injuries occur, the explanation for the injury does not match, and/or injuries occur in places not commonly injured like the inner abdomen. bottom of the feet. back and neck; • Changes in the person's health are not assessed by the nurse or no appointment is made with their community physician; • Medications are missing, missed or the individual gets someone else's medication; • Staff are not trained, do not follow the plans written to keep the person safe (healthcare plan, medical emergency plan, physical therapy plans), or don't pay attention to the people they are supporting; • Skin breakdown regularly appears and is not assessed, or treatment instructions are not followed; • Personal spending money or belongings go missing. I **understand that abuse, neglect, exploitation, suspicious injuries, environmental hazards and death are to be reported immediately to the IMB Hotline at 1-800-445-6242.** 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 Community Support Coordinator Agency within 24 hours. Additional information, including how to report suspected abuse, neglect and exploitation to IMB's hotline can be found at: **dhi.health.state.nm.us**

Participant Initials	Acknowledgements
	Individual Client Rights Regulation (NMAC 7.26.3) The regulations governing client rights promote the health, safety and welfare of individuals with developmental disabilities who are receiving supports and services from provider agencies certified by or funded with state funds administered through the Department of Health, through contracts and agreements. The client rights regulations define rights of individuals with developmental disabilities so that these rights can be readily identified, exercised and protected. Unless expressly modified by court order, or specifically granted to a guardian or conservator, all individuals served have the same legal rights guaranteed to all other individuals under the United States Constitution, the New Mexico State Constitution, and federal and state laws. The Department of Health will enforce remedies for substantiated complaints of violation of the rights of an individual served as provided in the Client Complaint Procedures. If you have any complaints regarding Community Supports Coordinator services, you can file your complaint with another personnel at the Community Supports Coordinator Agency or with the **Department of Health Developmental Disabilities Supports Division Supports Waiver Unit (DOH/DDSD/MVU) at 1-800-283-5548.**

Participant Initials	Acknowledgements
	Client Complaint Procedures Regulation (7 NMAC 26.4) As an individual receiving supports and services through a community agency contracted with the Department of Health or as a legal guardian of an individual receiving services, a complaint procedure is available to you. If, at any time, you feel that a service provider, its employee, or person acting under contract with the service provider has violated your rights, you may initiate the complaint process with the service provider within one hundred eighty (180) days of the event of the occurrence. If the complaint alleges abuse or neglect, or involves a dangerous condition, or a risk to health and safety, the complaint may be made with the division's office without initiating a complaint with the service provider. If your complaint initiated with the service provider is not resolved, you can file your complaint orally or in writing with the division's designated office within twenty (20) days. A written report of the investigation will be prepared within forty-five (45) days of receipt of your complaint. The Director of the Developmental Disabilities Supports Division will review this report and issue a written decision within in ten (l0) days of receipt of the report. If you as a complainant, are not satisfied with the decision of the Director, you may request an Administrative Hearing. Your request must be filed in writing within twenty (20) days from the receipt of the Director's decision. If you have further questions about the process, or want a copy of these State Regulations, please contact the **Developmental Disabilities Supports Division at (505) 827-2574.**

I have had the above rights, which pertain to me, explained to me. I have received, or been told, where to receive a copy of the relevant regulation pertaining to my rights.

☐ Checking this box affirms that there was a discussion of abuse, neglect, and exploitation at this ISP meeting.

☐ Checking this box affirms that there was a discussion of Home and Community Based Services (HCBS) Rights and Freedoms.

Person Completing Form Printed Name: _____

Person Completing Form Signature: _____

Date: _____

*It is the responsibility of the Community Support Coordinator to call Guardians and family members listed in the ISP who did not attend the ISP meeting to review the ISP, including the Supports Waiver ISP Back Up Plan Acknowledgement Form, and ANE information.

Supports Waiver Individual Service Plan Back-Up Plan Acknowledgement Form

Participant's Name: _____

Print Name of Person Completing Form: _____

Instructions for Community Support Coordinators:
Please review these questions carefully with the participant as part of the process of developing the ISP. 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 ISP cannot be submitted through FOCoSonline or through the TPA 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 l 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, to include contacts identified in the ISP, fire, police, doctor, utility company, crisis hotline and the nearest hospital. I have developed and made any service providers aware of my emergency back-up plan and where my emergency "Go Bag" or written list of equipment and medication necessary in an evacuation are.

Participant Initials	Acknowledgements
	Abuse, Neglect and Exploitation (7 NMAC 1.4) The Division of Health Improvement's (DHI), Incident Management Bureau's (IMB) role is to ensure the health and safety of waiver participants and to ensure compliance with state and federal regulations by community-based providers. Common warning signs and indicators of abuse, neglect and exploitation may include: • Changes in normal patterns occur seemingly without explanation (sleeping pattern, eating pattern, toileting); • Sudden and unexplained changes in behavior; • Unexplained injuries occur, the explanation for the injury does not match, and/or injuries occur in places not commonly injured like the inner abdomen. bottom of the feet. back and neck; • Changes in the person's health are not assessed by the nurse or no appointment is made with their community physician; • Medications are missing, missed or the individual gets someone else's medication; • Staff are not trained, do not follow the plans written to keep the person safe (healthcare plan, medical emergency plan, physical therapy plans), or don't pay attention to the people they are supporting; • Skin breakdown regularly appears and is not assessed, or treatment instructions are not followed; • Personal spending money or belongings go missing. I **understand that abuse, neglect, exploitation, suspicious injuries, environmental hazards and death are to be reported immediately to the IMB Hotline at 1-800-445-6242.** 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 Community Support Coordinator Agency within 24 hours. Additional information, including how to report suspected abuse, neglect and exploitation to IMB's hotline can be found at: **dhi.health.state.nm.us**

Participant Initials	Acknowledgements
	Individual Client Rights Regulation (*NMAC* 7.26.3) The regulations governing client rights promote the health, safety and welfare of individuals with developmental disabilities who are receiving supports and services from provider agencies certified by or funded with state funds administered through the Department of Health, through contracts and agreements. The client rights regulations define rights of individuals with developmental disabilities so that these rights can be readily identified, exercised and protected. Unless expressly modified by court order, or specifically granted to a guardian or conservator, all individuals served have the same legal rights guaranteed to all other individuals under the United States Constitution, the New Mexico State Constitution, and federal and state laws. The Department of Health will enforce remedies for substantiated complaints of violation of the rights of an individual served as provided in the Client Complaint Procedures. If you have any complaints regarding Community Supports Coordinator services, you can file your complaint with another personnel at the Community Supports Coordinator Agency or with the **Department of Health Developmental Disabilities Supports Division Supports Waiver Unit (DOH/DDSD/MVU) at 1-800-283-5548.**

Participant Initials	Acknowledgements
	Client Complaint Procedures Regulation (7 NMAC 26.4) As an individual receiving supports and services through a community agency contracted with the Department of Health or as a legal guardian of an individual receiving services, a complaint procedure is available to you. If, at any time, you feel that a service provider, its employee, or person acting under contract with the service provider has violated your rights, you may initiate the complaint process with the service provider within one hundred eighty (180) days of the event of the occurrence. If the complaint alleges abuse or neglect, or involves a dangerous condition, or a risk to health and safety, the complaint may be made with the division's office without initiating a complaint with the service provider. If your complaint initiated with the service provider is not resolved, you can file your complaint orally or in writing with the division's designated office within twenty (20) days. A written report of the investigation will be prepared within forty-five (45) days of receipt of your complaint. The Director of the Developmental Disabilities Supports Division will review this report and issue a written decision within in ten (l0) days of receipt of the report. If you as a complainant, are not satisfied with the decision of the Director, you may request an Administrative Hearing. Your request must be filed in writing within twenty (20) days from the receipt of the Director's decision. If you have further questions about the process, or want a copy of these State Regulations, please contact the **Developmental Disabilities Supports Division at (505) 827-2574.**

I have had the above rights, which pertain to me, explained to me. I have received, or been told, where to receive a copy of the relevant regulation pertaining to my rights.

☐ Checking this box affirms that there was a discussion of abuse, neglect, and exploitation at this ISP meeting.

☐ Checking this box affirms that there was a discussion of Home and Community Based Services (HCBS) Rights and Freedoms.

Person Completing Form Printed Name: _____

Person Completing Form Signature: _____

Date: _____

*It is the responsibility of the Community Support Coordinator to call Guardians and family members listed in the ISP who did not attend the ISP meeting to review the ISP, including the Supports Waiver ISP Back Up Plan Acknowledgement Form, and ANE information.