agency for persons with disabilities
State of Florida

Person-Centered Support Plan

Support Plan Effective Date: Click to enter Date

About Me

Last Name _____ First Name _____ Nickname _____ Date of Birth _____
SSN _____ Medicaid ID _____ PIN _____ Legal Status _____

Where I Live

Street Address _____ City _____ State _____ Zip _____
Email Address _____ Home Phone _____ Work Phone _____ Region _____

Deliver my mail to _____ City _____ State _____ Zip _____

Best way to contact me Home phone: ☐ Cell phone: ☐ Email: ☐ Permission to leave a voicemail message? ☐

My Legal Representative(s)

#1

Last Name _____ First Name _____ Guardian/Legal Representative Type _____
Relationship _____ Other _____
Address _____ City _____ State _____ Zip _____
Day Phone _____ Night Phone _____ Cell Phone _____
Email Address _____

To include a second legal representative, click the ▶ below:

▶

My Waiver Support Coordinator

Name	Agency (if applicable)	Email	Phone Number(s)
			1. 2.

This form contains additional information wherever there is a ❶. To see the text box, place your cursor on or next to the ❶.

Name: **Support Plan Effective Date**: Click to enter Date

My Family, Friends, and Support System ℹ

Name	Relationship	Email	Phone
			1. 2.
			1. 2.
			1. 2.

Other People Who Support Me or Work for Me ℹ (Teachers, Providers, Doctors, CDC+ Representative)

Name	Relationship	Email	Phone
			1. 2.
			1. 2.
			1. 2.
			1. 2.

Other Funding Sources for Supports (Vocational Rehab/Job Coach, Division of Blind Services, MSP Behavior Therapy)

Support Need	Funding Source
	Choose an item.
	Choose an item.
	Choose an item.
	Choose an item.

People Who Can Provide Information for My Support Plan (Doctor, Service Providers, Family, Friends)

Last Name	First Name	Relationship	Phone	Invite to Support Plan Meeting Y/N?
				Y ☐ N ☐
				Y ☐ N ☐
				Y ☐ N ☐
				Y ☐ N ☐

If more lines are needed, please attach an additional page and check this box: ☐

This form contains additional information wherever there is a ℹ. To see the text box, place your cursor on or next to the ℹ.

Name: **Support Plan Effective Date**: Click to enter Date

My Life ℹ

My current day-to-day life: (This is a "day in the life" description of me: where I live, if alone or with others, **my daily routines** ℹ, services received during the day and/or night. List **the housing information** ℹ I was provided and where I choose to live in the future)

How I get around in my community ℹ**:**
Choose an item.

My interests, talents, abilities, strengths, preferences, and skills ℹ**:**

Things I would like to change ℹ**:**

Things I want to stay the same ℹ**:**

This form contains additional information wherever there is a ℹ. To see the text box, place your cursor on or next to the ℹ.

Name: **Support Plan Effective Date**: Click to enter Date

Important aspects from my personal history ⓘ: (Medical, Social, Behavioral history)
Date:

How I communicate and make choices and decisions ⓘ:

Employment ⓘ

Job I Have	**Job I Want**	**What do I need to succeed in my employment goals ⓘ?**
Choose an item.		

Have I tried to access services from Vocational Rehabilitation?	Yes ☐ No ☐
What was the outcome? (identify the outcome of VR referrals, if any)	

This form contains additional information wherever there is a ⓘ. To see the text box, place your cursor on or next to the ⓘ.

Name: **Support Plan Effective Date**: Click to enter Date

Other Services Needed for Health and Safety ℹ

This Information is captured in the QSI. Identify: **A)** Areas of critical needs/potential risk to the health/safety of myself or others **B)** The specific issue, how it is addressed or where to find this information **C)** The service/support to address need **D)** The source of funding

Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
Functional (Choose all that apply)			
☐ Vision			Choose an item.
☐ Hearing			Choose an item.
☐ Eating			Choose an item.
☐ Ambulation			Choose an item.
☐ Transfers			Choose an item.
☐ Toileting			Choose an item.
☐ Hygiene			Choose an item.
☐ Dressing			Choose an item.
☐ Communications			Choose an item.
☐ Self-protection			Choose an item.
☐ Ability to Evacuate (Home)			Choose an item.
Behavioral (Choose all that apply)			
☐ Hurtful to Self/Self-injurious			Choose an item.
☐ Aggressive/Hurtful to Others			Choose an item.

This form contains additional information wherever there is a ℹ. To see the text box, place your cursor on or next to the ℹ.

Name: **Support Plan Effective Date**: Click to enter Date

Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
☐ Destructive to Property			Choose an item.
☐ Inappropriate Sexual Behavior			Choose an item.
☐ Running Away			Choose an item.
☐ Other Behaviors that May Result in Separation from Others. List "Other" behaviors:			Choose an item.
Physical (Choose all that apply)			
☐ Injury to Person Caused by Self-injurious Behavior			Choose an item.
☐ Injury to the Person Caused by Aggression to Others or Property			Choose an item.
☐ Use of Mechanical Restraints or Protective Equipment for Maladaptive Behavior			Choose an item.
☐ Use of Emergency Chemical Restraints			Choose an item.
☐ Use of Psychotropic Medications			Choose an item.
☐ Gastrointestinal Conditions (includes vomiting, reflux, heartburn, or ulcer)			Choose an item.
☐ Seizures			Choose an item.
☐ Antiepileptic Medication Use			Choose an item.

This form contains additional information wherever there is a ⓘ. To see the text box, place your cursor on or next to the ⓘ.

Name: **Support Plan Effective Date**: Click to enter Date

Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
☐ Skin Breakdown			Choose an item.
☐ Bowel Function			Choose an item.
☐ Nutrition			Choose an item.
☐ Treatments			Choose an item.
☐ Assistance in Meeting Chronic Health Care Needs			Choose an item.

Back-up Plans for My Critical Needs/Risks ℹ (in case my primary supports are not available)

Service/Support	Back-up Plan	Specific Strategies (as needed)

What I Accomplished Last Year ℹ

My accomplishments last year:

Goals I worked on last year	Progress on each goal

This form contains additional information wherever there is a ℹ. To see the text box, place your cursor on or next to the ℹ.

Name: **Support Plan Effective Date**: Click to enter Date

My Personal and Future Plans ℹ

What I Want in the Next Few Years: (Supports, accomplishments, dreams, desires, interests, or activities I want in my life in the next few years)

Personal Goals ℹ

The most important things I want to achieve this coming year. Identify goals/desired outcomes and be as specific as possible.	**What service will help me?**	**Paid or Non-Paid. If non-paid, provide name and relationship.**

Personal Rights: (not related to guardianship)

Signatures on the last page indicate that the individual or their Legal Representative are aware of the individual's personal rights and the Bill of Rights for Persons with Developmental Disabilities.

Is there a right in which I would like to learn more? **Yes** ☐ **No** ☐

Do I have restrictions on my rights? This might include limited restrictions such as not being able to lock my bedroom door with a key, restricted visitation, inflexible schedule, limited food or environmental access, etc. **Yes** ☐ **No** ☐ If yes, complete the table.

Right Limited	**Reason** (the assessed need for the restriction and what less intrusive methods were tried but did not work out)	**What is being done to help me obtain my full rights?**	**When will it be reviewed to determine ongoing effectiveness, or to terminate restriction?**

This form contains additional information wherever there is a ℹ. To see the text box, place your cursor on or next to the ℹ.

Name: **Support Plan Effective Date**: Click to enter Date

WSC, initial as assurance that the interventions and supports cited above will not be harmful

Safety Plan Required and Attached (if applicable) ℹ **Yes** ☐ **No** ☐

My Health

Important health history about me ℹ:

Hospitalizations in the past year **Yes** ☐ **No** ☐

If yes, why I was hospitalized?

My medication information (Current as of support plan meeting date) ℹ

Medications	Dosage/Frequency	Purpose of Medication	Side Effects/Problems Experienced

Allergies: (Including any reactions to any medications, substances, chemicals, etc.)

My critical health follow-up areas and preventative health plan ℹ: (How will I maintain my Health and Health Stability?)

This form contains additional information wherever there is a ℹ. To see the text box, place your cursor on or next to the ℹ.

Name: **Support Plan Effective Date**: Click to enter Date

My Health Care Contact Information: Include all doctors you see, any therapists, and anyone you have designated to act as your decision maker in health-related issues (health care surrogate)

Name	Date of Last Visit	Findings	Follow Up Activities

Health Care Decision Maker Name	Role	Follow Up Activities

Equipment and Supplies

Do I use any adaptive equipment, special equipment, glasses, hearing aids or need any adaptations made to my home? Yes ☐ No ☐ If yes, please list below.

Do I need any consumable supplies? Yes ☐ No ☐ If yes, please list below.

Personal Disaster Plan

I have a Personal Disaster Plan Yes ☐ No ☐

Date Personal Disaster Plan Completed or Updated Click or tap to enter a date.

This form contains additional information wherever there is a ❶. To see the text box, place your cursor on or next to the ❶.

Name: **Support Plan Effective Date**: Click to enter Date

Signature Page

I have participated in the development of this plan. I have been informed of my due process rights under Florida Statutes 120 and acknowledge that I may appeal any portion of this plan. I understand that if my needs change, an update to this plan may be needed. I also understand that I may request to change something in my plan throughout the support plan year. Supports should be identified according to my needs or the needs of my family, regardless of the availability of funding. Supports and services needed to meet my needs will be sought from my personal resources, community resources, and government resources. When government resources are necessary, they shall be provided based on the availability of funds. My Support Coordinator reviewed the Bill of Rights for Persons with Developmental Disabilities with me and I understand my personal rights.

Date Sent to Individual _____ **Date Sent to APD** _____

Consumer Signature _____ **Date** _____

Witness Signature (if needed) _____ **Date** _____

Legal Representative Signature _____ **Date** _____

Waiver Support Coordinator Signature _____ **Date** _____

Signature of Support Plan Meeting Participants:

Relationship	Signature	Signature Date	Date Copy Sent

This form contains additional information wherever there is a ⓘ. To see the text box, place your cursor on or next to the ⓘ.

Name: **Support Plan Effective Date**: Click to enter Date