MI VIA REVIEW GUIDE

My Path, My Way

BACKGROUND INFORMATION

Class Member:	SS #	Date of Birth:	Age:	Gender:
Address where Class Member Resides:				
Guardian:		Telephone:	E-Mail:	
Consultant:		Telephone:	E-mail:	
Relative:		Telephone:	E-Mail:	
Physician or Primary Care Provider:		Telephone:	E-Mail:	
Other People Relied Upon:				
		Telephone:	Relationship:	
		Telephone:	Relationship:	
Plan Start Date:		Plan End Date:	Plan Budget:	
Plan Approved on:		Approved by:	Budget Allocation:	
Reviewer:		Onsite Date:	Case Judge:	

Background: Mi Via

The Mi Via Home and Community Based Services Waiver is a program that supports eligible New Mexicans with disabilities to live safely in their communities and prevent or delay out of home placement. Mi Via is a self-directed waiver that allows participants to hire, fire, supervise and manage providers of their choosing with support from a representative and/or consultant.

Based on assessed need and the participant's qualifying disability, the participant develops a service and support plan through person centered planning that outlines the services and supports the participant needs in order to live independently in their own home or community. The services and supports purchased from Mi Via are in addition to natural and other paid supports and are intended to increase independence or be a substitute to human assistance.

I. INDIVIDUAL BUDGET ALLOCATION (IBA)

There categories of services in Mi Via include:

1. Community Direct Support/Navigation (H2021)
2. Community Direct Support/Navigation – Exception (H2021E)
3. In Home Living Supports
4. Health and Wellness Supports
5. Transportation (Mile)
6. Other Supports

Level of Care by Age Group	12 Month Budget	Per Month	Allocated Budget
Child (0 to 18)			
Young Adult (18 through 20 as needed)*			
Adult (21 and older)			

* Young adult (18 through 20) Customized In-Home Living Supports=Enhanced Support IBA up to $68,589

Budget

Service Code	Description	Budget Amount
H2021		
T2033		
T2049		
Total		
Authorized Annual Budget		
Source:		

Total Budget Amount

Service/Good	Rate per Service	Cost to Budget (Taxes included). Tax w/wC=R 14.04%; W/o WC = R 10.95%	Type of Units Per wk/mo/yr	Number of wks/mo/yr	Total # of Units	Total Cost	Total Paid/ Billed	Balance	Comments
In Home Living Supports									
Community Direct Support									
Transportation									

My Qualifying Conditions/Diagnoses (found in all documents provided for survey):

Condition	Source	Dates

My Medications (found in all documents provided for survey):

Name and Strength of Medication	Dosage and Frequency	Target Symptoms	Source

A. SERVICE: COMMUNITY DIRECT SUPPORT NAVIGATION

Provider:
Pay Rate:
Effective Start Date:

Monthly Budgets

Month #	Month	Pretax Amount	Est. Tax	Est. Total
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				

Month #	Month	Pretax Amount	Est. Tax	Est. Total
12.				
13.				
Total				

Goal:

My Qualifying Condition(s):

Habilitative Need:

How Will This Goal Be Achieved?

Expected Outcome:

B. SERVICE: COMMUNITY DIRECT SUPPORT/NAVIGATION

Provider:
Pay Rate:
Effective Start Date:

Monthly Budgets

Month #	Month	Pretax Amount	Est. Tax	Est. Total
1.				
2.				
3.				
4.				
5.				
6.				

Month #	Month	Pretax Amount	Est. Tax	Est. Total
7.				
8.				
9.				
10.				
11.				
12.				
13.				
Total				

Goal:

My Qualifying Condition(s):

Habilitative Need:

How Will This Goal Be Achieved?

Expected Outcome:

C. SERVICE: IN-HOME LIVING SUPPORTS

Provider:
Pay Rate:
Effective Start Date:

MONTH #	MONTH	PRETAX AMOUNT	EST. TAX	EST. TOTAL
1.				

MONTH #	MONTH	PRETAX AMOUNT	EST. TAX	EST. TOTAL
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
TOTAL				

Goal:

My Qualifying Condition(s):

Habilitative Need:

How Will This Goal Be Achieved?

Expected Outcome:

D. SERVICE: TRANSPORTATION

Provider:

Pay Rate:
Effective Start Date:

MONTH #	MONTH	PRETAX AMOUNT	EST. TAX	EST. TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
TOTAL				

Goal:

My Qualifying Condition(s):

Habilitative Need:

How Will This Goal Be Achieved?

Expected Outcome:

E. Service:

Provider:
Pay Rate:
Effective Start Date:

Month #	Month	Pretax Amount	Est. Tax	Est. Total
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
Total				

Goal:

My Qualifying Condition(s):

Habilitative Need:

How Will This Goal Be Achieved?

Expected Outcome:

F. SERVICE:

Provider:
Pay Rate:
Effective Start Date:

MONTH #	MONTH	PRETAX AMOUNT	EST. TAX	EST. TOTAL
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
TOTAL				

Goal:

My Qualifying Condition(s):

Habilitative Need:

How Will This Goal Be Achieved?

Expected Outcome:

II. SERVICES AND SUPPORT PLAN (SSP)

Question #1: What do I want to have happen as a result of my participation in the Mi Via Program at home at work and in the community related to my health, friends and relationships? (All questions have been changed to BOLD font)
Answer:

Question #2. What Strengths do I have?
Answer:

Question #3: If you currently have a PATH or MAP or similar information, do you want to use it as part of your SSP planning?
Answer:

Question #4: Do you want to use Mi Via Plan Facilitation service as part of your SSP planning?
Answer:

A. IN HOME LIVING SUPPORTS

Living Supports Definition: Individually determined supports that help you stay in your own home and community. These supports can provide needed assistance with activities of daily living home management, supports for health and safety as well as independent living skills. Supports can be provided using three (v. 4) different models and are to occur in a participant's private residence, not in a home owned by their provider agency:

- Homemaker/Direct Support Services
- Home Health Aide
- In-home Living Supports.

How can Mi Via support you to live independently in your own home?

Identify any supports provided to this person intended to enable him/her to successfully and safely complete daily activities or build skills in the areas listed below:

Activity/Services	Non-Mi Via Paid Supports (Hours per week)	Unpaid Supports (Hours per Week)	Mi Via Supports (Hours per Week)	Total Hours (Hours per Month)*
Eating				
Dressing				
Bathing				
Transfers				
Toileting				
Heavy Housework				
Light Housework				
Cooking				
Grocery Shopping				
Taking Medication				
Routine Communications				
Banking tasks				
Managing Bills				
Miscellaneous Finance				
Working with Vendor/Employees				
Scheduling Appointments				
Managing Other Benefits				

Activity/Services	Non-Mi Via Paid Supports (Hours per week)	Unpaid Supports (Hours per Week)	Mi Via Supports (Hours per Week)	Total Hours (Hours per Month)*
Exterior Supports (gardening, Yard maintenance				
Total Hours per Week				

***Total hours per month= Sum of total hours per week for each category multiplied by 4.3**

Details of Living Supports

Living Support	Proj. Amount, Frequency and Duration	Expected Outcome	What Qualifying Condition results in need for this service?	How does this support meet your needs related to qualifying condition?
In Home Living Supports:				
Total Estimated Cost?				

Question #5: Do any of your Mi Via paid Living Support providers live in the same home with you?
Answer:

Question #6. Are any of your paid Mi Via Living Support providers a Legally Responsible Individual (LRI) such as your parent or guardian (for minors) or spouse?
Answer:

Question #7. Has your LRI been approved by DOH to be a paid Mi Via provider for you?
Answer:

Work Schedule for (name of LRI):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Question #8. How will I measure if my Living Support Services are working well for me and meet my identified needs?
Answer:

B. COMMUNITY MEMBERSHIP SUPPORTS

Community Membership Supports Definition: These supports help you participate in community life in order to enhance relationships with others work or participate in meaningful activities. These supports include:

- Community Direct Support
- Employment Supports
- Customized Community Group Supports.

Based on the person's preferences, list the areas where he/she needs support to participate in activities in the community or to build skills related to community membership.

Question #9: How do you want to be involved in the community?
Answer:

Question #10: Are you interested in exploring what your interests or opportunities might be in the community?
Answer:

Question #11. Are you currently involved in any community activities such as clubs, bowling league, scouting or other?
Answer:

Question #12: Do you have any interest in volunteering in areas such as community projects, charitable organizations or other special events in the community?
Answer:

Question #13: Do you know how or where to access community activities or volunteer opportunities you are interested in?
Answer:

Question #14: Do you need transportation to participate in community or volunteer activities?
Answer:

Question #15: Are you currently employed?
Answer:

If you are currently employed, please answer the following questions:

Where do you work?

How many hours do you work? (per week)

How long have you been employed?

Do you enjoy your employment?

What would make your employment better?

Do you feel included in your work environment?

Are there other employment opportunities (i.e. another job or career) you would like to pursue?

Based on your answers above, please list the areas where you need support to participate in activities in the community or build skills related to community membership.

Activity/Services	Non-Mi Via Paid Supports (Hours per week)	Unpaid Supports (Hours per week)	Mi Via Supports (Hours per Week)	Total Hours (Hours per month) *
Employment				
Volunteering				
Educational				

Activity/Services	Non-Mi Via Paid Supports (Hours per week)	Unpaid Supports (Hours per week)	Mi Via Supports (Hours per Week)	Total Hours (Hours per month) *
Leisure/Recreational *Does not include Related Goods				
Building Relationships				
Interpreter				
Translator/Interpreter				
Total Hours per Week				

***Total hours per month= Sum of total hours per week for each category multiplied by 4.3**

Based on your physical or cognitive needs and qualifying condition, please identify the services needs to address your Community Membership Supports.

Available Community Membership Services (Totals should be from Mi Via column ONLY from above):

Community Membership Service	Hours per Month
Community Direct Support	
Employment Supports	
Customized Community Group Supports	
Total Hours per Month	

Details of Community Membership Supports:

Community Membership Support	Projected Amount, Frequency and Duration	Expected Outcome	Qualifying Condition?	How does this support meet your needs?

Community Membership Support	Projected Amount, Frequency and Duration	Expected Outcome	Qualifying Condition?	How does this support meet your needs?
Total Estimated Cost				

Question #16: Do any of your paid Mi Via Community Membership Support Providers live in the same home with you?
Answer:

Question #17. Are any of your paid Mi Via Community Membership Support providers a Legally Responsible Individual (LRI) such as your parent or guardian (for minors) or spouse?
Answer:

Question #18. Has your LRI been approved by DOH to be a paid Mi Via Provider for you?
Answer:

Work Schedule for (name of LRI):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Question #19: How will I measure if my Community Membership Support services are working well for me and meet my identified needs?
Answer:

III. HEALTH AND WELLNESS SUPPORTS

Health and Wellness Supports Definition: These supports are made available in Mi Via to assist the person with medically related or behavioral health needs that are not covered by the person's health plan and will enhance his/her ability to remain in his/her home and community. These supports are generally provided by a licensed health professional and include:

- Skilled Therapy for Adults – OT, PT and SLP
- Behavior Support Consultation
- Nutritional Counseling
- Private Duty Nursing for Adults
- Specialized Therapies

Question #20: What do I want to have happen as a result of my participation in the Mi Via Program related to my health and wellness needs?
Answer:

Question #21. What will I need to address any health or safety concerns?
Answer:

Question #22: Do you have any health concerns that have not been addressed? (Be sure to consider medical/health issues, eating and nutrition concerns, and behaviors that might not be safe or helpful in your life.)
Answer:

Question #23: Has a health professional recommended a special nutritional plan or special diet for you?
Answer:

Question #24: Has a health professional recommended that you take nutritional supplements?
Answer:

Question #25: Do you need reminders to eat?
Answer:

Question #26: Do you have health and wellness needs in addition to the services provided through your regular Medicaid coverage?
Answer:

Question #27: Do you need additional health and safety supports from Mi Via, which are not covered by Medicaid insurance to be independent?
Answer:

Question #28: Do you need support from Mi Via to be physically active?
Answer:

Skilled Services

Question #29: **Do you need the services of a licensed nurse, therapist, and/or nutritional counselor?**
Answer:

Question #30: Do you have a need for any other specialized service(s) to address your health and wellness needs?
Answer:

Available Health and Wellness Supports

Based on your physical or cognitive needs and qualifying condition, please identify the services needed to address your Health and Wellness Supports.

Activity/Services	Non-Mi Via Paid Supports (Hours per week)	Unpaid Supports (Hours per Week)	Mi Via Supports (Hours per Week)	Total Hours (Hours per Month)
Total Hours per Week				

Details of Health and Wellness Supports

Health and Wellness Supports	Projected Amount, Frequency and Duration	Expected Outcome	Qualifying Condition	How does this support meet your needs?
Total				

Question #31: Are any of your paid Mi Via Health and Wellness Support providers a Legally Responsible Individual (LRI) such as your parent or guardian (for minors) or spouse?
Answer:

Question #32: Has your LRI been approved by DOH to be a paid Mi Via provider for you?
Answer:

Work Schedule for (Name of LRI):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Question #33: How will I measure if my health and wellness support services are working well for me and meet my identified needs?
Answer:

IV. OTHER SUPPORTS

Other Supports Definition: These supports are available to enhance or enable the person to receive other services on his/her plan, or to decrease the need for more direct services, thereby increasing his/her independence. These include:

- Transportation
- Emergency Response Service
- Respite (to give the unpaid, primary care giver time away from his/her duties)
- Related Goods

If requesting Respite, please provide the name of the unpaid primary care giver utilizing the respite and their relationship to you:

a. Based on your physical or cognitive needs and qualifying condition, please identify the transportation, emergency response and respite needed to address your Other supports.

Activity Services	Non-Mi Via Paid Supports	Unpaid Supports	Mi Via Supports	Total Hours/Miles/Trips
Transportation by Mile	Miles per month:	Miles per month:	Miles per month:	Miles per month:
Transportation by Trip	Miles per month:	Miles per month:	Miles per month:	Miles per month:
Transportation by Hour	Hours per month:	Hours per month:	Hours per month:	Hours per month:
Emergency Response Services	Hours per month:	Hours per month:	Hours per month:	Hours per month:
Respite Care	Hours per month:	Hours per month:	Hours per month:	Hours per month:

Detail of Other Supports

Other Support	Projected Amount, Frequency and Duration	Expected Outcome	Qualifying Condition	How does this meet your needs?
Emergency Response				
Respite				

Question #34: Are any of your paid Mi Via Transportation providers your spouse (a Legally Responsible Individual (LRI)?
Answer:

Question #35: Has your LRI been approved by DOH to be a paid Mi Via Transportation provider for you?
Answer:

If yes, or currently requesting please provide the LRI's planned work schedule. Both sections (name of LRI and Work Schedule) are mandatory if the response is yes.

Work Schedule for (Name of LRI):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Question #36: Are any of your paid Mi Via Respite providers a Legally Responsible Individual (LRI) for you such as your parent or guardian (for minors) or your spouse?
Answer:

Question #37: Has you LRI been approved by DOH to be a paid Mi Via Respite provider for you?
Answer:

***If yes, or currently requesting please provide the LRI's planned work schedule. Both sections (name of LRI and Work Schedule) are mandatory if the response is yes**.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

b. Based on your physical or cognitive needs and qualifying condition, please identify the Related Goods needed to address your Other Supports.

Related goods must meet the following requirements:

- Must be responsive to your qualifying condition; and
- Meet your clinical, functional, medical or habilitative needs; and
- Supports you to remain in the community and reduce the risk for institutionalization; and

- Promote your person al safety and health; and
- Afford you greater independence; and
- Decrease your need for other Medicaid services; and
- Accommodate you to manage your household; or
- Facilitate your activities of daily living.

Related Goods	Projected Amount, Frequency and Duration	Expected Outcome	Qualifying Condition?	How does this support meet your needs?
Total Estimated Cost				

Question #38: How will I measure if each of the Other Support services identified above are working well for me and meet my identified needs?
Answer:

V. ENVIRONMENTAL MODIFICATIONS

Question #39. Have you had any 'home modifications for accessibility or safety purposes funding by a NM Medicaid Waiver Program in the past five (5) years? Examples: Ramps, Grab Bars, Doorway/hallway modifications, bathroom modifications
Answer:

If yes, explain

If yes, please provide the following information:

Item/Modification	Date Completed	Cost	Paid By	Contractor
Total Cost of all environmental Modifications to date:				

Question #40: Are there any environmental modifications covered under Mi Via that you need? (Please refer to Mi Via regulations).
Answer:

VI. EMERGENCY BACK UP PLAN

Question #41: If regularly scheduled employees or service providers are unable to report to work I will contact the following:

Service	Name	Address, City, State, Zip	Times available	Phone
In-Home Living/Community Direct Support				
In-Home Living/Community Direct Support				
In-Home Living/Community Direct Support				

Relative(s): You must list parent(s) (required for minors), spouse (required if applicable) or at least one relative, or mark "n/a".

Name	Relationship to Participant	Address, City, State, Zip	Phone	Email

Consultant/Support Guide

Name	Address, City, State, Zip	Phone	Email

Physician or Primary Care Provider (Mandatory: You must list at least one health care provider)

Name	Type of Service Provided	Address, City, State, Zip	Phone

Others you rely on: Mandatory, you must list legal guardian or Power of Attorney (if applicable)

Name	Relationship	Address, City, State, Zip	Phone	e-mail

Consultant Acknowledgement:
Signed by:
Date:

*Consultant must acknowledge: I have provided the participant with a copy of the SSP Emergency Back-Up Plan Acknowledgement Form, and I have reviewed the form with him/her. I confirm that the participant has complete the form in its entirety. A copy of the completed form will be kept by the participant and in the consultants file.

VII. CONSULTANT/SUPPORT GUIDE SERVICES

Question #42. Do you need assistance putting your Mi Via plan into action?
Answer:

Question #43: Do you have access to a fax?
Answer:

Question #44: Do you know how to use a fax?
Answer:

Question #45: Do you have access to the Internet?
Answer:

Question #46: Do you need support using the Internet?
Answer:

Question #47: Do you need assistance with any of the following program administration activities?
Answer:

	Yes	No		Yes	No		Yes	No
Processing Timesheets			Managing program budget			Finding related goods		
Processing invoices			Operating a fax machine					
Identifying other resources			Operating a computer					

Question: #48: Do you need help with any of your employer responsibilities and/or the management of your Mi Via program and budget?
Answer:

Question #49: Do you need assistance with any of the following employer responsibilities?

Answer:

	Yes	No		Yes	No		Yes	No
Scheduling employees			Resolving employee conflicts			Encouraging good performance		
Disciplinary actions			Interviewing/Hiring employees			Supervising employees		
Developing Interview Questions			Checking references					

Question #50: Your consultant will be contacting you by phone monthly and will conduct four (4) in –person visits with you per year. Do you want more contact?
Answer:

Question #51: Based on your physical or cognitive needs and qualifying condition, what type and level of support will you need from your Consultant/Support Guide?
Answer:

Question #52: How will I measure if my Consultant/Support Guide services are working for me and meet my identified needs?
Answer:

Question #53: Please describe the plan/agreement you have for Consultant/Support Guide services.
Answer:

VIII. PERSON'S PARTICIPATING IN THE DEVELOPMENT OF THE SSP

Developed By	Title/Relationship to Participant	Date of Entry

IX. PEOPLE INTERVIEWED

The following list identifies those individuals typically interviewed as a part of this review process. Individuals who **may be** interviewed include:

- Class Member
- Consultant
- Guardian or legal representative
- Service Provider, if any
- Others: (list based on person interviewed)

Summary of those Interviewed Follow:

#	Date of Interview	Name of Person Interviewed	Title	Contact Information Phone & E-Mail	Type of Interview (phone, virtual, in person)
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

INTERVIEW: Mi Via Participant/Jackson Class Member

Name:
Date of Interview:

	Questions
1.	What has happened as a result of your participation in the Mi Via Program at home, at work and in the community related friends and relationships?
2.	What are your strengths? What are you really good at?
3.	What are your favorite places to go in the community? (Activities, clubs, church, art, etc.) What do you do?
4.	Who are your friends? How often do you get to see these friends?
5.	What do you do during the day? Are you interested in having more interests or doing more things in the community?
6.	Do you or are you interested in volunteering in your community? (Doing things with other people, helping at events in the community)?
7.	How would you go about volunteering if you were interested? Is there anything that keeps you from volunteering if you want to?
8.	Do you have the transportation you want so you can go places in the community?
9.	Do you have a job? If yes, describe (Where do you work? What do you do? How many hours a week? How long have you been employed? Do you like your job? Would you like to explore other work opportunities?
10.	(If not working) Are you interested in working or having a job? If yes, what would you like to do?
11.	What can Mi Via do to help with your health-related needs?
12.	What do you need to address any health or safety concerns?
13.	Do you have any health concerns that have not been addressed? (Consider medical issues, eating and nutrition concerns, and behaviors that might

	not be safe or helpful in his/her life).
14.	Has a health professional recommended a special nutritional plan or special diet for you?
15.	Has a health professional recommended that you take nutritional supplements?
16.	Do you need reminders to eat?
17.	Do you need additional health/safety supports that you don't currently have?
18.	Do you have the supports you need to be physically active?
19.	Do you need help from a licensed nurse, therapist, and/or nutritional counselor?
20.	Have you had to go to the hospital or emergency room in the past year? If yes, describe for what and how often.
21.	Have you had any 'home modifications' made to your house in the past five (5) years? (E.g., ramps, grab bars, doorway/hallway modifications, bathroom modifications).
22.	Are there modifications that you need to your home or your car?
23.	Are there other special services that you need to help you be healthy and feel good that you need? If yes, explain.
24.	Do you like where you live now? What do you like/not?
25.	Do you get along with the people you live with?
26.	Do you like the people who help you at home and when you go out? What do you like/not about them?
27.	Are you learning new things? What are you learning?

28.	Do you need help putting your Mi Via Plan into action? If yes, what kind of help do you need?
29.	Do you need assistance with any of the following program administration activities? Process timesheets Processing invoices Identifying other resources Operating a fax machine Finding related goods Managing program budget Operating a computer If yes, explain:
30.	Does your consultant contact you monthly by phone or in person?
31.	Does your consultant see you at least 4 times in-person each year?
32.	Does your consultant meet with you in your home at least one time a year?
33.	Do you want your consultant to contact you more?
34.	What services do you get from your consultant/support guide?
35.	Is that adequate?
36.	Do you know how to report abuse, neglect or exploitation?
37.	Have you ever had to report abuse, neglect or exploitation? If so, are you comfortable sharing what happened?
38.	How do you know that your Mi Via Services are working for you?
38.	Now that I am done asking you questions, do you have any questions for me?

INTERVIEW 2: Mi Via Waiver Consultant

Name:
Title:
Date of Interview:

	Questions
1.	Have you been told what we are doing, or have you been through a review before?
2.	Did you get a chance to see the protocol on the web so that you know the type of information we gather and the questions that we are going to ask?
3.	Before we start, do you have any questions of me?
4.	How long have you been (Name) consultant?
5.	Tell me a little about (Name)
6.	What type of assistance does (Name) need from the Mi Via Waiver?
7.	Is _____ receiving it? If not, why?
8.	How are _____ Mi Via Services measured to be sure they are effective?
9.	Are there any services or supports that (Name) needs that are not provided to her?
10.	Anything else that is important for (Name) that you are addressing?
11.	Add questions
12.	This concludes our interview. Do you have any questions for me?

INTERVIEW 3: Guardian

Name:
Title:
Date of Interview:

Based on your file review, modify these questions as appropriate and add specific ones based on the individual's needs and information gathered from the file that needs further clarification.

	Questions
1.	Tell me a little about (Name) and your family history. What are the important people and events in her life and your family's life that we should know and remember?
2.	When did s/he leave Los Lunas or Ft. Stanton? What supports, and services has s/he received since then?
3.	What kinds of things do you like best about (Name), what has s/he taught you? Challenges?
4.	(Optional Question depending on circumstances:) You are her Guardian, have you been thinking about who you want to be (Name) Guardian with or after you?
5.	Tell me about the transition to Mi Via Waiver. Why did you decide to change to the Mi Via Waiver? When, what has that been like?
6.	(Optional for new enrollees:) The process of transitioning to Mi Via seems to have begun in (Month), what did the transition consist of? What did you have to do? What did the counselor do? Are you satisfied?
7.	What type of services does (Name) receive now?
8.	What type of support do you receive? What type of breaks do you need/receive?
9.	Over the years you have identified specific needs for (Name) that I'd like to follow up on to be sure (Name) received them. (Retrieve this information from sources such as previous CPR's, interviews… if nothing has been identified skip this question.) Clarify this question.

	Questions
10.	What are his/her favorite things to do?
11.	Is (Name) at risk of aspiration? Does s/he have or need a CARMP? Do you find it helpful? Can I see it?
12.	What immunizations has s/he had and when? Who helps you keep track of these kinds of things?
13.	Has s/he had preventative screens (see what Healthfinder.com recommends)?
14.	Are there supports that you need that we could highlight or things that (Name) needs that s/he is not receiving?
15.	How would you report suspected abuse or neglect?
16.	Add questions
17.	This concludes our interview. Do you have any questions for me?

INTERVIEW 4: Individual who provides day to day supports

Name:
Title:
Date of Interview:
Start Time:

Based on your file review, modify these questions as appropriate and add specific ones based on the individual's needs and information gathered from the file that needs further clarification.

	Questions
1.	Tell me a little about (Name), what is he/she like?
2.	What are (Name's) strengths and preferences? What does he/she really like or like to do?
3.	How long have you known (Name)?
4.	What does a typical weekday look like for (Name)? How do you decide what you are going to do?
5.	How many days a week do you support (Name)? For how many hours a day?
6.	What does (Name) do on the weekends?
7.	What are your primary responsibilities when you and (Name) are together?
8.	What barriers, if any, have you encountered in working with (Name)? If barriers are identified, ask what has been done about those barriers and if that intervention was helpful/successful? Describe.
9.	Are there support needs that (Name) has that are not being met?
10.	Is (Name) at risk of aspiration? If yes, what is her/her risk level?
11.	Has s/he ever aspirated?
12.	Does (Name) have other health related issues that might impact him/her day to day? If so, what are they and what do you watch for/do?
13.	Does (Name) take any medication? If yes, what does he/she take and what is each for?
14.	Add questions
15.	This concludes our interview. Do you have any questions for me?

OBSERVATIONS

Observation 1

Start Time: **Location:** **Number of paid support present:** **Number of Individuals:** **Stop Time:**

Comments:

Observation 2

Start Time: **Location:** **Number of paid support present:** **Number of Individuals:** **Stop Time:**

Comments:

X. DOCUMENTS REVIEW (LIST ALL DOCUMENTS PROVIDED FOR REVIEW AND COMMENT ON ADEQUACY AND/OR ANY IDENTIFIED ISSUES)

Document	Date	Signed By	Relevant Information	Justifications/Comments
Mi Via Documentation				

Document	Date	Signed By	Relevant Information	Justifications/Comments

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