Mi Via Service and Support Plan (SSP)

Overview of Needs, Goals, and Preferences
Q1. Home Life: What do you need, want, or hope for in your home life? How will your services and supports help you with your needs, help you reach your goals, and support the way you want to live at home? Please describe.
Q2. Work and Community Life: What do you need, want, or hope for related to work and your community? How will your services and supports help you make an informed choice about employment, meet your needs, promote your goals, and support your preferences related to work and life in your community? Please describe.
Q3. Friends and Relationships: What do you need, want, or hope for in your friends and relationships? How will your services and supports help you with your needs, help you reach your goals, and support your friends and relationships? Please describe.
Q4. Health: What do you need, want, or hope for with your health? How will your services and supports help you with your needs, help you reach your goals, and support your health? Please describe.
Q5. Strengths: What strengths do you have?
Q6. Cultural, Spiritual, and/or Religious Considerations: Do you have any cultural, spiritual, or religious preferences that feel important to share, impact your decision making, or impact the delivery of your services? Please describe.

Q7. If you 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

Q8. What disability(ies) or medical condition(s) qualifies you for the Mi Via Waiver?

SECTION 1: LIVING SUPPORTS

Q9. How can Mi Via support you to live as independently as possible in your home and community? How can Mi Via support you to complete your activities of daily living (ADLs)?

Q10. How would you like your Living Supports to be provided? Do you have any preferences about the delivery of your Living Supports?

Activities of Daily Living

Activity or Services	Non-Mi Via Paid Supports (Hours per Week)	Unpaid Supports (Hours per Week)	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				
Managing Bills				
Banking and/or Miscellaneous Finance				
Working with Vendors				
Scheduling Appointments				
Managing Other Benefits				
Exterior Supports				
Other Support Needed				
Total Hours per Week				

Briefly describe your "Other Support Needed" if you added to that row above. What other supports do you need?

Available Living Support Services

The totals should be from the above Mi Via Supports column ONLY

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

Q11. How will you and your support team know if your Living Support services are working well for you and meeting your needs and preferences?

SECTION 2: COMMUNITY PARTICIPATION, EMPLOYMENT, AND VOLUNTEERING

Q12. How do you like to spend your time? For example, preferences, activities, school, college classes, hobbies, places, people? What new things do you want to try?

Q13. Are you involved in any community activities? Such as clubs, classes, general community activities, or recreational activities in your community? Do you want to do more, less, or different activities in your community?

Q14. Are there any dislikes, barriers, environmental triggers, or things or settings you prefer to avoid when out in the community? For example, loud noises, large crowds, certain weather conditions?

Q15. Do you need transportation to participate in community, school or college, work or volunteer activities?

☐Yes ☐No

Q15.1 If "Yes" please explain:

Q16. What is your current education status?

☐ Currently Enrolled in Elementary School

☐ Currently Enrolled in Middle School

☐ Currently Enrolled in High School

☐ High School Graduate

☐ Enrolled in Trade School

☐ Trade School Graduate

☐ Enrolled in Higher Education/College, Part-time

☐ Enrolled in Higher Education/College, Full-time

☐ Higher Education/College Graduate

☐ Not Currently Enrolled in Any School

☐ Not in School but Want to Enroll in School

☐ Other, *specify:*

Employment

Q17. Are you currently employed? ☐Yes ☐No ☐I am retired

If "Yes" you are currently employed, answer questions 18 – 25 and question 35. Then, move to the Volunteering section.

If "No" you are not currently employed, skip questions 18 – 25, and answer questions 26 – 35.

If you select "I am retired" skip questions 18 – 35 and move on to the Volunteering section.

Q18. Type of employment: ☐ Employed in the community ☐ Self-employed
☐ Other, *specify:*

Q19. Who is your employer:

Q20. What is your job title:

Q21. How is your job? What do you like or not like about your job? How many hours per week you work.

Q22. How do you get to and from work?

Q23. Do you have any employment supports? ☐Yes ☐No

Q23.1 If "Yes", you do have employment supports, what is it like working with them? Please describe:

Q24. What other jobs might you be interested in, if any:

Q25. Do you want to explore other job opportunities or support for career advancement? ☐Yes ☐No

Q26. Which option best describes your thoughts or feelings about having a job/working:
☐ I do not have a job, but I want to have a job
☐ I do not have a job, and I am unsure whether or not I want to have a job
☐ I do not have a job, and I am not interested in working or having a job at this time

Q27. What's your biggest question about working or having a job?

Q28. Imagine yourself working. What would you be doing?

Q29. What worries you about getting a job?

Q30. What's the best thing that can happen if you get a job?

Q31. What strengths, skills, or interests do you have that you could use at a job:

Q32. Do you have any barriers to working or getting a job?

Q33. Do problems with transportation affect your ability to work?
☐ Yes ☐ No

Q34. Are you interested in supports for getting and keeping a job?
☐Yes ☐ No

Q35. Are you currently working with the New Mexico Department of Vocational Rehabilitation (NM DVR)?
☐Yes ☐No

Q35.1 If "Yes" you are currently working with the NM DVR, please describe:

Volunteering

Q36. Do you currently volunteer? ☐Yes ☐No

If "Yes" you currently volunteer, answer questions 37 – 40 below.

If "No" you do not currently volunteered skip questions 37 – 40.

Q37. Where do you volunteer:

Q38. What are your volunteer duties:

Q39. What do you like about volunteering:

Q40. Where are other places you have volunteered:

Community Membership Support Services				
Activity or Services	**Non-Mi Via Paid Supports (Hours per Week)**	**Unpaid Supports (Hours per Week)**	**Mi Via Supports (Hours per Week)**	**Total Hours (Hours per Week)**
Employment				
Volunteering				
Educational				
Leisure/Recreational				
Building Relationships				
Translator/Interpreter				
Other Support Needed				
Total Hours per Week				

Briefly describe your "Other Support Needed" if you added to that row above. What other supports do you need?

Available Community Membership Services *(Totals should be from Mi Via column ONLY from above)*	
Community Membership Support Service	**Hours per Week**
Community Direct Support	
Employment Supports	
Customized Community Group Supports	
Total Hours per Week	

Q41. How will you and your support team know if your Community Membership Support services are working well for you and meeting your needs and preferences?

SECTION 3: HEALTH AND WELLNESS SUPPORTS

Safety and Risk Assessment

- *If you currently have or are susceptible to the risk described in the "Risk" column, check "Yes" in the "Risk Present" column.*
- *If this risk is not present in your life or you do not experience this risk, check "No" in the "Risk Present" column.*
- *If you have a history of the risk, check "History" in the "Risk Present" column.*

Risk	Risk Present	Description of Risk and/or Follow-up *(if "Yes" or "History" is marked)*
Overall 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	
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 I need intravenous (IV) fluids due to dehydration in the past year).	☐Yes ☐No ☐History	
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	
4. Constipation: I am at risk of constipation. (I take bowel medications routinely or more than twice a month within the past year, have required a suppository or enema for constipation within the past year, or routinely use food or diet to take a bowel movement.)	☐Yes ☐No ☐History	
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	
6. Complications of Diabetes: I have been diagnosed with prediabetes or diabetes and want help managing this issue.	☐Yes ☐No ☐History	

7. 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	
8. 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	
9. Injury Due to Falling: I want support to avoid an injury due to falling. Have you suffered any falls or accidents that have resulted in hospitalization in the last 12 months? (Consider risk due to mobility or transfer support needs.)	☐Yes ☐No ☐History	
10. Respiration: I need help managing breathing issues, asthma, oxygen consumption, or other respiratory concerns.	☐Yes ☐No ☐History	
11. Allergies and Intolerances: I have allergies or intolerances, and I want help avoiding or managing my exposure to these allergens and intolerant things (What are you allergic or intolerant to, what happens when you are exposed to these things.)	☐Yes ☐No ☐History	
12. Other Serious Health or Medical Issues: I want help with a health issue that was not listed above. List specific additional risks (if any).	☐Yes ☐No ☐History	
Mental Health		
13. I want support managing or coping with my mental health. (Consider all mental health areas including past trauma, depression, anxiety disorder, addiction, mood disorders, suicide ideation, etc.)	☐Yes ☐No ☐History	
14. Do you have any mental health diagnoses? If “Yes” or “History”, what are/were they and how is your mental health being managed?	☐Yes ☐No ☐History	
Substance Use		
15. I want help managing my substance use (i.e. drugs or alcohol. Have you tried to cut down using substances but failed?)	☐Yes ☐No ☐History	
Behaviors		

16. Do you have any behaviors that you don't understand, make you uncomfortable, or cause a risk to yourself or others? If "Yes", how are these being addressed?	☐Yes ☐No ☐History	
Overall Safety		
17. Fire Evacuation Safety: I need assistance to evacuate when a fire or smoke alarm sounds.	☐Yes ☐No ☐History	
18. Household Chemical Safety: I want support to avoid any serious injury from household chemicals.	☐Yes ☐No ☐History	
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	
20. 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	
21. Other Safety Issues: Consider any other important, serious safety issues at home or in any other setting that you want help with (workplace, in your community, etc.)	☐Yes ☐No ☐History	
Personal Safety and Finances		
22. Court Involvement: Do you have any court orders in place (such as protective orders or restraining orders to keep you safe) or current court involvement?	☐Yes ☐No ☐History	
23. Abuse, Neglect, and Exploitation (ANE): In your opinion (opinion of the waiver recipient), have you been abused, neglected or exploited in the last 12 months? If "Yes" or "History" How was this situation handled? Was a safety plan put in place?	☐Yes ☐No ☐History	
24. Potential for Financial Abuse: Do you have someone that manages your money? If "Yes", who? Does this person have legal authority to assist you?	☐Yes ☐No ☐History	
25. Potential for Financial Abuse: Are you included in your financial decisions?	☐Yes ☐No ☐History	

26. Abuse, Neglect, and Exploitation (ANE): Do you want or need training on abuse, neglect, or exploitation (ANE)?	☐Yes ☐No ☐History	
Determinants of Health		
27. Housing: Within the past 12 months, have you ever stayed: outside, in a car or tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing), or been unable to get utilities (heat, electricity) when it was really needed?	☐Yes ☐No ☐History	
28. Food: Within the past 12 months, did you worry that your food would run out before you got money to buy more?	☐Yes ☐No ☐History	

Name of Contributor(s) to Safety and Risk Assessment	Title / Relationship
	Person receiving services
Date of last Safety/Risk Assessment update:	

Health and Wellness Supports

Q42. Do you have a need for Durable Medical Equipment? If you do need Durable Medical Equipment, what Durable Medical Equipment do you need?

Q43. Has a health professional recommended a special nutritional plan, special diet, and/or nutritional supplement for you?

☐Yes ☐No

Q43.1 If "Yes", explain what that plan is and what it says:

Q44. Do you need reminders to eat or to be physically active?

☐ Yes, I need reminders to eat

☐ Yes, I need reminders to be physically active

☐ Yes, I need both reminders to eat and to be physically active

☐ No, I do not need reminders to eat or to be physically active

Q44.1 If “Yes”, explain what those reminders are and how often you need them:

Q45. What health and wellness supports do you plan to access, or are you already accessing through your Managed Care Organization (MCO)? Do you have health and wellness needs that are not covered by your MCO? Please explain:

Q46. What other health or safety concerns do you have that have not been addressed?

Skilled Services

Q47. Do you need the services of a licensed nurse, therapist, and/or nutritional counselor?
☐Yes ☐No

Q47.1 If “Yes”, explain what for:

Q48. Do you have a need for any other specialized service(s) to address your health and wellness needs?
☐Yes ☐No

Q48.1 If “Yes”, explain what for:

Other Health and Wellness Support Needed

Activity or Services	Non-Mi Via Paid Supports (Hours per Week)	Unpaid Supports (Hours per Week)	Mi Via Supports (Hours per Week)	Total Hours (Hours per Week)
OT for Adults				
PT for Adults				
SLP for Adults				
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				

Briefly describe your "Other Support Needed" if you added to that row above. What other supports do you need?

Q49. How will you and your support team know if your Health and Wellness Support services are working well for you and meeting your needs and preferences?

Rights, Decision-Making, and Safety in Settings

50. Do you have a Do Not Resuscitate (DNR) order, Advanced Directive, and/or Medical Power of Attorney in place?

☐ DNR ☐ Medical Power of Attorney ☐ Advanced Directive ☐ I have none of these

50.1 Where is each located:

51. Do you have a Surrogate Health Decision Maker (if you have a guardian, and your guardian can make medical decisions on your behalf, then they are your Surrogate Health Decision Maker)? ☐ Yes ☐ No

51.1 If “Yes” list their name and relation to waiver recipient. Also include type of guardianship: Full, Limited, or Joint.

52. Do you have a Supported Decision Maker/a Supported Decision-Making Agreement?
☐ Yes ☐ No

52.1 If “Yes” list the Supported Decision Maker’s name and relation to waiver recipient:

53. Do you want more information about DNRs, Advanced Directive, and/or Medical Power of Attorney (POA)? ☐ Yes ☐ No

53.1 If “Yes”, what information do you want:

Q54. Do you have a key to your home? ☐Yes ☐No

Q54.1 If “No” please explain:

Q55. Does your bedroom have a lock? ☐Yes ☐No

Q55.1 If “No” please explain:

Q56. Does your bathroom have a lock? ☐Yes ☐No

Q56.1 If “No” please explain:

Q57. Are there one or more cameras installed inside the home? ☐Yes ☐No

Q57.1, If “Yes” please explain the number of camera(s), what room(s) have camera(s), and why there are one or more cameras in the home:

Q58. Are there any privacy restrictions within your living conditions? What privacy restrictions are there, if any, and why are these restrictions in place?
Q59. Are there any considerations that impact your home environment? What things, if any, affect your home environment or how you get around your home?

SECTION 4: OTHER SUPPORTS

Activity or Services	Non-Mi Via Paid Supports	Unpaid Supports	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:
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:

Q60. How will you and your support team know if each of the support services (transportation, transportation carrier pass, emergency response services, and respite care) are working well for you and meeting your needs and preferences?

SECTION 5: RELATED GOODS

Q61. Do you need any related goods? ☐ Yes ☐ No
If "Yes", complete the table below.

What Related Good do you need?	What is the estimated cost?	How does this relate to your needs or preferred way of getting support?

SECTION 6: ENVIRONMENTAL MODIFICATIONS

Q62. 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?
☐Yes ☐No

If "Yes", provide the following: ***(*Indicated items will be subject to review / approval*)***

Item/Modification	Date Completed	Cost	Paid By	Contractor

Total Cost of all Environmental Modifications to Date:

Q63. Are there any environmental modifications covered under Mi Via that you need?
☐Yes ☐No

Q63.1 If “Yes”, please explain:

SECTION 7: TECHNOLOGY

Q64. Do you have reliable access to the Internet? ☐Yes ☐No

Q65. Do you have devices to access the internet (for example, phone, tablet, computer, etc.)? ☐Yes ☐No

Q66. Are you familiar with using technology? In what ways? Briefly describe:

Q67. Do you need assistance to use the Internet (i.e. screen reader, computer)?
☐Yes ☐No

Q67.1 If “Yes” briefly describe what support do you need to use the Internet:

Q68. Are you using Mi Via services to access technology or help you use technology?
☐Yes ☐No

Q68.1 If “Yes”, how do your Mi Via services help you access or use technology:

Q69. Do any paid or unpaid non-Mi Via services help you access technology or help you use technology? ☐Yes ☐No

SECTION 8: EOR QUESTIONNAIRE

Q70. Do you want to be your own EOR? ☐Yes ☐No

Q71. Are you a minor? ☐Yes ☐No

Q72. Do you have a plenary or limited guardianship or conservatorship over financial matters in place? ☐Yes ☐No

Q73. Do you have power of attorney (POA) over financial matters in place? ☐Yes ☐No

If you are interested in being your own EOR, answer all of the questions below.
If you are a minor (under the age of 18), if you have a plenary or limited guardianship or conservatorship over financial matters in place, or if you have a financial POA, skip questions 74 through 82, and go to question 83 below and specify who your EOR is.

Q74. Do you need assistance arranging for the delivery of services, supports and goods as approved in the Service and Support Plan (SSP)? ☐Yes ☐No

Q74.1 If "Yes", explain/ what assistance is needed:

Q75. Do you need assistance orienting, training, and directing employees in providing the services that are described and authorized in the participant's SSP? ☐Yes ☐No

Q75.1 If "Yes", explain/ what assistance is needed:

Q76. Do you need assistance to establish a schedule for employees' services in writing and/or provide fair notice of changes in the employee's work schedule in the event of unforeseen circumstances or emergencies? ☐Yes ☐No

Q76.1 If "Yes", explain/ what assistance is needed:

Q77. Do you need assistance to submit all required documents to the Fiscal Management Agent (FMA) according to the timelines and rules established by the State. Documents include, but are not limited to, vendor and employee agreements, vendor information forms, criminal background check forms, time-sheets via the Mi Via online system, payment request forms 6 (PRFs) and invoices, updated employee information, and other documentation needed by the FMA to process payment to employees and vendors?
☐Yes ☐No

Q77.1 If "Yes", explain/ what assistance is needed:

Q78. Do you need assistance to tell an employee that they may not begin work until all materials necessary for a criminal background check have been received by FMA and the employee has successfully passed the Consolidated Online Registry (COR) Background Check? ☐Yes ☐No

Q78.1 If “Yes”, explain/ what assistance is needed:

Q79. Do you need assistance to review and approve employee timesheets and Request of Payment forms in order to pay employees and vendors? ☐Yes ☐No

Q79.1 If “Yes”, explain/ what assistance is needed:

Q80. Do you need assistance to maintain employee and service records and documentation in accordance with Mi Via Self-Directed Waiver rules and Federal and State employment rules? ☐Yes ☐No

Q80.1 If “Yes”, explain/ what assistance is needed:

Q81. Do you need assistance using a computer? ☐Yes ☐No

Q81.1 If “Yes”, explain/ what assistance is needed:

Q82. Based on the responses above, would the participant be conducting the functions of the Employer of Record (EOR)? ☐Yes ☐No

Q83. Who is your Employer of Record (EOR)? List below.

EOR Name:

EOR Email:

EOR Phone Number:

SECTION 9: CONSULTANT SERVICES

Q84. Does the Employer of Record (EOR) know how to perform all EOR duties? EOR duties include but are not limited to 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 within your budget, encouraging good performance with staff, developing interview questions for staff, and checking references?

☐Yes ☐No

Q84.1 If “No” briefly describe the EOR’s plan to familiarize themselves with EOR duties.
Q85. Your consultant will contact you by phone monthly and will have twelve (12) in-person visits with you per year. Do you want more contact from your consultant? ☐Yes ☐No **Q85.1** If “Yes”, please explain why you prefer more contact from your consultant:
Q86. How will you and your support team know if the consultant services are helping you and being provided in the way you prefer?
Q87. Describe how much support you need from your consultant.

SECTION 10: SSP PREPARATION INFORMATION

Prepared by	Title	Date(s) of Entry

SECTION 11: EMERGENCY BACKUP PLAN

IF THERE IS AN EMERGENCY, CALL 911

My name is:
Diagnoses/Conditions:
Managed Care Organization (MCO):
MCO Care Coordinator (name, phone and email):
Do you have a copy of your Comprehensive Needs Assessment from your MCO Care Coordinator? ☐ Yes ☐ No ☐ Not applicable because I do not have an MCO Care Coordinator
Do you have a Do Not Resuscitate (DNR) order in place? ☐ Yes ☐ No If "Yes", where is your DNR located:
Vendor agencies chosen to provide your services (names, phone, email and location):

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

Service	Name	Address, City, State, Zip	Times Available	Phone	Vendor Agency

Relative(s)

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

Consultant:

Name	Address, City, State, Zip	Phone	Email

In-Home Living Provider:

Agency Name	Address, City, State, Zip	Phone	Email

Physician or Primary Care Provider and Other Medical Professionals You See:

Name	Type of Service Provided	Address, City, State, Zip	Phone	Email

Other People You Rely On:

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

Consultant Acknowledgement

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

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.

The SSP cannot be submitted through the Mi Via online system until you have checked the online acknowledgement box that confirms 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 the **Division of Health Improvement (DHI) Incident Management Bureau 12-hour Reporting Hotline at 800-445-6242** if I am receiving services from a Medicaid Waiver Provider Agency at the time of an incident.