



Personal Information Summary: Planning Ahead:

- Benefits and Services
- Religious Affiliation
- Family and Friends
- Daytime Activities
- Bedtime Preparation
- Safety Precautions
- Likes and Dislikes
- Fears and Phobias
- Awareness of Death
- Special Occasions
- Vacations
- Residential History/Plans
- Education
- Employment/Retirement
- General Health Information
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- Current Physicians
- Allergies
- Prescription Medicines
- Adult Immunizations
- Protecting Legal Rights
- Financial Information
- Guardianship
- Parent/Family Wills
- Insurance Coverage
- Final Arrangements
- Quick Reference

“Somewhere there is a map of how it can be done.”

Ben Stein

PERSONAL INFORMATION SUMMARY

FOR:

Prepared by:

Check or circle appropriate choices.
When necessary to add written answers, give as much detail as possible

Name:			Nickname:		
Social Security Number:		Medicare #:		Medicaid #:	
Date of Birth:		Place of Birth:			
Gender:	Male	Female		Race:	
Height:	Weight:		Eye Color:	Hair Color:	
US Citizen:	Yes	No	Registered to Vote:	Yes	No
Registered Selective Service:	Yes	No	Date Registered:		
Primary Spoken Language:					

BENEFITS AND SERVICES

This section deals with government benefits and services provided to the person.
Check any that apply. Use reverse side or attach extra pages as needed.
Refer to the Financial Section for details regarding funding benefits.

Person is now receiving:					
Social Security Benefits as:		Worker <input type="checkbox"/>		Dependent <input type="checkbox"/>	
Food Stamps	Housing Assistance	Medicare	Supplemental Security Income (SSI)	Medicaid	
Other Benefits:					

Takes part in the following programs:

Program	Name of Provider	Phone Number	Paid By
Residential Habilitation			
Day Training (ADT)			
Sheltered Workshop			
Supported Living			
Supported Employment			
Respite Care			
Day Care			

Senior Center			
Homemaker			
Personal Care			
Transportation			
Other (Name)			

A consumer in the Developmental Disabilities Program?	Yes	No
On the Developmental Disabilities Home and Community-Based Medicaid Waiver?	Yes	No

District Phone #	Address

Support Coordinator is: (Name)	Address	Phone Number

Other Social Worker(s) Involved: (Name)	Address	Phone Number

RELIGIOUS AFFILIATION					
Regularly attends religious services:	Yes	No			
These services are held at:					
Address:				Phone Number:	
Usually attends on:	(day)	AM	PM		
Is a member:	Yes	No	Requires assistance to attend:	Yes	No
Attends church related activities:				Yes	No

FAMILY and FRIENDS of MOTHER			
Name:			
Current Address:			
Phone Number: (Home)	(Work)	Social Security No.:	
Date of Birth:	Place of Birth:	Where Reared:	
If Deceased, Date:			

Race:	Blood Type:	Religion:	US Citizen:	Yes	No
Served in Military:	Yes	No	Railroad Employee:	Yes	No
Number of Brothers:	Sisters:				
Marital Status:	Married	Widowed	Separated	Divorced	Single
Primary Spoken Language:					

Spouse (beginning with current):		
NAME	DATE OF MARRIAGE	DATE OF DEATH (D) OR DIVORCE (DI)

FAMILY and FRIENDS of FATHER					
Name:					
Current Address:					
Phone Number: (Home)	(Work)	Social Security No.:			
Date of Birth:	Place of Birth:	Where Reared:			
If Deceased, Date:					
Race:	Blood Type:	Religion:	US Citizen:	Yes	No
Served in Military:	Yes	No	Railroad Employee:	Yes	No
Number of Brothers:	Sisters:				
Marital Status:	Married	Widowed	Separated	Divorced	Single
Primary Spoken Language:					
Spouses (beginning with current):					
NAME	DATE OF MARRIAGE	DATE OF DEATH (D) OR DIVORCE (DI)			

FAMILY and FRIENDS of BROTHERS AND SISTERS			
NAME	ADDRESS	PHONE NUMBER	DATE OF BIRTH

List relatives who are emotionally closest to the person:

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List other relatives who know and care about the family member:

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP

List special friends who are well known and liked by the person:

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP (Personal, co-worker, neighbor, other)	LENGTH OF RELATIONSHIP (YEARS)

The following individual(s) has at times been an advocate helping get needed services and supports: (Identify with * if named official client advocate by the Developmental Disabilities Program.)

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP (Personal, co-worker, neighbor, other)

s The person has _____ ha not _____ learned self-advocacy skills.

HAS A CIRCLE OF FRIENDS (ORGANIZED SOCIAL GROUP): YES NO

Contact Person for Circle of Friends	Name	Address	Phone Number

Frequency of Meetings: Weekly Monthly Other

A DAY IN THE LIFE OF: _____
(NAME)

List morning medications:						
Arises at:		AM				
Needs assistance with:	Hygiene		Dressing		Grooming	
Prefer:	Shower	Bath	Taken:	PM	AM	
Aids or appliances used to get around include:						
Braces	Special shoes	Walker	Wheelchair	Crutches	Positioning aids	Other
Uses:						
Eyeglasses	Contact lens	Hearing aids	Telecommunication devices (TDD)		Communication board	
Other Communication Devices (list):						

Able to eat without help:	Yes	No	If No, needs help with:			
Uses:	Special plate	Special utensils		Special cup		Straw
Has problems with choking:	Yes		No			
Is able to drink:	Thin Liquids			Thickened Liquids		
Usually ready to start the day at:	AM		By going to:			
Transported by:						

BEDTIME PREPARATION						
List bedtime medications:						
List any routine activities performed at bedtime.						
Usual bedtime:	PM					
Is there a quiet time/meditation:	Yes	No	If Yes, describe:			
Help needed getting to sleep:	Yes			No		
Describe sleep pattern (how well, how long usually sleeps)						
SAFETY PRECAUTIONS						
Can the person be left unsupervised:	Yes			No		
For how long?	Minutes		Hours		Days	

Recognizes danger of: (Circle those that apply)			
Heat Sources	Poisonous Materials	Open Windows	
Sharp Objects	Hot Water	Traffic	
Can evacuate building on hearing alarm?		Yes	No
Needs physical/verbal prompt to evacuate building?		Yes	No

LIKES AND DISLIKES		
Likes		
Favorite people to live with:		
NAME	ADDRESS	PHONE NUMBER

Favorite people to spend time with:		
NAME	ADDRESS	PHONE NUMBER

Favorite pets:	
NAME	TYPE

Favorite color:

Favorite clothing or possessions:	
CLOTHING	POSSESSIONS



LIKES AND DISLIKES

Likes (con't.)

Favorite foods, drinks, restaurants:

FOODS	DRINKS	RESTAURANTS

Recipe for favorite foods may be found:

Favorite recreation:

TV SHOWS	MOVIES	MUSIC	SPORTS	HOBBIES

OTHER:

Dislikes

Dislikes living with:

Dislikes spending time with:

Disliked pets:

NAME	TYPE

Disliked clothing or possessions:

CLOTHING	POSSESSIONS

Disliked foods, drinks, restaurants:

FOODS	DRINKS	RESTAURANTS



Dislikes (con't.)

Disliked recreation:				
TV SHOWS	MOVIES	MUSIC	SPORTS	HOBBIES
OTHER:				

Do violent or sexually suggestive TV, movies, music, sports activities lead to behavior problems?	Yes	No
When has the person been most unhappy?		

FEARS AND PHOBIAS		
Afraid of: (Circle those that apply)		
Strange people	Enclosed spaces	Buses
Animals	Open spaces	Loud noises
Heights	The dark	Cars
Other		

COMMENTS:

SPECIAL OCCASIONS	
Special dates usually observed:	
Holidays (Name which)	

Birthdays (Name and date):					
NAME			DATE		
Usually buys cards:	Yes	No	Attends party:	Yes	No
Usually buys gifts:	Yes	No	Price Range:	\$	\$

VACATIONS				
Activities enjoyed: (Circle those that apply)				
Group Day Trips	Arts and Crafts	Fishing	Visiting Neighbors	
Senior Center Activities	Community Outings	A Hobby	Taking Trips	
Visiting Family/Friend	Going to Recreation Parks	Specialized Camps		
Other (Describe):				
Traveling enjoyed:				
Car	Bus	Train	Plane	Boat/Ship
Usual travel companion is:				
Favorite vacation destinations:				
Frequency of trips:		Planned by:		
Unpleasant vacation experiences in the past:				
Has spending money for vacation:	Yes	No	Amount range:	\$

RESIDENTIAL HISTORY/PLANS				
Describe the type of home or residence where the person has lived in the past, where he lives now, and how he would like to live in the future.				
Currently lives in:				
Own Home/Apartment	Shared Home/Apartment	Family Home	Assisted Living Facility	Foster Home
Group Home	ICF/DD	Residential Habilitation Center	Skilled Nursing Home	
Other (Describe):				
Requires the following support services to live there:				
Lives with:				
Optimal level of supervision required:	Low	Med	High	
Other:				

Monthly Cost is:	Paid by:	
Caregivers with whom the person has lived previously (start with most current):		
NAME	ADDRESS	REASON FOR LEAVING

In the future, the particular type of home we prefer is:				
Own Home/Apartment	Shared Home/Apartment	Family Home	Assisted Living Facility	Foster Home
Group Home	ICF/DD	Residential Habilitation Center	Skilled Nursing Home	
Other (Describe):				

If a group setting, preference for number of residents who live there is:			
If with family or friends, arrangements	HAVE	HAVE NOT	already been made with:
Name:	Address		Phone Number

The type of neighborhood preferred is:	Urban	Suburban	Rural
The home should be near:	Bus Stop	Grocery Store	Work place
	Hospital	Church	Family members
Other:			
Can use this kind of transportation:			
	Bus	Train	Taxi
With Help	Yes / No	Yes / No	Yes / No
Other:			Yes / No

SPECIAL OCCASIONS			
Cannot use:			
Bus	Train	Taxi	Other:

EDUCATION					
School Records					
Last school attended:					
Name:				Phone Number:	
Address:					
Classes: Regular	Yes	No	Mainstreamed Special Education:	Yes	No
Other Special Program:					
Relationship with peers:	Excellent	Good	Fair	Poor	
Learning Style					
Adapts to new situation easily:	Yes	No	Becomes upset/agitated in new situations:	Yes	No
Becomes destructive or self abusive when agitated:	Yes		No		
Describe behaviors:					

What calms person when agitated?					
Overly friendly/affectionate to strangers:	Yes	No	Has age appropriate manners:	Yes	No



AWARENESS OF DEATH		
Have you discussed your own death with the person?	Yes	No
Have you discussed the person's death with him/her?	Yes	No
Has the person experienced the death of a loved one?	Yes	No
Has the person experienced the death of a pet?	Yes	No
Has the person visited a funeral home?	Yes	No
Has the person visited a cemetery?	Yes	No
Has discussed the person's desires regarding organ or tissue donation?	Yes	No

List the members of the immediate family who have died during the person's lifetime. Indicate their relationships (uncle, grandmother, etc.), and date when each death occurred.

Relative who Died	Who told about the death	Date of Death	Attended funeral (Yes No)

How did the person grieve these losses? Describe these behaviors.

Did the person ever undergo grief counseling?	Yes	No
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Name others who were close to the person and left either to retire, relocate or for other reasons. List these persons and their relationships.

NAME	RELATIONSHIP	CAN BE REACHED AT:

EMPLOYMENT/RETIREMENT								
During the day goes to:								
A regular job		Full time			Part time			
Activities program		Sheltered workshop		Service center		Volunteer		
Other:								
Receives health benefits:		Yes	No	Dress for work:		Uniform	Casual	Dress
Has a job coach:		Yes	No	Name			Phone Number	
Complete employment table on the next page if person has an employment record.								
It is anticipated that the person will be ready to retire by:								

ADDITIONAL NOTES:

GENERAL HEALTH INFORMATION

Provide a brief summary of Medical History

This section deals with health issues of the person with a disability. First gather all current medications and medical records, past and present. Addresses and phone number for health care providers are also needed, so have them handy. Provide as much detail as possible.

Birth date	Age	Height:	Feet	Inches
Weight:	Average	Overweight	Underweight	
Special diet:				
Blood Type:		Blood Disorder:		
Name of Physician:		Phone Number:		
Date of Last Physical:				
Who has person's medical records?	Name:			
Address:		Phone Number:		

DISABILITY INFORMATION

Primary Diagnosis:	Cause, if known:
Secondary Diagnosis:	Cause, if known:

Other Chronic Health Conditions:	Yes	No
CONDITION	TREATMENT/MEDICATION	

Does person smoke?	Yes	No	Amount:	
Drinks alcohol?	Yes	No	Amount:	
Use recreational drugs?	Yes	No	Drug Used:	Frequency:



CURRENT PHYSICIANS			
Name	Profession	Phone Number	Date Last Seen
	Primary physician		
	Dentist		
	Optometrist/Ophthalmologist		
Specialists and other health care providers (speech/physical therapist, nutritionist, nurse practitioner, psychologist, etc.):			
ALLERGIES (Food, Medicine or Substances)			
List:			
When an allergic reaction occurs, this is what happens:			

Non-prescription (over-the-counter) medicines taken for headaches, colds, constipation, skin problems, indigestion, etc. Indicate whether as needed or regularly and for what condition:

Able to take medication without assistance:	Yes	No
Describe assistance needed or special way required (e.g. crushed, with food, etc.):		

Knows names of own medication:	Yes	No
Recognizes own medications:	Yes	No
Knows purposes of own medications:	Yes	No

PRESCRIPTION MEDICINES
Look at the bottles of medicines now being taken for the following information. Copy this information on the form provided on the following page.

Special equipment or assistive device(s):				
Device	Purchased at:	Maintained at:	Phone Number	Method of Payment

Signs own consent forms for health care:	Yes	No	Copies are located:
Has signed an advance directive:	Yes	No	Copies are located:
Living Will:	Yes	No	Copies are located:
Health Care Surrogate: Name			Copies are located:
Do not resuscitate order:	Yes	No	Copies are located:
Carries a copy in wallet or purse	Yes	No	*Attach a copy with this Personal Information Summary
Has signed an organ/tissue donation card:	Yes	No	

Has been admitted to a hospital within the past five (5) years:

Reason	Emergency (Yes or No)	Hospital (Location)	Date

Surgery (an operation):			
Reason	Name of Surgeon	Hospital (Location)	Date

Presently receiving physical or occupational therapy:			
Type of Therapy	Therapist's Name	How Often	Date Started

Receiving Mental Health service:			
Type of Services	Physician's Name	How Often	Date Started

The following activity (e.g., being overheated) results in seizures:

Certain activities can cause other problems (e.g., ear infections). Activity and problem that results:

List preference for performing health and hygiene routines in special ways.

Task Needed	How Performed

Date of adult immunizations are:

Name of Immunization	Date	Booster(s) Date
Tetanus and Diphtheria		
Measles		
Hepatitis B		
Flu Shot (Influenza)		
Pneumonia (pneumococcus)		

Special Diet:

Special Food Preparation:

Functions sometimes requiring assistance:

Life Area		Help Needed
<i>Thinking / Understanding</i>		
<i>Seeing / Vision</i>	Normal	Normal with Glasses
	Impaired	Legally Blind
	Last Eye Exam:	
	Frequency Required:	
<i>Hearing</i>	Normal	Normal with hearing aid
	Hypersensitive	Impaired
	Deaf	
<i>Speech</i>	Normal	Uses sign language
	Impaired	Uses Communication Device
<i>Mobility</i>	Normal	Wheelchair
	Special Shoes	Impaired
	Uses Walker	Uses Artificial Limb
	Uses other Orthopedic devices (List):	

Periodic health screenings are an important way to stay healthy. Indicate the most current medical examinations.

Examination	Date	Examination	Date
Mammogram		Dental Checkup	
Vision Check		Blood Pressure Check	
Gynecological exam, Pap smear		Annual Physical Checkup	
Hearing Check		Glaucoma (family history)	
Prostate			

A doctor has recommended that the person have the following special checkups regularly:

Prescribed by:	Where Administered	For What Problem	Frequency Required	Duration

Frequency of bowel movement:

Problems with constipation:	Yes	No	Remedy:
Problems with urination:			
Urinary Infections	Frequent Urination	Bladder Leakage (Frequency):	

PROTECTING LEGAL RIGHTS AND FINANCIAL STATUS

This section describes the financial arrangements that have been made to benefit the person and protect legal rights. Be sure that the names of any financial advisors are included as well as copies of court orders or other legal papers.

Person needs assistance with:

Banking	Paying Bills	Making Purchases	Counting Money	Recognizing Denominations of Money
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Financial Safeguards:

Two Signature Checking Accounts	Representative Payee	A Trust
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Other (Describe):

Name of Trust:

This trust is:	Revocable	Special Needs	Irrevocable
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TRUSTEES	NAME(S)	ADDRESS(ES)	PHONE NUMBER(S)
Current			
Successors			
Copy of the trust can be found:			

POWER OF ATTORNEY

Has power of attorney been given to anyone:	Yes	No	Limited	Durable
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If Yes, Name:

Phone Number:

Address:

REPRESENTATIVE PAYEE

Does a representative payee receive benefits for the person?	Yes	No
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Name:

Phone Number:

Address:

Does the person receive?	Yes/No	Amount Per Month
A pension / retirement income?		
Trust income		
Social Security benefits		
Supplemental Security income		
Other benefits / income (specify):		



BANKING INFORMATION

Name of Bank	Name (s) on Account (Signature Authority)	Account #	Type (Savings, Checking, Joint)

FUTURE BENEFITS

Is person named as beneficiary of another's person's policies or accounts?		Yes	No
Policy Holder:			
Name	Address	Phone Number	

Insurance Company (Name)	Address	Policy Number

GUARDIANSHIP

A guardian has been appointed.		Yes	No	
Type of guardianship:				
Plenary Guardian	Limited Guardian	Guardian Advocate	Co-Guardian	Co-Guardian Advocate
Date of appointment:	City	County	State	

A copy of the guardianship court order, and/or case number can be found (name place or person).

Name of Guardian, Guardian Advocate, and Co-Guardian	Relationship	Address	Phone Number

Name areas for which guardian must give consent:

Identification cards are with:		
Name	Address	Phone Number

Premiums are paid by:		
Name	Address	Phone Number

Copies of policy(ies) are with:		
Name	Address	Phone Number

FINAL ARRANGEMENTS
Persons to contact at time of death:

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP (Personal, co-worker, neighbor, other)

Funeral and burial arrangements have been made:	Yes	No	Prepaid:	Yes	No
Burial plot purchased:	Yes	No	Headstone/Marker	Yes	No
Type of Marker preferred and epitaph:					
If prepaid, policies, contracts can be found:					

Cemetery/Mausoleum Name:	Address	Other:

Preferred funeral company (if applicable):		
Name:	Address	Phone Number

Cremation:		
Burial of ashes	Internment of Ashes	
Ashes Given to:	Name	Address

Memorial Service:	Yes	No	Location:
Special content of service:	Yes	No	Describe:
Flowers	Yes	No	Specified donations:
Songs to be played:			

Invite these persons to the service:			

Preferred Clergy/Eulogist	Address	Phone Number

QUICK REFERENCE

Is currently known to the following developmental disabilities professionals:

Social Worker:	Phone Number:
Support Coordinator:	Phone Number:
Other professional (coach, supervisor, etc.):	
Agency Title:	Phone Number:

Needed services or benefits that have not been provided are:		
Name of Service (Benefit)	On Waiting List	
	Yes	No

The current support plan is attached to this Information Summary.	Yes	No
The date(s) when the next Support Plan is due is:	____/____/____	____/____/____



____/____/____	____/____/____	____/____/____
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Date Personal Information Summary has been updated:		
Page	Date of Change	Signature


Page	Date of Change	Signature

Include current photograph.

Attach Support Plan to this document.

Authority Signature

Date

|  Section 2, The Personal Information Section

NAVIGATING THE DEVELOPMENTAL DISABILITIES PROGRAM: YOU'RE THE DRIVER



SECTION 3

HELPFUL ATTACHMENTS

Sponsored by The United States Department of Health and Human Services.,



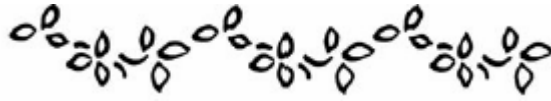
Developmental Disabilities Council, Inc.

Sponsored by The United States Department of Health and Human Services
Administration on Developmental Disabilities and the Florida Developmental Disabilities Council, Inc.

Section 3, Helpful Attachments

MY TRIP PLANNER: PLANNING AHEAD





Suggested form of a Living Will, Florida Statutes Section 765.303.

A living will may, BUT NEED NOT, be in the following form:

LIVING WILL

Declaration made this ____ day of _____ 2_____, I _____
Willfully and voluntarily make known my desire that my dying not be artificially
prolonged under the circumstances set forth below, and I do hereby declare that,
if at any time I am incapacitated and

_____ (initial) I have a terminal condition.

or _____ (initial) I have an end stage condition.

or _____ (initial) I am in a persistent vegetative state.

and if my attending or treating physician and another consulting physician have
determined that there is no reasonable medical probability of my recovery from
such condition, I direct that life-prolonging procedures be withheld for withdrawn
when the application of such procedures would serve only to prolong artificially the
process of dying, and that I be permitted to die naturally with only the
administration of medication or the performances of any medical procedure
deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as
the final expression of my legal right to refuse medical or surgical treatment and
to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and
informed consent regarding the withholding, withdrawal, or continuation of life-
prolonging procedures, I wish to designate, as my surrogate to carry out the
provisions of this declaration:

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

I understand the full import of this declaration, and I am emotionally and mentally
competent to make this declaration.

Section 3, Helpful Attachments

MY TRIP PLANNER: PLANNING AHEAD



Additional Instructions (optional):

(Signed): _____

Witness _____ Witness _____

Street Address _____ Street Address _____

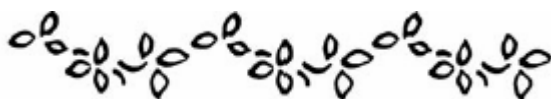
City, State, Zip _____ City, State, Zip _____

Phone _____ Phone _____

The principal's failure to designate a surrogate shall not invalidate the living will

~ This form offered as a courtesy of The Florida bar and the Florida Medical Association ~





Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203

Designation of Health Care Surrogate

Name _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name _____

Street Address _____

City _____ State _____ Zip _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____

Street Address _____

City _____ State _____ Zip _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____

Name _____

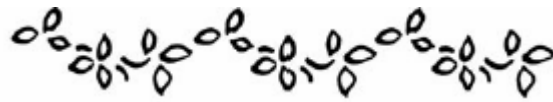
Signed: _____

Witnesses 1. _____ 2. _____

At least one witness must not be a husband or wife of a blood relative of the principal.

~ This form offered as a courtesy of The Florida Bar and the Florida Medical Association ~

Section 3, Helpful Attachments



My Personal Outcomes

WHO AM I?

What goals have I set for myself?

Where and with whom do I want to live?

What do I want to do for my work?

Who is closest to me?

How satisfied am I with the services and supports I receive?

How satisfied am I with my personal life situation?

MY SPACE

What are my preferred daily routines?

Do I have the time, space and opportunity for the privacy I need?

Am I in control of who knows personal information about me?

Do my home, work and other environments support me to do what I want and need to do?

MY COMMUNITY

Do I have access to the places I want to be?

Do I participate in what happens in my community?

Am I pleased with the type and extent of my interaction with other people in my community?

Am I known for the different social roles I play?

Do I have enough friends?

Am I respected by others?

MY SUCCESSES

Are the supports and services I receive the ones I want?

Have I realized any of my personal goals?

MY SAFEGUARDS



Am I connected to the people who support me most?

Am I safe?

MY RIGHTS

Do I exercise the rights that are important to me?

Do I feel that I am treated fairly?

MY HEALTH

Is my health as good as I can make it?

Am I free from abuse and neglect?

Do I have a sense of continuity and security?

The Personal Outcome Measures (often referred to as the “POMs”) are 25 areas of a person’s life that are used to discover who you are and what is important to you. Support Coordinators and providers are encouraged to discuss with you the POMs and other person-centered approaches to discover important aspects of your life. The POMs also look at very critical foundations in your life such as

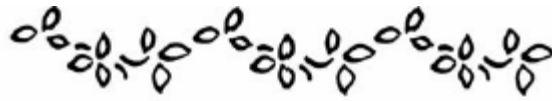
- health and safety,
- continuity and security,
- rights and fair treatment,
- abuse, neglect and exploitation, and
- respect.

The Council on Quality & Leadership developed the Personal Outcome Measures. You can find out more about the Personal Outcomes by visiting the Council’s website at www.thecouncil.org.

(Footnotes)

1 The Personal Outcome Measures are copyrighted by the Council on Quality and Leadership.





Bill Of Rights

In June of 1975 the Governor of Florida signed in to law the “Bill of Rights”. The purpose of this law is to give importance to rights for individuals with developmental disabilities who are citizens of Florida. These rights include:

The Right to dignity, privacy and humane care,

The Right to religious freedom and practice,

The unrestricted Right to communication,

The Right to personal possessions and effects,

The Right to education and training,

The Right to participate in community activities and to social interaction,

The Right to prompt and appropriate medical care and treatment,

The Right to behavioral and leisure time activities,

The Right to physical exercise,

The Right to humane discipline,

The Right to physical examination prior to subjection to a treatment program to eliminate bizarre or unusual behaviors,

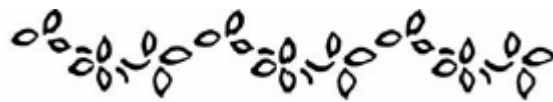
The Right to minimum wage protection and fair compensation,

The Right to vote,

The Right to be free from physical restraint, and

The Right to a central record.





Redesign Initiatives – A Brief Overview

In February 2002 the Department of Children and Families, Developmental Disabilities Program, now the Agency for Persons with Disabilities, began working with the Agency for Health Care Administration and stakeholders ~ individuals with developmental disabilities, their family members, service providers and other advocates ~ on a system of redesign of the Home & Community Based Waiver. That redesign addressed seven components:

- appropriate assessment,
- individual budgets,
- flexible services,
- fair and equitable rates,
- a redefined role of support coordinators,
- direct billing for providers, and
- communication.

The appropriate assessment developed for use by the Developmental Disabilities Program is called the Individual Cost Guidelines (ICG) and replaces the Florida Status Tracking Survey. It is a tool for predicting a person's individualized costs and may only be administered by someone who is trained and certified in its use. In September, 2003 the program began using this new tool which serves as the first step in the support planning process.

The individual budget is based on the results of each person's ICG, and is considered the second step in the support planning process. Using the individual's needs identified on the ICG, and incorporating the standardized statewide rates for services, the state is able to approximate one's individual budget. Another tool that was developed for use during this part of the process was the Personal Budget Worksheet, which can be used to identify costs related to ALL needs and preferences for the person. It can serve as an aid during the planning and decision-making process.

A system of flexible services was proposed that would make it easier for individuals to move their approved cost plan dollars around and change services based on the changing needs of their lives. The 32 current waiver services were collapsed into eight broad categories of similar services. The implementation of this component is still in the development stage.

In July 2003 the Developmental Disabilities Program instituted a new statewide standardized rate system for all Medicaid Waiver providers. The purpose of the rate system was to establish statewide rate consistency and to accommodate current and long-term system funding needs.

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These new rates are driven by direct care staff salaries and provide multiple fixed rates with limited exceptions.

Stakeholders requested a change in the responsibilities of waiver support coordinators so that they could increase assistance to individuals. Direct-provider billing allowed Medicaid Waiver providers to submit invoices for payment directly to Medicaid. That change eliminated that task from the responsibility of waiver support coordinators. With the introduction of standardized rates, support coordinators no longer needed to be involved in rate negotiations. Another change in support coordination includes the creation of a limited support coordination option. Individuals who live with families can now opt for less support from the support coordinator. The agency has established a specific policy for limited support coordination. If you feel you are interested in limited support coordination, you should thoroughly review and research this alternative and talk with your support coordinator or staff at the agency before making this change.

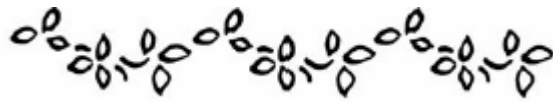
The final component of the system redesign is improved communication:

- Regularly send E-Bulletins
- Conduct district forums
- Improve the DD website
- Expand Choice Counseling to all individuals receiving services from the agency (previously only available to persons in ICFs)
- Strengthen the role of the Family Care Councils, and
- Implement web-based training

The Developmental Disabilities Program began regularly sending E-Bulletins to anyone interested in keeping up with the changes and learning more about services and supports. Their web site was updated and expanded. It continues to be a source of up-to-date information about the program. The web-site address is **www.apd.myflorida.com**.

The system redesign that began in 2002 was the beginning of changes that are meant to improve the program for individuals with developmental disabilities. Following the 2003 legislative session, the Consumer Directed Care Plus Waiver was approved by CMS as a Florida waiver. It allows Florida to continue the Robert Wood Johnson Consumer Direct Care pilot project and is open to individuals who were part of the experimental project and those who were participating in the Choice and Control pilot. Further expansion of this waiver has not been determined yet. During the 2004 session, the Florida Legislature expanded the Family Supported Living waiver and opened it to children, as well as adults. Five services are available through this waiver and it will be offered to people who are on the waiting list for services. In addition, the Legislature created the Agency for Persons with Disabilities. The new agency will take responsibility for the Developmental Disabilities Program and the Developmental Services Institutions (including the Mentally Retarded Defendant Program ((MRDP)) on October 1, 2004. A Blue Ribbon Task Force was formed to address the many aspects of forming the Agency for Persons with Disabilities. The final report from this task force is available on the APD website. Users of this guide are highly encouraged to visit the referenced web site for updates and changes.

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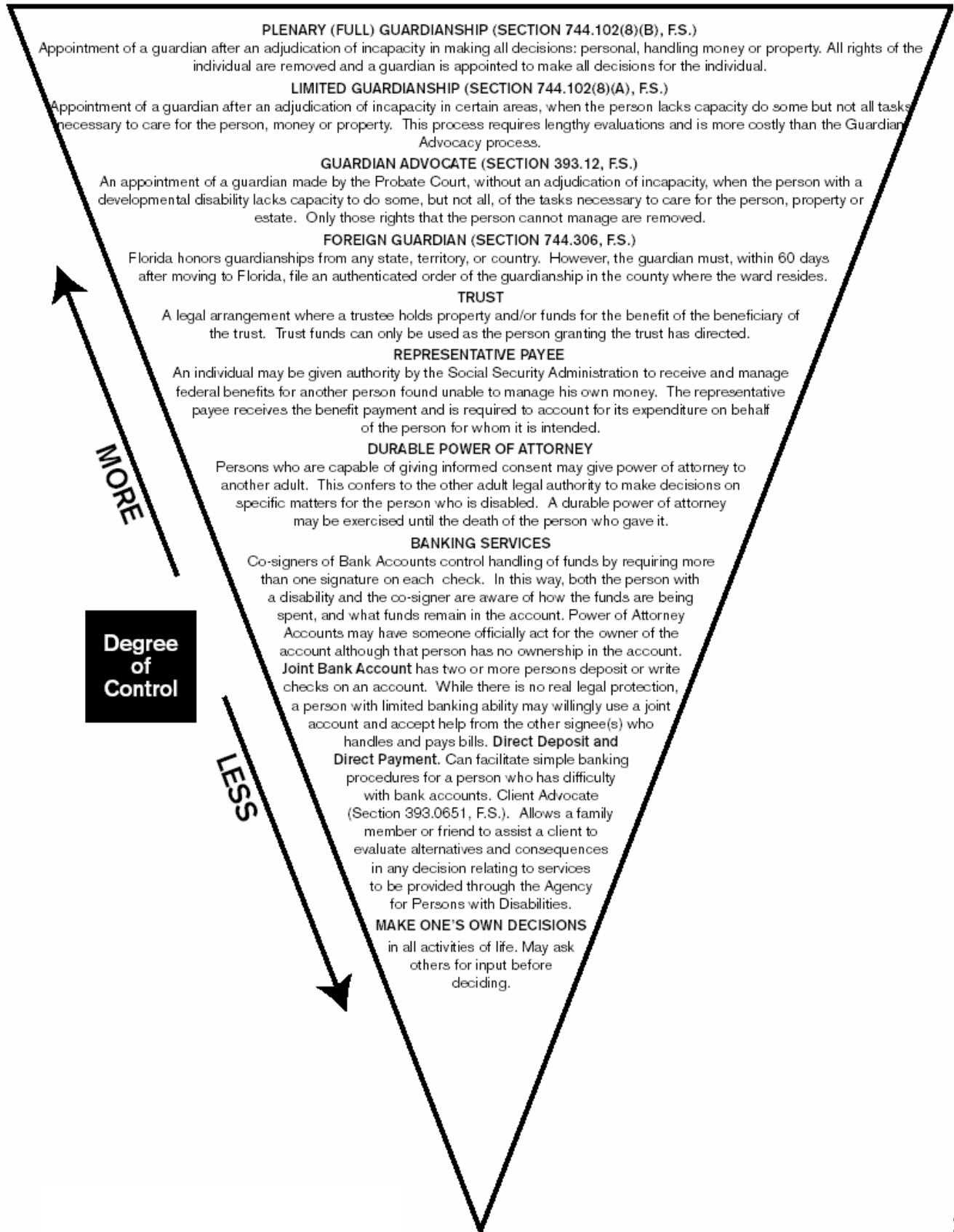
A Comparison Of Guardianship Statutes

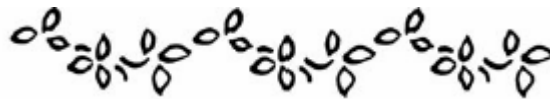
Chapter 393	Chapter 744
<p>Petition to determine incapacity:</p> <p>NONE</p>	<p>Petition to determine incapacity:</p> <p>Petitioner alleges person to be incapacitated, specifying information on which belief is based; states which rights enumerated in statute is incapable of exercising. The petition for appointment of a guardian must be filed WITH this petition</p>
<p>Examining Committee:</p> <p>NONE.</p> <p>Existing evaluations that have been performed by the appropriate professionals for the alleged disability are used, as well as any other existing evaluations and support plans that exhibit the need for appointment of a guardian. These are usually evaluations that have been used to determine eligibility for services in the Developmental Disabilities Program and plans identifying which services are needed.</p>	<p>Examining Committee to determine incapacity:</p> <p>3 members – One must be psychiatrist or other physician; one may be either a psychologist, gerontologist, another psychiatrist or other physician, a registered nurse, nurse practitioner or licensed social worker; one may be any of the above. One member of the committee must have knowledge of the alleged disability. Members of the committee may not be related to or associated with one another or with the petitioner or alleged incapacitated person. Petitioner or family physician MAY NOT be on committee. However, if the family physician is available, the committee MUST consult with him/her.</p>

<p>Adjudicatory hearing to determine incapacity:</p> <p>NONE</p>	<p>Adjudicatory hearing to determine incapacity:</p> <p>Alleged incapacitated person must be present unless waived by him/her. Partial or total incapacity must be established by clear and convincing evidence</p>
<p>Petition for appointment of guardian advocate:</p> <p>Must state name, age, address of petitioner and relationship to person with DD, specify why person needs a guardian advocate and areas of incapacity; state name of proposed guardian advocate.</p>	<p>Petition for appointment of guardian:</p> <p>Must be filed with petition to determine incapacity.</p>
<p>Removal of rights:</p> <p>Only those rights that evaluations and testimony of witnesses have identified are delegated to the appointed guardian advocate.</p>	<p>Removal of rights:</p> <p>Rights the committee has identified as those the individual cannot perform are removed and given to the appointed guardian advocate.</p>
<p>Fees:</p> <p>NONE. (If person with the developmental disability cannot afford counsel, the court shall appoint one to represent the person.)</p>	<p>Fees:</p> <p>Examining committee and attorney appointed are paid from general fund of the county and county has a creditor's claim against guardianship property.</p>
<p>Hearing for appointment of guardian advocate:</p> <p>Is held as soon as practicable after petition is filed, but reasonable delay for investigation, discovery, or procuring counsel or witnesses shall be appointed</p>	<p>Hearing for appointment of guardian:</p> <p>May be held at conclusion of hearing on incapacity.</p>



LEGAL WAYS OF PROTECTING RIGHTS





Guardianship To-Do List

(Step-by-Step Procedure
)

This is a short reminder list – like your grocery list – of what you can expect to be involved in IF you decide that you NEED to seek guardianship. It is based on what you have learned from Chapter 8 of PLANNING AHEAD.

1. Determine what is the least restrictive and most appropriate action you need to take:
 - Durable power of attorney
 - 393.12 – Guardian Advocate
 - 744 – Guardian

2. It is assumed that you have decided that need to become a guardian advocate as found in Chapter 393, F.S.
 - Select an attorney (with input from the “potential ward” to the extent possible)

3. Engage your selected attorney and provide him/her with the most current evaluations from:
 - School
 - Agency for Persons with Developmental Disabilities
 - Psychologists, Physicians, or others who can document incapacity

4. Discuss with your attorney who you wish, and who is willing, to be **standby guardian**.

5. Involve the potential ward in the process helping him/her understand what the outcome will be, the process for getting there, and what his/her role will be.

6. Sign the petition for guardian advocate (393.12, F.S.)

7. With the potential ward, attend the hearing and be prepared to testify if requested by your attorney.

8. When court order is received, read it. Make certain it is clearly understandable. Notify appropriate service providers, offices, and agencies by providing them with a copy of the order when appropriate.

9. Annually provide the court with an annual report for the past year as well as a guardianship plan for the following year.

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BIBLIOGRAPHY



The Accreditation Council on Services for People with Disabilities, Outcome Based Performance Measures, Towson, Maryland, 1993.

Association for Retarded Citizens, Roadmap to Supports and Services in Florida for People with Mental Retardation and Other Developmental Disabilities, July 1997.

Berkobien, Richard, A Family Handbook on Future Planning, Association for Retarded Citizens of the United States, Arlington, Texas, 1991.

The Council on Quality and Leadership in Supports for People with Disabilities, Personal Outcome Measures, Towson, Maryland, 1997.

Developmental Services, Florida Department of Children and Families, Due Process Rights, March 2000.

Dinerstein, JD, Robert D., Herr, JD, D Phil, Stanley S., O'Sullivan, Joan L. (eds.), A Guide to Consent, American Association on Mental Retardation. The Family Trust, Family Trust Personal Planning Guide, Pittsburgh, Pennsylvania.

Florida Developmental Disabilities Council, Incorporated in association with The Florida Department of Children and Families Developmental Services Program, Choices and Planning: Supports and Services for Individuals With Developmental Disabilities, Tallahassee, Florida, October 1999.

Florida Developmental Disabilities Council and the Department of Children and Families A Guide to Supported Living in Florida, Tallahassee, Florida, September 1997.

Florida Developmental Disabilities Council and the Florida Department Health and Rehabilitative Services, Developmental Services Program Office, Support Coordination Guidebook, July 1996.

Section 3, Helpful Attachments

Maryland Developmental Disabilities Council, Planning Now: A Futures and Estate Planning Guide for Parents of Children and Adults with Developmental Disabilities, Baltimore, Maryland, July 1999.

New York State Developmental Disabilities Planning Council, Planning for the Future: A Guide for Families and Friends of People with Developmental Disabilities, New York, 1997.

Rinere, Vicki, Opening Public Agency Doors – Title II of the Americans with Disabilities Act and People with Mental Illnesses: A Collaborative Approach for Ensuring Equal Access to State Benefit and Service Programs, Judge David L. Bazelon Center for Mental Health Law, Washington, D.C., August 1995.

Russell, J.D., L. Mark, Grant, J.D., Arnold E., Joseph, C.F.P., Suzanne M., and Fee, M.Ed., M.A., Richard W., (eds.) Planning For The Future: Providing a Meaningful Life for a Child with a Disability after Your Death, Evanston, Illinois, 1993.

Sherman, Jean, Ed.D., RN, PREPPARE: A Curriculum for Parents and Caregivers of Adults with Developmental Disabilities, University of Miami School of Medicine, 1996.

State of Florida, Department of Children and Families Developmental Services, Home and Community-Based Services Waiver Services Directory.

