



CONSUMER SUPPORT GRANT NARRATIVE PLAN

PARTICIPANT NAME: _____

DATE: _____ to _____

Identify and explain the purpose of the support, generic services and goods the participant (their legal representative) plans to purchase. Purpose must relate to the disability/health condition of the participant.

1. INFORMAL SUPPORT (paid parent staffing, support staff, caregiver relief, related expenses - mileage, training, etc.)

2. FORMAL SUPPORT (agencies, companies, organizations)

3. SERVICES AND GOODS (services available to the general public used for a disability/condition specific reason)

4. OTHER: You are required to use a **Financial Management Service (FMS)** to manage the Consumer Support Grant funds. There will be **FMS Fees** for using these services. The cost of the Financial Management Service (FMS Fees) will need to be included in the Consumer Support Grant budget. If applicable, the Financial Management Service will assist you in paying your providers, assist with **Payroll withholding** responsibilities you may have as an employer, assist with **PTO fees**. If applicable, the Financial Management Service will assist with payment of goods/services. Please list your Financial Management Service Provider here. If you are utilizing **Support Planner** Services, please list that here as well.

Participant/Guardian Signature

Date

Case Manager or CSG Review Team Signature

Date