



## Choosing Mi Via: Understanding Participant Responsibilities – Annual

I, \_\_\_\_\_

### Participant Name (Print)

choose to participate in Mi Via, the New Mexico Medicaid Self-Directed Home and Community-Based Services Waiver. I understand that my participation in Mi Via is voluntary and comes with certain responsibilities, in accordance with program regulations. I understand that I am expected to meet these responsibilities by myself, with the help of my consultant and with the help of others as needed.

As a participant and/or legal guardian of a participant in the Mi Via Waiver program:

- I/we will follow the rules and regulations that govern the Mi Via program.
- I /we will complete my annual Level of Care (LOC) by meeting in person with the Third-Party Assessor (TPA) for an annual in-home assessment as well as working with my doctor to complete the Long-Term Care Assessment Abstract (LTCAA) and have an annual history and physical. I will submit a copy of the LTCAA and history and physical to the TPA. I will seek assistance with this process, as needed, from my consultant.
- I /we will complete required documentation demonstrating medical and financial eligibility as part of the annual recertification process with Income Support Division (ISD). I will seek assistance with this process, as needed, from my consultant.
- I /we will work with my consultant to develop a Service and Support Plan (SSP), which addresses all my assessed health and safety needs and is in line with my budget and the Mi Via program regulations.
- I /we will create and update an Emergency and Backup Plan in my SSP.
- I/we will make contact with my consultant in person at least monthly for routine follow up and meet face to face with my consultant 12 times a year; at least four visits per year, one per quarter, must be conducted in my residence with my consultant.
- I /we will notify my consultant if my needs change, so that my consultant can help me to revise my SSP.  
I /we will choose who provides my services and support. I understand that all employees, providers and vendors must be enrolled with the Fiscal Management Agency (FMA) before they provide any goods or services for me.
- I/we understand that the paid provider cannot be in a romantic relationship with the participant (boyfriend/girlfriend). Per NMAC 7.1.14.1 AA "Sexual conduct engaged in by an employee with a person for whom they are providing care or services is sexual abuse per se."
- I /we will identify individuals(s) who will support/assist me in this process as needed.
- I/we will use state funds appropriately, by only requesting and purchasing goods and services that are covered by the Mi Via program and identified on my approved SSP.
- I/we will report concerns or problems with any part of my Mi Via program to my consultant or designated Department of Health or Human Services Department

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Participant/Guardian Initials \_\_\_\_\_ Date \_\_\_\_\_

contacts.

- I /we will keep track of all budget expenditures and not exceed my annual budget.
- I /we will work with my consultant to appropriately document service delivery and maintain those documents for a period of six (6) years (invoices from vendors and/or copy of timesheets, mileage sheets, and copies of signed employee and vendor agreements, receipts for goods purchases, daily progress notes, attendance logs), as evidence of services I have received.
- I /we will provide documentation and information, as requested, from my consultant, FMA, and TPA within the required timelines (i.e. guardianship orders, Power of Attorney, doctor's letter, Division of Vocational Rehabilitation (DVR), etc.).
- I /we will report to the local Income Support Division (ISD) office within ten (10) days of any change in circumstances, including a change in address, which might affect my eligibility for the program. I agree to also report changes in address or other contact information to my consultant within ten (10) days.
- I /we will submit all required documents to the FMA to meet employer-related responsibilities. This includes, but is not limited to, documents for payment to employees and vendors and payment of taxes and other financial obligations within required timelines.
- I /we will hire, manage, and terminate my employees or designate an EOR to assist with these responsibilities.
- I /we or the designated EOR understand that it is our responsibility for oversight of employees and vendor agencies service delivery.
- I /we or the designated EOR understand that the FMA will assist by paying the workers that I hire and deducting taxes from my employee's paychecks.
- I /we or the designated EOR will maintain records and documentation for at least six years from the first date of service and ongoing in accordance with 8.314.6.14.C.(5) NMAC.
- I /we or the designated EOR will report any incidents of abuse, neglect or exploitation to the Division of Health Improvement-Incident Management Bureau at 1-866-654-3219 and to my consultant.
- I /we or the designated EOR understand that failure to comply with these responsibilities or other program rules and regulations can result in involuntary termination from the program.



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I have read and understand my responsibilities as a participant in the Mi Via Waiver and have a copy of this document for my records.

\_\_\_\_\_  
Participant Signature/Date

\_\_\_\_\_  
If applicable, Legal Representative or Guardian/Date

\_\_\_\_\_  
Participant Name (Print)

\_\_\_\_\_  
Name (Print) – Legal Representative or Guardian

\_\_\_\_\_  
If applicable, Designated Employer of Record Signature/Date

\_\_\_\_\_  
Designated Employer of Record Name (Print)

\_\_\_\_\_  
HCA/DDSD Staff signature/Date

\_\_\_\_\_  
HCA/DDSD Name (Print)

**PARTICIPANT RESPONSIBILITIES are further described in 8.314.6.14 New Mexico Administrative Code (NMAC) and the Mi Via Waiver Program Manual and Service Standards.**

Participant/Guardian Initials \_\_\_\_\_<sup>3</sup> Date \_\_\_\_\_