Consumer Support Grant Expenditure Plan

Date:	
	Date of Birth:
Participant Name:	**PMI #:**
Participant Address:	
Case Manager, if applicable:	**Phone:**
Parent/Legal Representative:	
Phone:	**Email:**
Financial Management Service:	
Contact:	
Phone:	**Email:**
Grant Period: to	
Monthly Grant Amount: $	
Annual Grant Amount: $	
5% County Administration Fee: $	
Annual Grant Amount Less County Admin Fee: $	**(*carry to other side*)**
Date of Health & Safety Plan:	
Date of Community Support Plan:	

All services and items purchased with the Consumer Support Grant must meet all of the following criteria:

1. **Be over and above the normal cost of caring for the person if they did not have functional limitations.**
2. **Be directly attributable to the person's functional limitations.**
3. **Prevent out-of-home placement of the person.**
4. **Be consistent with the needs identified in the client's service or case plan, when applicable.**
5. **Support the person's health, safety, and general well-being.**
6. **Fall within the customary range for similar supports, goods, or services and represent a cost-effective strategy for meeting needs.**
7. **The costs for providing the services must be usual and customary designed to meet the individual's needs.**
8. **It must be justifiable to the taxpayer and to the funding source.**
9. **All services must meet needs identified in the Health and Safety Plan.**

Identified Support Needs

Financial Management Service Allowable Annual Grant Amount: $

Service Category	Unit	Rate	# of Units	Total Cost
INFORMAL SUPPORT				
		$		**$**
		$		**$**
		$		**$**
		$		**$**
			INFORMAL SUPPORT TOTAL:	**$**
FORMAL SUPPORT				
		$		**$**
		$		**$**
		$		**$**
		$		**$**
			FORMAL SUPPORT TOTAL:	**$**
SERVICES & GOODS				
		$		**$**
		$		**$**
		$		**$**
		$		**$**
			SERVICES & GOODS TOTAL:	**$**
OTHER				
FMS Fees		**$**		**$**
Payroll Withholdings		**$**		**$**
PTO Fees		**$**		**$**
Support Planner (If Applicable)		**$**		**$**
			OTHER TOTAL:	**$**

ANNUAL TOTAL OF ALL CATEGORIES: $_________________

SIGNATURES

I understand that this is the plan in effect unless and until any proposed changes are approved.

Participant/Legal Representative:	**Date:**
Case Manager or HHS Consumer Support Grant Review Team:	**Date:**