HART-SUPPORTED LIVING PLAN

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **RECIPIENT INFORMATION** | | | | |
| FIRST NAME: | | | LAST NAME: | |
| ADDRESS: | CITY: | | | ZIP CODE: |
| PERSON RESPONSIBLE (IF APPLICABLE): | | | | |
| TELEPHONE NUMBER: | | | | |
| FISCAL YEAR: | | EFFECTIVE DATE: | | |
| ORIGINAL HSL PLAN:  (check here) | | PLAN AMENDMENT:  (check here) | | |
| THIS PLAN IS APPROVED FOR:  ONGOING  ONE-TIME (check both if applicable) | | | | |
| DISABILITY: | | | | |

As a grant recipient, you are approved UP TO the amount listed in column “E”. If you do not utilize your approved allocation for the FY of funding, these funds may be reallocated to other HSL applicants. Plan amendments should be reserved for unforeseeable life circumstances that necessitate the transfer of funds between already approved supports and services. New or Additional supports should be requested using a new application.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| \*\*APPROVED Ongoing  Support or Service and Description | PROVIDER OF SUPPORT  (Agency  or  Individual) | A  Hours per Week Service Provided | B  Hourly Pay Rate | C  Average  Cost per  Week  (A X B) | D  Average  Cost per Month (E÷12) | E  \*\*APPROVED  Annual  Budget per  Fiscal Year  (C X 52) |
| 1**.** |  |  |  |  |  |  |
| DESCRIPTION: | | | | | | |
| 2. |  |  |  |  |  |  |
| DESCRIPTION: | | | | | | |
| 3. |  |  |  |  |  |  |
| DESCRIPTION: | | | | | | |
| 4. |  |  |  |  |  |  |
| DESCRIPTION: | | | | | | |
| Total Annual Budget, this page |  |  |  |  |  |  |
| Total Annual Budget from page 2 (if any) |  |  |  |  |  |  |
| **TOTAL ANNUAL ON-GOING BUDGET** |  |  |  |  |  |  |

HART-SUPPORTED LIVING PLAN

ONE-TIME SUPPORTS

|  |  |  |
| --- | --- | --- |
| \*\*APPROVED One-Time Support and Description . | PROVIDER OF ONE-TIME SUPPORT  Contractor or Vendor | APPROVED BUDGET AMOUNT  Expenses per estimate\*  \*Estimate obtained (three if possible) and approved and made part of plan |
| 1**.** |  |  |
| DESCRIPTION: | | |
| **2.** |  |  |
| DESCRIPTION: | | |
| **3.** |  |  |
| DESCRIPTION: | | |
| 4**.** |  |  |
| DESCRIPTION: | | |
| TOTAL ONE-TIME EXPENSE  (Add totals from page 2, if any) |  |  |
| TOTAL PLAN: Total Annual On-Going PLUS Total One-Time Expenses |  |  |

\*\*ANY desired changes to your supported living plan MUST first be requested using the DAIL-HSL-03 Plan Amendment form.

**HART-SUPPORTED LIVING PLAN**

(Regulatory requirements in *italics*)

By initialing and signing below, the recipient and the family or individual responsible for implementing the plan indicates an understanding of the following:

1. \_\_\_\_\_\_\_ **(Recipient Initials):** Hart-Supported Living regulations require the following of the recipient:

1. *Participate in the development of a supported living plan in coordination with the Hart- Supported Living Coordinator;*
2. *Adhere to the supported living plan and request a plan amendment for a desired change.* Any desired change(s) to your supported living plan MUST first be requested using the Request for Plan Amendment. Plan amendments should be reserved for unforeseeable life circumstances that necessitate the transfer of funds between already approved supports and services in your plan. New or Additional supports should be requested using a new application.
3. *Negotiate the services to be provided by a service- providing agency or an individual who provides services as an employee or independent contractor.*

2.\_\_\_\_\_\_\_ **(Recipient Initials):**Hart-Supported Living regulations require the following of a recipient who is an employer:

1. *Be responsible for the computation, payment and reporting of payroll, withholdings, workers’ compensation, unemployment and actual payment of required withholdings, workers’ compensation and taxes;*
2. *Establish terms of employment for an employee, to include time, duties, and responsibilities. This shall be in the form of a signed agreement;*
3. *Establish terms of employment for an independent contractor to include services to be provided and compensation. This shall be in the form of a signed agreement.*

3. \_\_\_\_\_\_\_ **(Recipient Initials):** It is the responsibility of the family or individual to recruit and hire individuals with an acceptable background and to ensure that necessary training in areas pertinent to the individual is provided. An employee who transports a person receiving Hart-Supported Living must have a valid driver’s license and automobile insurance.

4. \_\_\_\_\_\_\_**(Recipient Initials):** Hart-Supported Living Regulations require that a recipient *not sell or donate equipment, or another item purchased with Hart-Supported Living funds without the written consent of the council.*

5. \_\_\_\_\_\_\_ **(Recipient Initials):** Supported Living regulations require that supported living funds not be used for *equipment or service which is obtainable from another program for which the applicant qualifies.* If a recipient becomes eligible for supports or services from another source and the support is currently being funded by Supported Living, this must be reported immediately to the H-SL Coordinator. H-SL cannot reimburse funds for a duplicated service. A Request for Plan Amendment should be completed to terminate these duplicated services.

6. \_\_\_\_\_\_\_ **(Recipient Initials):** Termination of a Supported Living Grant: Supported Living regulations require that a grant **shall** be terminated if the recipient: *1) Does not use the funds in accordance with the principles and definition of Supported Living; 2) Does not comply with employer responsibilities; 3) Takes up residency outside of Kentucky; 4) Requests termination of the supported living grant; or 5) dies.*

7. \_\_\_\_\_\_\_ **(Recipient Initials):** Documentation of Expenditure (DOE) forms with sufficient documentation attached to indicate that the service or support has been provided must be submitted to the Regional Coordinator no later than the second business day of each month immediately following the month in which services were provided.

**SIGNATURES**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Recipient or Guardian Date Family member or person responsible Date

for implementing plan (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Regional Coordinator Date Other (Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Date

HART-SUPPORTED LIVING PLAN

ADDITIONAL APPROVED SUPPORTS AND SERVICES

NAME:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HSL ID#:     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*\*Approved Ongoing  Support or Service  And  Description\*\* | Provider of Support:  Agency  or  Individual | **A**  Average  # of hours  per week | **B**  Cost per  Hour | **C**  Average  Cost per  Week  (A X B) | | **D**  Average  Cost per Month (E÷12) | | **E**  \*\*Approved  Annual  Budget per  Fiscal Year  (C X 52) |
| 5. |  |  |  |  | |  | |  |
| 6. |  |  |  |  | |  | |  |
| 7. |  |  |  |  | |  | |  |
| 8. |  |  |  |  | |  | |  |
| Total Annual Budgetthis page (Add to page 1) |  | | | | | | |  |
|  |  |  |  |  | |  |  | |
| \*\*APPROVED One-Time Support and Description | PROVIDER OF ONE-TIME SUPPORT  Contractor or Vendor | | | | APPROVED BUDGET AMOUNT  Expenses per estimate\*  \*Estimate(s) obtained  (three if possible) approved and made part of plan | | | |
| 5. |  | | | |  | | | |
| 6. |  | | | |  | | | |
| 7. |  | | | |  | | | |
| 8. |  | | | |  | | | |
| Total One-Time Expense, this page  **(Add to page 1)** |  | | | |  | | | |

If necessary, other additional pages can be added, with appropriate number of changes.