



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 (support staff, caregiver relief, related expenses – mileage, training, etc.)

Paid Parent of Minor – Job Description

1. Will provide assistance to (Name) with his/ her daily schedule.
2. Will help (Name) with hand over hand assistance with personal care routine
3. Will assists when fine motor tasks are a struggle for (Name)
4. Will assist (Name) with follow up after toileting to assure proper cleanliness
5. Will provide continuous supervision and redirection
6. When behaviors are loud or destructive, immediate redirection and support is provided
7. Available to respond to medical needs – (Name) has a weaker immune system than typical children his/her age, so someone knowledgeable of his/her needs is necessary.

These responsibilities are above and beyond duties and tasks for a child of his/her age.

Name of Staff	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

2. FORMAL SUPPORT (agencies, companies, organizations)

West Metro Learning Connections – Sessions, Classes and their description and type of support to individual. Goals and skills being worked on.

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

Music Therapy – Alternative Treatment Form signed by Physician Needed -

Participation in Music Therapy will achieve

- 1) cognition, reasoning, and attention
- 2) Gross & Fine motor skills development
- 3) pain and behavior management
- 4) sensory processing planning and acuity
- 5) speech and language skills

Daily Supplements – Alternative Treatment Form signed by Physician Needed –

Supplements as recommended by (Name's) GI specialist and primary doctor to aid in his/her digestive health and improving his/her overall health and wellness.

Supplements include but are not limited to Omega 3 and Probiotics

Sensory Items – OT/PT letter of recommendation needed and list of items

Sensory items will be purchased for calming and finger dexterity. Recommendations will be sought from therapists and schools specialists identified.

4. FMS FEE – PAYROLL

<https://mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/programs-and-services/fms.jsp>

Depends on the Financial Management Service used. Consult with them for details.

PTO, Taxes, and any fees for goods and services

Support Planner and rate – typically 2-3 hours needed for development of plan.

Participant/Parent/Guardian Signature

Date

Case Manager or Review Team Signature

Date