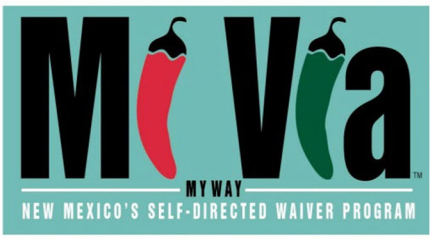
Participant Name:



Mi Via Service and Support Plan (SSP)

INSTRUCTIONS

The Service and Support Plan (SSP) is organized by the following four categories of services:

1. Living Supports
2. Community Membership Supports
3. Health and Wellness Supports
4. Other Supports

Other Sections Include:

5. Environmental Modifications
6. Emergency Back-up Plan
7. Consultant Services
8. SSP Preparation Information

You need to fill out every portion of every section. However, if the question does not apply to you, just put "not applicable" or "n/a" in the space provided and move on.

The SSP can be written out by hand, or the consultant can use the Word fillable version of the form to type in the answers. However, for the SSP to be submitted to the Third-Party Assessor (TPA), all information must be entered into the Mi Via online system by the consultant.

Mi Via Overview

The Mi Via Home and Community Based Services Waiver is a program that supports eligible New Mexicans with disabilities and medically fragile to live safely in their communities. Mi Via is a self-directed waiver that allows participants to hire, terminate, supervise, and manage employees of their choosing with support from a representative and/or consultant.

Based on assessed need, the participant develops a service and support plan (SSP) through person centered planning that outlines the services and supports the participant desires and preferences for the delivery of services and supports to live independently in their own home or community.

The SSP must reflect the services and supports that are important for the participant to meet his or her support and, as applicable, clinical, needs identified through the assessment of functional need, as well as what is important to the participant about preferences for the delivery of such services and supports.

Both paid and unpaid supports can be referenced, if there is documentation of how each need is met/addressed. This can also include information about services and supports that you are receiving from your Centennial Care MCO and care coordination.

The services and supports from Mi Via are in addition to natural and other paid supports and are intended to increase the participant's independence. This can also include assistive or adaptive technology devices.

My Mi Via Service and Support Plan

Q1. My needs, goals and preferences related to home, work and my community related to my health, friends and relationships. Here is what I want to happen with my services and supports:

Q2. What strengths do I have?

Q3. If you currently have a Purpose, Approach, Thinking, and Habits (PATH) or Measure of Academic Progress (MAP) assessments or similar information, do you want to use it as part of your SSP planning?

☐ Yes ☐ No

Q4. What is the DD/ MF Qualifying condition?

1. Living Supports

Living Supports Definition: Individually determined supports that help you live in your own home and community. These supports can provide needed assistance with activities of daily living, home management, supports for health and safety as well as independent living skills.

Supports can be provided using four different models:

- Homemaker/Direct Support Services
- Home Health Aide
- In-Home Living Supports

Activities of Daily Living Definition: Means the basic skills of everyday living such as toileting, bathing, dressing, grooming, and eating and the skills necessary to maintain the normal routines of the day, such as housekeeping, shopping, and preparing meals.

Q5. How can Mi Via support you to live as independently as possible in your own home and community?

Please identify any supports or services needed based on the assessment of functional need and your preferences for the delivery of supports and services to successfully and safely complete daily activities or build skills in the areas listed below:

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week)** **Identify/describe what this looks like**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Week)**
Eating				
Dressing				
Bathing				
Transfers				
Toileting				
Heavy Housework				
Light Housework				
Cooking				
Grocery Shopping				
Taking Medication				
Routine Communications				
Banking				
Managing bills				
Miscellaneous finance				
Working with Vendors				
Scheduling Appointments				
Managing other benefits				
Exterior Supports (gardening, yard maintenance)				
*Other Support Needed				
Total Hours per Week				

Please provide description of "other support" if selected.

Based on assessment of functional needs, identify the services or related goods needed to support your Living Supports.

Q6. Do any of your Mi Via paid Living Support providers live in the same home with you?

Q7. Are any of your paid Mi Via Living Support providers a Legally Responsible Individual (LRI) such as your parent or guardian (for minors) or spouse?

Q8. Has your LRI been approved by DOH to be a paid Mi Via provider for you?

Available Living Support Services
(Totals should be from Mi Via column ONLY from above)

Living Support Service	Hours per Month
Homemaker/Direct Support	
Home Health Aid	
In-Home Living Supports	
Total Hours per Month	

Goods related to Living Supports that I need

Related Goods	Estimated Cost	Expected Outcome	Association to assessed needs or preferences for delivery of services and supports

Q9. How will I and my support team know if my living support services are working and meeting my identified needs and preferences for the delivery of services and supports?

2. Community Membership Supports

Community Membership Supports Definition: These supports help you participate in community life to enhance relationships with others, work or participate in meaningful activities. This term also includes exercising, personal, social, and communication skills.

These supports include:

- Community Direct Support
- Employment Supports
- Customized Community Supports

The Mi Via Program supports participants to become involved in their community.

Q10. How do you like to spend your time? (preferences, activities, hobbies, places, people…) How do you want to be involved in your community?

Q11. What activities in the community will you explore or try during this planning period?

Q12. What community activities are you currently involved with, such as social and religious clubs, bowling league, girls and boy scouts, or other?

Q13. What interest(s) do you have in volunteering in areas, such as community projects, charitable organizations or other special events in the community?

Q14. Do you need transportation to participate in community or volunteer activities?

☐ Yes ☐ No

If yes, please explain.

Q15. Would you like to have a job or earn money**?**
☐ Yes ☐ No

Are you currently working with the NM Department of Vocational Rehab (DVR)?

☐ Yes ☐ No

Are you currently employed?

☐ Yes ☐ No

If yes, please explain.

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?

How do you feel about your employment?

Are you interested in other employment opportunities?

☐ Yes ☐ No

If yes, please explain.

Based on your answers above, please list the areas where you need support to participate in activities in your community or build skills related to community membership.

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week)** **How is this being addressed?**	**Mi Via Supports (Hours per Week)**	**Total Hours** **(Hours per Week)**
Employment				
Volunteering				
Educational				
Leisure/Recreational				
Building Relationships				
Interpreter				
Translator/Interpreter				
*Other Support Needed				
Total Hours per Week				

Please provide description of "other support" if selected.

Based on the assessment of your functional needs and preferences for the delivery of service and supports, please identify the services or related goods needed to support your community supports.

Available Community Membership Services
(Totals should be from Mi Via column ONLY from above)

Community Membership Service	Hours per Month
Community Direct Support	
Employment Supports	
Customized Community Group Supports	
Total Hours per Month	

Goods related to Community Membership Supports that I need

Related Goods	Estimated Cost	Expected Outcome	Association to assessed needs or preferences for the delivery of services and supports

Q16. How will I and my support team know if my community membership support services are working well for me and meeting my identified needs and preferences for the delivery of services and supports?

Safety/Risk Assessment

Instructions:

- For each risk area, mark "Yes" or "No" to indicate if the person is at present risk.
- If "Yes" is marked, write a brief description of the specific issue or concern posing a risk and the circumstances and frequency which the risk occurs. **Also indicate what support or actions are necessary to address the risk or safety concern.**
- If there is a history of risk, mark "History" and give a description and timeframe for when the incident last occurred.
- Follow-up: mark "Yes" or "No" to indicate whether follow-up is needed.

Risk	Risk Present	Description of Risk and/or Follow-up (if Yes or History is marked)
Health and Medical		
1. Aspiration: I am at risk of aspirating. (I have a feeding tube; someone else puts food, fluids or medications into my mouth; I have a diagnosis of dysphagia; or I have been identified to be at risk for aspiration by a qualified medical professional.)	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
2. Dehydration: I am at risk of dehydration. (I often need help to get something to drink, or I receive fluids through a tube, or	☐ Yes ☐ No ☐ History Follow-Up Needed:	

I needed intravenous (IV) fluids due to dehydration in the past year.)	☐ Yes ☐ No	
3. Choking: I am at risk of choking. (I ingest non-edible objects, or place non-edible objects in my mouth, or I have a diagnosis of Pica. I may eat or drink too rapidly frequently or more than occasionally cough or choke while eating or drinking.)	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
4. Constipation: I am at risk of having constipation. (I take bowel medications routinely or more than twice a month within the past year or have required a suppository or enema for constipation within the past year.)	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
5. Seizures: I am at risk of having a seizure. (I have a diagnosis of seizures or epilepsy and/or have taken medication to control seizures within the past five years.)	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
6. Medication Management: I want help managing my medication. (I may take too much of it, or miss taking a dose, or eat or drink things or take other medication that conflict with the medication.) **7.**	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
8. Medication Management: I want help making sure my prescription doesn't run out or I need help making sure my medications are stored safely.	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	

Risk	Risk Present	Description of Risk and/or Follow-Up (if Yes or History is marked)
Health and Medical		
9. Medication Management: I want help to make a list of all the medications I take and help understanding why I take each medication.	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
10. Complications of Diabetes: I have been diagnosed with pre-diabetes or diabetes and want help managing this issue.	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
11. Complications associated with having an ostomy or tube, such as a urinary catheter, colostomy, etc.: I have an ostomy or tube and want help managing complications associated with it.	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
12. Unreported pain or illness: I want help reporting pain, signs of illness, or where it is located. (I can have difficulty reporting or describing pain and illness.)	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
13. Injury due to falling: I want support to avoid an injury due to falling. (Consider risk due to mobility or transfer support needs.)	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
14. Other serious health or medical issue: I want help with a health issue that was not listed above. List specific additional risks (if any).	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
15.Respiration: I need help managing breathing issues, asthma, oxygen	☐ Yes ☐ No ☐ History	

consumption, or other respiratory concerns.	Follow-Up Needed: ☐ Yes ☐ No	

Risk	Risk Present	Description of Risk and/or Follow-Up (if Yes or History is marked)
Safety		
16. Water temperature safety: I want help to adjust water temperature to avoid getting burned.	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
17. Fire evacuation safety: I need assistance to evacuate when a fire or smoke alarm sounds.	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
18. Household chemical safety: I want support to avoid any serious injury from household chemicals.	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
19. Vehicle safety: I want assistance to remain safe around traffic while getting in or out of a vehicle or while riding in vehicles.	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
20. Court-mandated protection: **S*omeone else*** has a court-mandated condition or restriction against them to address my safety (e.g. protective orders or restraining orders to keep this person safe).	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	**If yes,** list court order and date:

Risk	Risk Present	Description of Risk (if Yes or History is marked)
Safety		
21.Significant risk of exploitation: I want help in recognizing and preventing any abuse or exploitation of me. (Mark "yes" if there is evidence, signs, or circumstances of significant increased risk of abuse or exploitation.)	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
22.Safety and cleanliness of the residence: There are some conditions where I live that may lead to injury, illness, eviction, or significant loss of property.	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	**If yes**, list the conditions:
23.Other safety issues: Consider any other important, serious safety issues at home or in any other setting that you want help with. (e.g. workplace equipment, bullying, harassment).	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	If any, list specific additional safety risk(s):

Risk	Risk Present	Description of Risk and/or Follow-Up (if Yes or History is marked)
Financial		
Potential for financial abuse: I want assistance in making sure that I am at low risk for financial abuse. (Mark "yes" if there have been complaints or evidence of significant increased risk of financial exploitation. e.g. employees or foster provider handles the person's money, participant frequently loans money or property to others, bills are unpaid, etc.)	☐ Yes ☐No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
Mental Health		
Mental Health: I want support managing or coping with my mental health. (Consider all mental health areas including past	☐ Yes ☐No ☐ History	

trauma, addiction, mood disorders, suicide ideation, etc.) **List mental health risk(s) if any**:	Follow-Up Needed: ☐ Yes ☐ No	
Behavior		
I do not threaten, harass, or physically abuse other people and understand *personal* boundaries of others: (Mark "yes" if this is true to indicate there is no risk present in this category.)	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	
Other behavior issues: Consider any other important, serious behavior issues at home or in any other setting that could create a risk to yourself or others. **List specific additional behavior risk(s) if any**:	☐ Yes ☐ No ☐ History Follow-Up Needed: ☐ Yes ☐ No	

Contributors to this Safety / Risk Assessment	
Name	**Title / Relationship**
	Person receiving services
Date of last update:	

3. Health and Wellness Supports

Health and Wellness Supports Definition: These supports are made available in Mi Via to assist you with medically related or behavioral health needs that are not covered by your health plan and will enhance your ability to remain in your home and community. These supports are generally provided by a licensed health professional and include:

- Skilled Therapy for Adults - Occupational, Physical and Speech Therapy
- Behavior Support Consultation
- Nutritional Counseling
- Private Duty Nursing for Adults

- Specialized Therapies – Acupuncture, Biofeedback, Chiropractic, Cognitive Rehabilitation Therapy, Hippotherapy, Massage Therapy, Naprapathy, and Play Therapy

Use the answers to these questions to think about how Mi Via can support you to be healthy and well.

Q17. Are you transitioning from another waiver or Medicaid programs such as the Developmental Disabilities Waiver (DDW) or Self-Directed Community Benefit (SDCB)?

☐ Yes ☐ No

Did you receive or access any health and wellness supports such as therapies under that program, such as Physical Therapy (PT), Speech Language Therapy (SLP), or Behavioral support Services? Do you plan on accessing these same or similar services under Mi Via?

List health and wellness supports previously accessed.
If you will not be accessing them under Mi Via, please note why.

Q18. What do I want to have happen as a result of my participation in the Mi Via Program related to my health and wellness needs?

Q19. What will I need to address any health or safety concerns?

Q20. What other health concerns do you have that have not been addressed? (Be sure to consider medical issues, eating and nutrition concerns, and behaviors that might not be safe or helpful in your life.)

Q21. Has a health professional recommended a special nutritional plan or special diet for you?

☐ Yes ☐ No

If yes, please explain what that plan is and what it says

Q22. Has a health professional recommended that you take nutritional supplements?

☐ Yes ☐ No

If yes, please explain what the recommendation is and what you are taking, or not

Q23. Do you need reminders to eat?

☐ Yes ☐ No

If yes, please explain what those reminders are and how often you need them

Q24. Health and wellness supports are available through your MCO, such as medical supplies, supplements, and other health services. What health and wellness supports do you plan to access, or are already accessing through your MCO?

Q25. Do you have health and wellness needs in addition to the services provided through your regular Medicaid coverage?

☐ Yes ☐ No

If yes, please explain what those needs are and how they will be met

Q26. Do you need additional health and safety supports from Mi Via, which are not covered by Medicaid insurance to be independent?

☐ Yes ☐ No

If yes, please explain what supports you need

Q27. Do you need support from Mi Via to be physically active?

☐ Yes ☐ No

If yes, please explain what support you need and how often

Skilled Services

Q28. Do you need the services of a licensed nurse, therapist, and/or nutritional counselor?

☐ Yes ☐ No

If yes, please explain what for

Q29. Do you have a need for any other specialized service(s) to address your health and wellness needs?

☐ Yes ☐ No

If yes, please explain what for

Other Health and Wellness Support Needed

Based on your physical or cognitive needs and preferences for the delivery of services and supports, identify the services or related goods needed to support your health and wellness.

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week) How is this being addressed?**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Week)**
OT for Adults				
PT for Adults				
SLP for Adults				

Activity/Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week) How is this being addressed?**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Week)**
Behavior Support Consultation				
Nutritional Counseling				
Private Duty Nursing for Adults				
Acupuncture				
Biofeedback				
Chiropractic				
Hippotherapy				
Massage Therapy				
Naprapathy				
Play Therapy				
Cognitive Rehabilitation Therapy				
*Other Support Needed				
Total Hours per Week				

Please provide a description of "other" support if selected.

Goods related to Health and Wellness Supports that I need

Related Goods	**Estimated Cost**	**Expected Outcome**	**How this tied to my assessed needs**

Related Goods	Estimated Cost	Expected Outcome	How this tied to my assessed needs

Q30. How will I and my support team know if my health and wellness support services are working well for me and meeting my identified needs and preferences for the delivery of services and supports?

4. Other Supports

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 Mi Via these supports include:

- Transportation
- Emergency Response Services
- Respite
- Related Goods

Based on your physical or cognitive needs and preferences for the delivery of services and supports, identify the services or related goods needed to maintain your other supports.

Activity/ Services	Non-Mi Via Paid Supports	Unpaid Supports How is this being addressed?	Mi Via Supports	Total Hours/ Miles/Trips
Transportation by MILE	Miles per Month:	Miles per Month:	Miles per Month:	Miles per Month:
Transportation by TRIP	Trips per Month:	Trips per Month:	Trips per Month:	Trips per Month:
Transportation by HOUR	Hours per Month:	Hours per Month:	Hours per Month:	Hours per Month:

Activity/ Services	**Non-Mi Via Paid Supports**	**Unpaid Supports** **How is this being addressed?**	**Mi Via Supports**	**Total Hours/ Miles/Trips**
Transportation Carrier Passes	Hours per Month:	Hours per Month:	Hours per Month:	Hours per Month:
Emergency Response Services	Hours per Month:	Hours per Month:	Hours per Month:	Hours per Month:
Respite Care	Hours per Month:	Hours per Month:	Hours per Month:	Hours per Month:

Goods related to Other Supports that I need

Related Goods	**Estimated Cost**	**Expected Outcome**	**How this is tied to my assessed needs**

Q31. How will I and my support team know if each of the support services are working well for me and meeting my identified needs and preferences?

5. Environmental Modifications

Q32. 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, Doorway or Hallway Modifications, Bathroom Modification

☐ Yes ☐ No

If yes, please provide the following information.

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

Q33. Are there any environmental modifications covered under Mi Via that you need? (Please refer to Mi Via regulations)

Indicated items will be subject to review / approval

☐ Yes ☐ No

If yes, please explain.

If you have had environmental modifications in the last five (5) years but need additional environmental modifications done, please contact your consultant to see if funds are still available. Each participant may be eligible to receive up to $5,000 every five (5) years for environmental modification.

6. Technology

Activity/Services	**Non-Mi Via Paid Supports**	**Unpaid Supports** **How is this being addressed?**	**Mi Via Supports**
Do you need access to the Internet?			
Do you have tools to access the Internet (phone, tablet, computer?)			
Do you need assistance using the telephone?			
Do you need access to a fax?			
Do you know how to use a fax?			
Do you need assistive supports to use the Internet (i.e. screen reader, computer)			

7. Consultant

Please answer the following questions. The answers will help you understand how much help you or your employer of record may need from your Consultant/ or others to be a successful employer.

Who is your Employer of Record? (Name, email and phone number. If you are your own EOR, write "Self."

Administrative Activities	**How will activity be fulfilled?**	**By Whom?** (Primary responsible person)
Putting your Mi Via plan into action?		
Approving timesheets		
Identifying other resources		
Processing invoices		
Managing program budget		
Finding related goods		
Recruiting and hiring staff		
Developing schedules for staff		
Training staff		
Giving feedback to staff		

Terminating staff		
Approving EVV records		
Making sure purchases are in accordance with your budget		
Encouraging good performance with staff		
Developing interview questions for staff		
Checking references		

Q34. Your consultant will be contacting you by phone monthly and will conduct twelve (12) in-person visits with you per year. Do you want more contact?

☐ Yes ☐ No

If yes, please explain.

Q35. Based on your physical or cognitive needs and preferences for the delivery of services and supports, what type and level of support will you need from your consultant?

Q36. How will I and my support team know if my Consultant support services are working well for me and meeting my identified needs and preferences for the delivery of services and supports?

Q37. Please describe the plan/agreement you have for your consultant.

8. SSP Preparation Information *(you must list at least one consultant.)*

Prepared By	Title	Date(s) of Entry

9. Backup Plan

Please print this section so that you can keep it easily available for your employees and other people who help you.
Consultants are required to offer to assist you with filling out your back up plan to ensure all information is complete and current.

1. My name is:
2. Diagnoses/Qualifying Condition:
3. MCO:
4. MCO Care Coordinator (name, phone and email):
5. Do you have a copy of your Comprehensive Needs Assessment from your MCO Care Coordinator?
6. DNR in place (if yes, where is it located?)
7. Vendor agencies chosen to provide your services (names, phone, email and location):

IF THERE IS AN EMERGENCY, PLEASE CALL 911

Q38. If regularly scheduled employees or service providers are unable to report to work, I will contact the following: *(You must list at least one alternate provider.)*

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

Relative(s) (*You must list at least one relative, or mark "n/a")*

Name	Relationship to Participant	Address, City, State, Zip	Phone	Email

Consultant: *(You must list at least one consultant.)*

Name	Address, City, State, Zip	Phone	Email

<u>Physician or Primary Care Provider</u> and Other Medical Professionals you see *(You must list at least one health care provider.)*

Name	Type of service provided	Address, City, State, Zip	Phone	Email

<u>Other people you rely on</u>

Name	Relationship to Participant	Address, City, State, Zip	Phone	Email

<u>Consultant Acknowledgement</u>

I have provided the participant with a copy of the SSP Back-Up Plan, Acknowledgement Form, and I have reviewed the form with him/her. I confirm that the participant has completed the form in its entirety. A copy of the completed form will be kept by the participant and in the consultant's file.

CONSULTANT MUST ACKNOWLEDGE

Mi Via Service and Support Plan
Emergency Back-Up Plan
Acknowledgement Form

Instructions for Consultants: Please review these questions carefully with the participant as part of the process of developing the SSP. 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 SSP cannot be submitted through Mi Via online system 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 I 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.
	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 report to my Consultant Agency within 24 hours.**
	If I am an adult (age 18 or older) and I or my guardian, caregiver, employee or anyone else believes that I am at risk of harm for abuse neglect or exploitation they should contact **Adult Protective Services (APS) at 1-866-654-3219 and report to my Consultant Agency within 24 hours.**
	I know I or my support person may also contact **Department of Health Improvement (DHI) at 1-800-445-6242** if I am receiving services from a Medicaid Waiver Provider Agency at the time of an incident.