Handout #17

CONSUMER-DIRECTED CARE PLUS Purchasing Plan (Version 3.0-B)

CDC+ Consumer-Directed Care Plus

Purchasing Plan Effective Date:	11/1/2010	Monthly Budget:	$ 2,482.31	APD Area:	3	Participant is on FFI: Yes [ ] No [X]

A. PARTICIPANT INFORMATION

Participant Name: First	M	Last	Participant ID #:	Participant's AGE:	23
Johnny		Sample	0011111		Official Use Only
Representative Name: First	M	Last	Phone #:	Cell #:	
Josephine		Sample	XXX-XXX-XXXX	XXX-XXX-XXXX	

REASON FOR SUBMITTING PURCHASING PLAN (TO BE COMPLETED BY CONSULTANT after Participant completes areas with *):

- [ ] New Start (This is the Participant's first Purchasing Plan .)
  - [ ] Budget Authorization Form is attached (Required)
  - [ ] Budget has changed from what was on the Application to _____ due to [ ] SP/CP Update or [ ] recalculation.
  - [ ] Add One Time Expenditure amount of up to 100% of what was approved in the Cost Plan: _____ Item must be entered in Section F with same effective date as this Purchasing Plan.
  - [ ] Add Short Term Expenditure amount not to exceed 92% of what was approved in the Cost Plan _____ Item must be entered in Section F with same effective date as this Purchasing Plan.
- [ ] Purchasing Plan **CHANGE** (This Purchasing Plan reflects a change in budget and/or addition of OTE/STE based on updated Support Plan and amended Cost Plan.)
  - [ ] Change Monthly Budget Amount to _____.
  - [ ] Add One Time Expenditure amount of up to 100% of what was approved in the Cost Plan: _____ Item must be entered in Section F with same effective date as this Purchasing Plan.
  - [ ] Add Short Term Expenditure amount not to exceed 92% of what was approved in the Cost Plan _____ Item must be entered in Section F with same effective date as this Purchasing Plan.
- [X] Purchasing Plan **UPDATE** (No Change in Budget Amount and no new OTE or STE.)
  - * [X] Revisions have been made on page(s): 2, 4
- [ ] Participant selected a new Representative effective _____. [ ] Participant Information Update form to change Representative is attached. (Required)
  - [ ] New Representative used work for participant -- has been removed from this Plan.
  - [ ] Former Representative is starting to work for participant -- is added to this Plan.
- * [X] Provider Packets for all new providers are attached, as shown below:
  - * 2 Employee packets for Employee #1, Employee #2
  - * 1 Vendor/IC packets for Isabel Independent Contractor, Gulf Coast Dental
- * [ ] Indicate below the names of your providers who will no longer be used:
  - * _____
  - * _____
  - * _____
- * [X] Total Number of Purchasing Plan Pages: 6

(Please number each page of your Purchasing Plan.)

PLEASE COMPLETE. REQUIRED FOR PROCESSING.

Con Initial — Consultant Initial

XXX-XXXX — How can we reach you if we have any questions? Enter phone/email.

Ai — Area Liaison Initial

XXX-XXXX — Phone Number

Confirms reason for submission; budget, OTE and STE calculations; and receipt/review/correctness of all required attachments.

KEY: FFI=Florida Freedom Initiative

Participant: Johnny Sample Effective Date of Plan: 11/1/2010

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B. NEEDS (To be completed by consultant and participant together. Consultant must give participant a copy of Support Plan and Cost Plan.)

1. The following needs/goals were identified on the participant's Support Plan dated 09/01/10 Enter updated SP date here:	2. The following services/supports, and units/frequency were funded as medically necessary on the Cost Plan. Indicate services that are time limited other than by CP.	3. List comparable units/frequency of CDC+ services and supports that will be provided to meet needs/goals (Col. 1). Indicate services that are OTEs or STES; provide dates.
Assistance with bathing, dressing, meal prep, daily living activities	8640 QH annually, 720 QH monthly, 180 Hr monthly	114 Hr PCA monthly, (66Hr to be provided as unpaid natural support each month)
Care is needed when primary caregivers are unavailable	1464 QH annually, 122 QH monthlyl, 30.5 Hr monthly	RESPITE will be provided by natural support until negative balance is reduced to 00.00
To maintain good oral hygeine	not funded	Savings - 2 annual cleanings, xrays, 2 fillings
3 boxes diapers, 2 boxes wipes	not funded	CASH - CMS
Being independent in learning to navigate my community without someone always going with me	not funded	CASH - TRAN monthly Bus pass
Gluten free products are needed to maintain health	not funded	CASH - NUTR(Gluten Free Bread)

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C.1 Budget Detail - SERVICES

Use as many pages as you need to list all your regular monthly providers and, if they are critical, their backup providers directly underneath them on the same page.

Service	Svc Code	Critical Y/N; If Y, next min. 2 must be EBU*	Provider	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit (Hr., Day, Trip)	Rate	Sub-Total	Employer Taxes	Total Cost	Total Monthly Cost	EBU Added Cost
PCA	32	Y	Employee #1	DHE	5	108	Hr.	$ 10.00	$ 1,080.00	$ 120.42	$ 1,200.42	$ 1,200.42	
PCA	32	EBU	Employee #2	DHE	5	108	Hr.	$ 10.00	$ 1,080.00	$ 120.42	$ 1,200.42	$ -	
PCA	32	EBU	Isabel Independent Contractor	IC	5	108	Hr.	$ 10.00	$ 1,080.00	$ -	$ 1,080.00	$ -	
PCA	32	Y	Employee #2	DHE	5	72	Hr.	$ 10.00	$ 720.00	$ 80.28	$ 800.28	$ 800.28	
PCA	32	EBU	Employee #1	DHE	5	72	Hr.	$ 10.00	$ 720.00	$ 80.28	$ 800.28	$ -	
PCA	32	EBU	Isabel Independent Contractor	IC	5	72	Hr.	$ 10.00	$ 720.00	$ -	$ 720.00	$ -	
RSPH	46	N	Isabel Independent Contractor	IC	5	30	Hr.	$ 9.00	$ 270.00	$ -	$ 270.00	$ 270.00	
									$ -	$ -	$ -	$ -	
									$ -	$ -	$ -	$ -	
									$ -	$ -	$ -	$ -	
									$ -	$ -	$ -	$ -	

Note: At least 2 EBU providers must be listed immediately under each critical service provider. **Page 2 C.1 Total:** $ 2,270.70 $ -

C.2 Budget Detail - SUPPLIES

Service	Svc Code	Provider	Detailed Description	# of Units	Unit	Rate	Total Cost
							$ -
							$ -
							$ -
							$ -
						Page 2 C.2 Total:	$ -

If you need additional space to list your providers in sections C1 and C2, please use Page 2A. **Check if you use 2A:**

* EBU=Emergency Backup; DHE=Directly Hired Employee; A/V=Agency/Vendor;IC=Independent Contractor; *Parent=1; **PARTICIPANT'S** Child under 21=2; Spouse=3; Person under 18=4; All Others=5

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D. Budget Detail - Purchases to be made with CASH

Service Category	Service Code	Detailed Description of Each Item to be Purchased (Required)	# of Units	Unit Type	Rate	Total Cost
CMS	63	2 boxes of wipes @ 12.50 ea, 3 boxes adult large diapers @ 15.00 ea,	1	ea	$ 70.72	$ 70.72
TRANS	60	Monthly Bus pass	1	ea	$ 20.00	$ 20.00
NUTR	66	Gluten Free bread	2	ea	$ 4.64	$ 9.28
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
						$ -
		You will receive a check for this amount each month to make ONLY the above purchases:				$ 100.00

Explain below how purchases requested in Section E meet your needs/goals, or increase your independence. Use the section below also to provide information APD should know in order to assist with their approval of this Purchasing Plan.

2 cleaning annually, x-rays and two fillings are needed to maintain good oral hygeine. 3 visits @ $200.00

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E. SAVINGS PLAN - Authorizations for use of Accumulated, Unrestricted Funds

Unexpended Balance on [ ] Stmt is: [ ] Total Amount of Unrestricted Funds Available: [ ] Unrestricted funds made available for these purchases each month: $ 111.61

Item/Service Description	Svc Code	Provider	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Estimated Cost	Last Date Purchase Will be Made	Actual Date Purchase was Made or Completed
Funds always reserved for Emergency Back Ups										$ -		
DENTAL	03	Gulf Coast Dental	A/V		3	Item	$ 200.00	$ 600.00	$ -	$ 600.00	10/31/11	
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		
								$ -	$ -	$ -		

F. Budget Detail - One Time and Short Term Expenditures

OTE/ STE	Item/Service Description	Svc Code	Provider	Provider Type	DHE Provider's Relationship to Participant*	# of Units	Unit	Rate	Sub-Total	Employer Taxes	Total Budget	Start Date	End Date
									$ -	$ -	$ -		
									$ -	$ -	$ -		
									$ -	$ -	$ -		
									$ -	$ -	$ -		

Any items entered in Section F must meet the definition of either a One Time Expenditure (OTE) or a Short Term Expenditure (STE), as specified on the CDC+ Service Code Chart. The **Start Date** must be the same as the Effective Date of the Purchasing Plan on which it is first entered, and services cannot be purchased prior to that date. An **End Date** must also be entered. The funds for items listed in this section are transferred to your account **in addition to** your monthly budget for the month the Purchasing Plan on which they are first listed is effective. Funds for STEs must be used to purchase **AT LEAST 92%** of the quantity of services approved on your DD/HCBS Cost Plan. Funds for OTEs and STEs not used in the time frame specified in this section of the Purchasing Plan will be returned to Medicaid.

* DHE = Directly Hired Employee, A/V = Agency/Vendor, IC = Independent Contractor; *Parent = 1, **PARTICIPANT'S** Child Under 21 = 2, Spouse = 3, Person Under 18 = 4, All Others = 5

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Budget Summary

This page summarizes the expenditures detailed on the previous pages of the Purchasing Plan.

	Authorized Budget Amount:	$ 2,482.31
Planned Expenditures:		
C. Services/Supplies	$ 2,270.70	
D. Cash	$ 100.00	
E. Savings Plan	$ 111.61	
NOTE: If the amount going into the Savings Plan each month is a negative number, you have done something wrong. It must be a positive number.	**Total Monthly Expenditures:**	$ 2,482.31
		This must equal the Authorized Budget Amount.

SIGNATURES (This page must always be newly signed and dated by all three required signers.)

Participant or CDC+ Representative	Consultant	Area 3 CDC+ Liaison
Josephine Sample	Consultant Signature	Area Liaison Signature
Signature	*Signature*	*Signature*
Josephine Sample	Consultant Name	Area Liaison NAME
Print Name	*Print Name*	*Print Name*
9/3/10	9/10/10	9/18/10
Date Signed	*Date Signed*	*Date Signed*
By signing this document, you are saying you developed this Purchasing Plan, that it meets the needs and goals specified on your Waiver Support Plan, and that the paperwork for all providers on the Plan has been submitted to APD for processing.	By signing this document, you are saying you did not write this Purchasing Plan, although you may have typed it for the participant, that you agree the Plan meets the participant's needs and goals, and that the Plan meets the requirements of the program.	Your signature means the Plan is **approved**: the monthly budget and funding for OTEs and STEs is correct, the quantity of restricted services is correct, and all purchase authorizations meet the participant's needs/goals, or foster his/her independence.