# Person-Centered Support Plan

## About Me

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name |  | First Name |  | Nickname |  |
| Date Birth |  | Medicaid ID |  | PIN |  |
| SSN |  | Legal Status |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Where I Live |  |  |  |  |  |
| The Address Where I Live |  |  |  |  |  |
| City |  | State |  | Zip |  |
| Home Phone |  | Work Phone |  |  |  |
| Client Email Address |  |  |  |  |  |
| My mail should be delivered to |  |  |  |  |  |
| City |  | State |  | Zip |  |

## My Legal Representative(s)

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name |  | First Name |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Guardian/Legal Representative Type |  |  |  |  |  |
| Relationship |  | Other |  |  |  |
| Address |  |  |  |  |  |
| City |  | State |  | Zip |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Daytime Phone |  | Nighttime Phone |  | Cell Phone |  |

|  |  |
| --- | --- |
| Email Address |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Last Name |  | First Name |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Guardian/Legal Representative Type |  |  |  |  |  |
| Relationship |  | Other |  |  |  |
| Address |  |  |  |  |  |
| City |  | State |  | Zip |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Daytime Phone |  | Nighttime Phone |  | Cell Phone |  |

|  |  |
| --- | --- |
| Email Address |  |

## My Waiver Support Coordinator

| **Name** | **Agency (if applicable)** | **Email** | **Phone** |
| --- | --- | --- | --- |
|  |  |  |  |

## My Family, Friends, and Support System

| **Name** | **Relationship** | **Email** | **Phone** |
| --- | --- | --- | --- |
|  |  |  |  |
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## Other People Who Support Me or Work for Me

| **Name** | **Relationship** | **Email** | **Phone** |
| --- | --- | --- | --- |
|  |  |  |  |
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## Other Funding Sources for Supports

| **Support Need** | **Funding Source** |
| --- | --- |
|  | If "Other" is selected, list the funding source. |
|  | If “Other” is selected, list the funding source. |
|  | If “Other” is selected, list the funding source. |

**Who do I want to provide information for my support plan**?

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

## My Life

| My current day-to-day life (Identify if I live alone or with others and my daily routines): |
| --- |
|  |

| My interests, talents, abilities, preferences, and skills: |
| --- |
|  |

| Things I would like to change: |
| --- |
|  |

| Things I want to stay the same: |
| --- |
|  |

| Important aspects from my personal history: |
| --- |
|  |

| How I make choices and decisions: |
| --- |
|  |

## My Personal and Future Plans:

|  |
| --- |
| What I Want in the Next Few Years: |
|  |

## Personal Goals

| The most important things I want to achieve the upcoming year. Identify goals and be as specific as possible. | What service will help me? | Paid or Non-Paid. If non-paid, provide name and relationship. |
| --- | --- | --- |
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## Other Services Needed for Health and Safety

Insert drop down list of services to address health/safety, i.e. nursing, personal supports, etc.

| **Identified Need** | **Service/Support** | **Source of Support** |
| --- | --- | --- |
| Functional (May choose more than one) |  |  |
| Vision |  | If "Other" is selected, list the source of support. |
| Hearing |  | If "Other" is selected, list the source of support. |
| Eating |  | If "Other" is selected, list the source of support. |
| Ambulation |  | If "Other" is selected, list the source of support. |
| Transfers |  | If "Other" is selected, list the source of support. |
| Toileting |  | If "Other" is selected, list the source of support. |
| Hygiene |  | If "Other" is selected, list the source of support. |
| Dressing |  | If "Other" is selected, list the source of support. |
| Communications |  | If "Other" is selected, list the source of support. |
| Self-protection |  | If "Other" is selected, list the source of support. |
| Ability to Evacuate (place of residence) |  | If "Other" is selected, list the source of support. |

|  |  |  |
| --- | --- | --- |
| **Identified Need** | **Service/Support** | **Source of Support** |
| Behavioral (May choose more than one.) |  |  |
| Hurtful to Self/Self-injurious |  | If "Other" is selected, list the source of support. |
| Aggressive/Hurtful to Others |  | If "Other" is selected, list the source of support. |
| Destructive to Property |  | If "Other" is selected, list the source of support. |
| Inappropriate Sexual Behavior |  | If "Other" is selected, list the source of support. |
| Running Away |  | If "Other" is selected, list the source of support. |
| Other Behaviors that May Result in Separation from Others. If “Other” is selected, please list the other behaviors. |  | If "Other" is selected, list the source of support. |
| **Identified Need** | **Service/Support** | **Source of Support** |
| Physical (May choose more than one) |  |  |
| Injury to Person Caused by Self-injurious Behavior |  | If "Other" is selected, list the source of support. |
| Injury to the Person Caused by Aggression to Others or Property |  | If "Other" is selected, list the source of support. |
| Use of Mechanical Restraints or Protective Equipment for Maladaptive Behavior |  | If "Other" is selected, list the source of support. |
| Use of Emergency Chemical Restraints |  | If "Other" is selected, list the source of support. |
| Use of Psychotropic Medications |  | If "Other" is selected, list the source of support. |
| Gastrointestinal Conditions (includes vomiting, reflux, heartburn, or ulcer) |  | If "Other" is selected, list the source of support. |
| Seizures |  | If "Other" is selected, list the source of support. |
| Antiepileptic Medication Use |  | If "Other" is selected, list the source of support. |
| Skin Breakdown |  | If "Other" is selected, list the source of support. |
| Bowel Function |  | If "Other" is selected, list the source of support. |
| Nutrition |  | If "Other" is selected, list the source of support. |
| Treatments |  | If "Other" is selected, list the source of support. |
| Assistance in Meeting Chronic Health Care Needs |  | If "Other" is selected, list the source of support. |

## What I Accomplished Last Year:

| My Accomplishments Last Year: |
| --- |
|  |

Goals and progress made in the past year:

| Goals/Service Need | Progress on Goal |
| --- | --- |
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## Personal Rights: (not related to guardianship)

I am aware of my personal rights and the Bill of Rights for Persons with Developmental Disabilities. Is there a right in which I would like to learn more? Choose Yes or No.

Do I have restrictions on my rights? Choose Yes or No.  This might include limited restrictions such as an unlocked bedroom door, limited food access, limited environmental access, etc.? If yes, complete the table.

| Right Limited | Reason | What is being done to help me obtain my full rights? | When it will the restriction be reviewed or terminated? |
| --- | --- | --- | --- |
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Safety Plan required and Attached (if applicable choose Yes or No.)

## My Health

Important Information About My Health

Hospitalizations in the past year Choose Yes or No.:

| If yes, why I was hospitalized? |
| --- |
|  |

My Medication Information (Current as of date of support plan meeting)

| Medications | Dosage/Frequency | Purpose of Medication | Side Effects/Problems Evident |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

| Important Health History about My Family and Me: |
| --- |
|  |

| My critical health follow up areas and preventative health plan: |
| --- |
|  |

| Allergies: |
| --- |
|  |

Health Care Contact Information: Please 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 |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

| Do I need any consumable supplies? Choose Yes or No.  If yes, please list below. |
| --- |
|  |

**If There Is An Emergency**

My Emergency Contact Person:

If there is an emergency, please call:

| Last Name | First Name | Phone | Address |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Where will I go if I need to leave my home in the event of a disaster or emergency?

|  |  |
| --- | --- |
| If shelter, identify address: |  |

How will I evacuate? Choose an item.

Who will take me, if I need help?

| Last Name | First Name | Phone | Address |
| --- | --- | --- | --- |
|  |  |  |  |

**Do I have any medical equipment that would need to be powered or transported with me in the event of an emergency, evaluation, or power loss?**  If yes, please explain.

**Generator?**  **Yes No**  **Working Properly?**  **Yes**  **No**

**I am registered with a Local Emergency Management Team**

**If yes, has my registration been updated or validated this year?**

**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 and update to this plan may be needed. 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.

|  |  |  |  |
| --- | --- | --- | --- |
| Consumer Signature |  | Date |  |
| Witness (if needed) |  | Date |  |
| Signature Legal Representative |  | Date |  |
| Waiver Support Coordinator Signature |  | Date |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Date Copy of Plan Provided to Individual |  | Date submitted to APD |  |

Signature of Support Plan Meeting Participants:

| Signature | Relationship | Date | Date Support Plan Provided |
| --- | --- | --- | --- |
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