DRAFT 1/13/03

SUPPORT SERVICES BROKERAGE
PLAN OF CARE
CRISIS ADDENDUM

_____ is currently enrolled in Support Services Brokerage _____
(Individual's name) (Name of Brokerage)
and requires the addition of Crisis Services to his/her current support plan. The circumstances resulting in a crisis situation are as follows:

_____
_____
_____

We, the undersigned, have participated in the development of this Plan addendum to address the crisis situation, and agree to the content unless otherwise noted.

INDIVIDUAL:_____
GUARDIAN:_____
Type:_____
County where filed:_____
Documentation Provided: Yes No
Crisis Services Provider:_____
Phone:_____
FAMILY:_____Phone:_____
FAMILY:_____Phone:_____

OTHER:_____Phone:_____
Personal Agent:_____
Phone:_____FAX:_____
Support Services Provider:_____
Phone:_____
CDDP Case Manager:_____
Phone:_____
CDDP Title XIX Specialist:_____
Phone:_____

SERVICE **Describe need or issue**	**ACTION** **Describe plan and timelines**	**RESPONSIBLE PERSON OR AGENCY**
RIGHTS	The Crisis Provider to review individual's rights by __/___/___	
FINANCIAL PLAN SSI_____ SSB_____ Other_____ Work_____ Total_____ *Needed/preferred purchases (Bus pass, etc.)* *personal money*	Move in date: _____ Prorated room & board amount: $ _____ Monthly room & board rate: $_____ is due to the provider by: _____ **Income will be reported to Social Security Administration by current reporter** _____ _____ _____ _____ _____ _____ _____ _____ _____ The individual is able to carry up to $_____ at any one time and will be given $_____ as a regular allowance in cash each ☐ day ☐ week ☐ month. Purchases over $ _____ need approval by ISP team. Call service coordinator.	

MEDICAL	Provider must have current medical orders for ALL treatments, protocols, delegations, assigned tasks, and medications (including PRN and over-the-counter) **at the time of move in.**	
Primary medical provider	Name:_____ Phone:_____ Address: _____ **A copy of the Medical Insurance Card is provided to Provider at move-in**	
Specialist	Name:_____ Phone:_____ Address: _____ **Specialty:** Name:_____ Phone:_____ Address: _____ Specialty:	
Medications	Does the individual currently take medications: □ yes □ no. If yes, is there a current physician order for the medications: □ yes □ no. **Current orders must be in place prior to move-in** **Condition for which medication is taken:** Is the individual able to self-administer medications: □ yes □ no. **If the individual needs any assistance or reminders in taking medication, please describe below.**	
Seizures □ yes □ no.	Supports:	
Chewing/ Swallowing/Choking issues □ yes □ no.	Supports:	
Constipation supports required □ yes □ no.	Supports:	
Dehydration risk □ yes □ no	Supports:	
Treatments/ protocols □ yes □ no	For What: **Attach copies**	
Medical Appointments	**The provider or _____ will accompany the person to all medical appointments.**	
Dental	Dentist: _____ Phone: address _____ Current dental problems? Explain: _____ _____	
Psychiatric or Mental Health	**Diagnosis:** **Psychiatrist:** Name:_____ Phone:_____ Address: _____ **Support needed, and provided by whom:**	

Behavioral Supports Does the individual currently engage in behaviors of concern? □ yes □ no. Does the individual currently have a Behavior Support Plan? □ yes □ no.	**Behaviors of concern:** **Supports needed:** **Target behaviors:** **Name of Behavior Specialist:** **Telephone Number:** **Attach copies of current functional assessment and behavior support plan**	
Court Ordered Restrictions □ yes □ no. **PSRB:** Contact: _____ Phone:_____ Expiration Date:_____ **Parole/Probation Officer**:_____ Phone:_____	Describe restrictions: Next Court date: Attach court document(s)	
Medical/Psychiatric/ Behavioral Follow-up Tasks (coordinate, access, assist to access, monitor, facilitate, evaluate) **Medical/psychiatric assessments needed?** □ yes □ no. **Behavioral assessment needed?** □ yes □ no. **Risk assessment needed?** □ yes □ no. **Referrals or evaluations for other/additional services needed?** □ yes □ no.	Next routine medical appointment scheduled for or by what date: Next routine psychiatric appointment scheduled for or by what date: If assessments are needed, note the name or position of the individual responsible for making the arrangement(s), and the date by which each assessment is to occur:	

SAFETY	**One-on-one supervision authorized by Region or County** □ yes □ no. If yes, how many hrs/day ___ List the specific one-on-one supervision needs, and to be provided by whom: _____ _____ _____ **24 hour supervision needed:** □ yes □ no **Supervision needed when in the community** □ yes □ no If yes, list specific supervision to be provided, and by whom: _____ _____ **Individual can respond appropriately in a fire or other emergency**: □ yes □ no If no, how is the individual supported and by whom: _____ _____ **Individual is ambulatory and alert enough to evacuate safely from a second story** **bedroom in case of fire or other emergency**: □ yes □ no □ N/A **Individual can be left alone at the residence for up to two hours unsupervised and** **can call 911 in an emergency**: □ yes □ no **Water Temperature Adjustment assistance needed**: □ yes □ no **Special conditions for night safety or other safety issues**: _____ _____ **Missing Person's Plan (missing from home or absent without leave)** The individual regularly leaves home at _____ (time) and comes home by _____ (time). If missing from home, the crisis care provider should immediately search the area. If the individual is not found, contact the guardian/family/_____. Call 911 and the Personal Agent. If the Personal Agent is not available, the provider will follow the Brokerage Back-Up Plan.	
ADL's (Activities of Daily Living) that the individual needs help with and type of assistance for which the provider is responsible	**Personal Care** (bathing, dressing, toileting) Does the individual require assistance with personal care: □ yes □ no If yes, specify assistance to be provided, and by whom: _____ _____ _____ **TRANSPORTATION** PROVIDED BY:_____phone/pager: **MOBILITY** TRAINING NEEDED: □ yes □ no Start date: The responsible trainer will be:	

ONGOING SUPPORT SERVICES Name of Brokerage:_____ _____ Name of Personal Agent:_____ Phone: _____ Pager:_____	What components of the current **BROKERAGE SUPPORT PLAN** will continue during the crisis placement: In addition to immediately reporting to the Personal Agent any situation in which the individual is missing, the crisis care provider agrees to promptly report all of the individual's absences from the home and ALL instances of illness, accidents, hospitalization, incarceration, or other unusual absences, or whenever the individual plans to travel	
ADL, SAFETY OR MISSING PERSON FOLLOW-UP TASKS *(coordinate, access/assist, monitor, facilitate, evaluate)*	Next Meeting will be on _____	
TRANSITION PLAN BACK TO HOME		