

Support Plan Development, Part 2 Assessing Needs and Risks

Supplemental Resources

Table of Contents

This document contains the forms, tables, lists, and websites that were either displayed or referred to in the Support Plan Development – Part 2 Pre-Service training. This document also contains additional resources to aide new WSCs in gaining the skills necessary to effectively coordinate the supports and services for individuals on their caseload.

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Support Plan Development, Part 2

Assessing Needs and Risks

Self-Determination and Significant Risks

It is important for the support plan to clearly identify significant risks present in the individual's life. Support coordination cannot eliminate risks completely, but it is the role of the WSC to ensure that the person's health and safety are maintained.

Dignity of Risk

"Dignity of risk" is a term that originated in the 1970s and centers on the issue of care for persons with developmental disabilities. Up to this point, people with disabilities were understood as being incapable of living independently and of making life choices, which essentially denied them the ability to experience life like anyone else. Dignity of risk means that all individuals have the right to experience life, and with that experience comes a certain amount of risk.

Dignity of risk is founded on the principle of self-determination, or the idea that the individual has the right to control and direct their life to the maximum extent possible. Both self-determination and dignity of risk require those caring for individuals to support them as they direct their own lives and, in turn, experience both success and failures.

What is a significant risk?

Significant risks are needs that, if not addressed, could result in institutionalization, medical attention, or legal action, or could endanger the individual or others. Significant risks have the potential to be life threatening or to result in abuse, neglect, or exploitation.

While information related to an individual's critical needs or risks should be included throughout the support plan as needed, the main sections for this type of information are:

- Other Services Needed for Health and Safety
- Back-up Plans for My Critical Needs/Risks
- Personal Rights
- My Health
- Equipment and Supplies
- Personal Disaster Plan

Information for these sections will come from the individual's most current Questionnaire for Situational Information (or QSI), medical case manager reports, doctor recommendations, behavior analysis reports, and other documentation from licensed practitioners, such as care plans and annual reports.

The following are images of the support plan sections that address health and safety needs.

Other Services Needed for Health and Safety

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			
Hearing			
Eating			
Ambulation			
Transfers			
Toileting			
Hygiene			
Dressing			
Communications			
Self-protection			
Ability to Evacuate (Home)			
Behavioral (Choose all that apply)			
Hurtful to Self/Self-injurious			
Aggressive/Hurtful to Others			
Destructive to Property			
Inappropriate Sexual Behavior			
Running Away			
Other Behaviors that May Result in Separation from Others. List "Other" behaviors:			
Physical (Choose all that apply)			
Injury to Person Caused by Self-injurious Behavior			
Injury to the Person Caused by Aggression to Others or Property			
Use of Mechanical Restraints or Protective			

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?

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

Safety Plan Required and Attached (if applicable) Yes No

My Health

Important health history about me:			
Hospitalizations in the past year	Yes	<input type="checkbox"/>	No <input type="checkbox"/>
If yes, why I was hospitalized?			

Equipment for Maladaptive Behavior			
Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
Use of Emergency Chemical Restraints			
Use of Psychotropic Medications			
Gastrointestinal Conditions (includes vomiting, reflux, heartburn, or ulcer)			
Seizures			
Antiepileptic Medication Use			
Skin Breakdown			
Bowel Function			
Nutrition			
Treatments			
Assistance in Meeting Chronic Health Care Needs			

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

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

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

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: (How will I maintain my Health and Health Stability?)

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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.

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

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Personal Disaster Plan

I have a Personal Disaster Plan Yes No

Date Personal Disaster Plan Completed or Updated

The role of the QSI in identifying needs and risks

Per 42 CFR 441.301, the support plan must “Reflect clinical and support needs as identified through an assessment of functional need.” The plan must “reflect risk factors and measures in place to minimize them, including individualized back-up plan and strategies when needed.”

Federal rules require that the support plan reflect needs that have been identified through a functional assessment. In addition, the support plan must clearly identify health and safety risks, along with measures in place to minimize these risks

The QSI is the agency’s assessment tool used to identify needs and potential health or safety risks, and it is part of a full needs’ assessment process. The QSI is a questionnaire designed to gather key information about a person that will describe his or her life situation for the purpose of planning supports.

Other Services Needed for Health and Safety

The Other Services Needed for Health and Safety section of the support plan contains most of the information about significant needs and risks. The information in this table is directly connected to the individual’s most current QSI.

When filling out the Other Services Needed for Health and Safety section, the following steps must be completed:

1. Pull the individual’s QSI assessment scores into the Other Services Needed for Health and Safety section. Detailed instruction on how to use the iConnect system will be provided in the iConnect training for WSCs.
2. Reviewing the individual’s current QSI comprehensive report to understand any risks and needs. Be sure to pay attention to the notes provided by the QSI assessor that describe the specific concern and the level of support needed to address the concerns.
3. Review any other documentation related to health and safety issues such as doctor reports, Medical Case Manager reports, behavior analysis information, and incident reports for the past 12 months.
4. For all items in the QSI where the score is 1 or above, the WSC must fill out the rest of the table to describe:
 - The specific concern/risk,
 - The strategies in place to address the need or risk,

- Who is responsible to address the need or minimize the risk, and the source of funding for this service or support. See the example below from a sample support plan.

Back-Up Plans for My Critical Needs/Risks

Defining back-up plan:

A back-up plan is a set of actions or additional supports that are agreed upon ahead of time to keep the individual safe and healthy. The back-up plan is used when the individual's critical providers are either temporarily or permanently unavailable. A strong back-up plan uses the person's circle of supports or other community resources.

The WSC's role in developing a back-up plan:

1. Have a conversation with the individual or their legal representative to discuss what his or her back up plan should be for each provider of a critical service.
2. Find out if there are family or friends already in his or her life that could provide care in case the primary worker is not available.
3. If the individual does not have someone else available to provide care, work with the individual to identify and agree on community resources that will be contacted to provide emergency support while a caregiver is located.

The following is a list of strategies to consider when thinking about how to minimize the risks identified by the QSI, the individual's supports and family, or from your own observation. These strategies can be included on the table within the Other Services Needed for Health and Safety section.

Risk Management Strategies to Consider:

- Paid or unpaid/natural supports
- Assistive technology or devices such as medical alerts and communication devices
- Environmental modifications (grab bars, locked cabinets for chemicals, door alarms)
- Protocols, safety plans, or financial plans
- Instruction/education for the person (what to do in case of...)
- Specific job descriptions/service agreements with paid providers
- WSC monitoring

Please note that any strategies recorded on your clients' support plan must be written in a way that is specific to your clients. Never simply copy and paste language such as from the example above.

For example, if your client is requiring environmental modifications in his or her home to remain safe, describe the kind of modifications that are being requested or installed. If assistive technology is needed, describe the specific device.

Personal Rights

Florida Statutes, Chapter 393.13 requires that services for individuals meet their needs **and** protect the integrity of their legal and human rights. The *Bill of Rights for Persons with Developmental Disabilities* provides a description of those personal rights.

Review the *Bill of Rights* annually with the individual and their legal representative. Indicate if there is a personal right that the individual would like to learn more about and take time to explain it more. The individual's signature on the last page of their support plan will indicate that they understand their personal rights.

The following is a copy of the Bill of Rights for Persons with Developmental Disabilities.

Bill of Rights for Persons with Developmental Disabilities

- (a) Persons with developmental disabilities shall have a right to dignity, privacy, and humane care, including the right to be free from abuse, including sexual abuse, neglect, and exploitation.
- (b) Persons with developmental disabilities shall have the right to religious freedom and practice. Nothing shall restrict or infringe on a person's right to religious preference and practice.
- (c) Persons with developmental disabilities shall receive services, within available sources, which protect the personal liberty of the individual and which are provided in the least restrictive conditions necessary to achieve the purpose of treatment.
- (d) Persons with developmental disabilities shall have a right to participate in an appropriate program of quality education and training services, within available resources, regardless of chronological age or degree of disability. Such persons may be provided with instruction in sex education, marriage, and family planning.
- (e) Persons with developmental disabilities shall have a right to social interaction and to participate in community activities.
- (f) Persons with developmental disabilities shall have a right to physical exercise and recreational opportunities.
- (g) Persons with developmental disabilities shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect.
- (h) Persons with developmental disabilities shall have a right to consent to or refuse treatment, subject to the powers of a guardian advocate appointed pursuant to s. 393.12 or a guardian appointed pursuant to chapter 744.
- (i) No otherwise qualified person shall, by reason of having a developmental disability, be excluded from participation in, or be denied the benefits of, or be subject to discrimination under, any program or activity which receives public funds, and all prohibitions set forth under any other statute shall be actionable under this statute.
- (j) No otherwise qualified person shall, by reason of having a developmental disability, be denied the right to vote in public elections.

Additionally, for individuals who live in licensed facilities, the WSC should review the *Resident Rights for Individuals Living in APD Licensed Facilities*.

The following is a copy of this document.

Resident Rights for Individuals Living in APD Licensed Facilities

- (a) Clients shall have an unrestricted right to communication:
1. Each client is allowed to receive, send, and mail sealed, unopened correspondence. A client's incoming or outgoing correspondence may not be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the client or others, in which case the chief administrator of the facility may direct reasonable examination of such mail and regulate the disposition of such items or substances.
 2. Clients in residential facilities shall be afforded reasonable opportunities for telephone communication, to make and receive confidential calls, unless there is reason to believe that the content of the telephone communication may be harmful to the client or others, in which case the chief administrator of the facility may direct reasonable observation and monitoring to the telephone communication.
 3. Clients have an unrestricted right to visitation subject to reasonable rules of the facility. However, this provision may not be construed to permit infringement upon other clients' rights to privacy.
- (b) Each client has the right to the possession and use of his or her own clothing and personal effects, except in those specific instances where the use of some of these items as reinforcers is essential for training the client as part of an appropriately approved behavioral program. The chief administrator of the facility may take temporary custody of such effects when it is essential to do so for medical or safety reasons. Custody of such personal effects shall be promptly recorded in the client's record, and a receipt for such effects shall be immediately given to the client, if competent, or the client's parent or legal guardian.
1. All money belonging to a client held by the agency shall be held in compliance with s. 402.17(2).

2. All interest on money received and held for the personal use and benefit of a client shall be the property of that client and may not accrue to the general welfare of all clients or be used to defray the cost of residential care. Interest so accrued shall be used or conserved for the personal use or benefit of the individual client as provided in s. 402.17(2).
 3. Upon the discharge or death of a client, a final accounting shall be made of all personal effects and money belonging to the client held by the agency. All personal effects and money, including interest, shall be promptly turned over to the client or his or her heirs.
- (c) Each client shall receive prompt and appropriate medical treatment and care for physical and mental ailments and for the prevention of any illness or disability. Medical treatment shall be consistent with the accepted standards of medical practice in the community.
1. Medication shall be administered only at the written order of a physician. Medication shall not be used as punishment, for the convenience of staff, as a substitute for implementation of an individual or family support plan or behavior analysis services, or in unnecessary or excessive quantities.
 2. Daily notation of medication received by each client in a residential facility shall be kept in the client's record.
 3. Periodically, but no less frequently than every 6 months, the drug regimen of each client in a residential facility shall be reviewed by the attending physician or other appropriate monitoring body, consistent with appropriate standards of medical practice. All prescriptions shall have a termination date.
 4. When pharmacy services are provided at any residential facility, such services shall be directed or supervised by a professionally competent pharmacist licensed according to the provisions of chapter 465.
 5. Pharmacy services shall be delivered in accordance with the provisions of chapter 465.
 6. Prior to instituting a plan of experimental medical treatment or carrying out any necessary surgical procedure, express and informed consent shall be obtained from the client, if competent, or the client's parent or legal guardian. Information upon which the client shall make necessary treatment and surgery decisions shall include, but not be limited to:

- a. The nature and consequences of such procedures.
 - b. The risks, benefits, and purposes of such procedures.
 - c. Alternate procedures available.
7. When the parent or legal guardian of the client is unknown or unlocatable and the physician is unwilling to perform surgery based solely on the client's consent, a court of competent jurisdiction shall hold a hearing to determine the appropriateness of the surgical procedure. The client shall be physically present, unless the client's medical condition precludes such presence, represented by counsel, and provided the right and opportunity to be confronted with, and to cross-examine, all witnesses alleging the appropriateness of such procedure. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the appropriateness of such procedures. The express and informed consent of a person described in subparagraph 6. may be withdrawn at any time, with or without cause, prior to treatment or surgery.
8. The absence of express and informed consent notwithstanding, a licensed and qualified physician may render emergency medical care or treatment to any client who has been injured or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation of emergency medical care or treatment would endanger the health of the client.
- (d) Each client shall have access to individual storage space for his or her private use.
 - (e) Each client shall be provided with appropriate physical exercise as prescribed in the client's individual or family support plan. Indoor and outdoor facilities and equipment for such physical exercise shall be provided.
 - (f) Each client shall receive humane discipline.
 - (g) A client may not be subjected to a treatment program to eliminate problematic or unusual behaviors without first being examined by a physician who in his or her best judgment determines that such behaviors are not organically caused.
 - 1. Treatment programs involving the use of noxious or painful stimuli are prohibited.
 - 2. All alleged violations of this paragraph shall be reported immediately to the chief administrator of the facility and the agency. A thorough investigation of each incident shall be conducted, and a written report of the finding and

results of the investigation shall be submitted to the chief administrator of the facility and the agency within 24 hours after the occurrence or discovery of the incident.

3. The agency shall adopt by rule a system for the oversight of behavioral programs. The system shall establish guidelines and procedures governing the design, approval, implementation, and monitoring of all behavioral programs involving clients. The system shall ensure statewide and local review by committees of professionals certified as behavior analysts pursuant to s. 393.17. No behavioral program shall be implemented unless reviewed according to the rules established by the agency under this section.
- (h) Clients shall have the right to be free from the unnecessary use of restraint or seclusion. Restraints shall be employed only in emergencies or to protect the client or others from imminent injury. Restraints may not be employed as punishment, for the convenience of staff, or as a substitute for a support plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the emergency ends. Restraints shall not cause physical injury to the client and shall be designed to allow the greatest possible comfort.
1. Daily reports on the employment of restraint or seclusion shall be made to the administrator of the facility or program licensed under this chapter, and a monthly compilation of such reports shall be relayed to the agency's local area office. The monthly reports shall summarize all such cases of restraints, the type used, the duration of usage, and the reasons therefor. The area offices shall submit monthly summaries of these reports to the agency's central office.
 2. The agency shall adopt by rule standards and procedures relating to the use of restraint and seclusion. Such rules must be consistent with recognized best practices; prohibit inherently dangerous restraint or seclusion procedures; establish limitations on the use and duration of restraint and seclusion; establish measures to ensure the safety of clients and staff during an incident of restraint or seclusion; establish procedures for staff to follow before, during, and after incidents of restraint or seclusion, including individualized plans for the use of restraints or seclusion in emergency situations; establish professional qualifications of and training for staff who may order or be engaged in the use of restraint or seclusion; establish requirements for facility data collection and reporting relating to the use of restraint and seclusion; and establish procedures relating to the documentation of the use of restraint or seclusion in the client's facility or program record. A copy of the rules adopted under this subparagraph shall

be given to the client, parent, guardian or guardian advocate, and all staff members of facilities and programs licensed under this chapter and made a part of all staff preservice and in-service training programs.

- (i) Each client shall have a central record. The central record shall be established by the agency at the time that an individual is determined eligible for services, shall be maintained by the client's support coordinator, and must contain information pertaining to admission, diagnosis and treatment history, present condition, and such other information as may be required. The central record is the property of the agency.
 - 1. Unless waived by the client, if competent, or the client's parent or legal guardian if the client is incompetent, the client's central record shall be confidential and exempt from the provisions of s. 119.07(1), and no part of it shall be released except:
 - a. The record may be released to physicians, attorneys, and government agencies having need of the record to aid the client, as designated by the client, if competent, or the client's parent or legal guardian, if the client is incompetent.
 - b. The record shall be produced in response to a subpoena or released to persons authorized by order of court, excluding matters privileged by other provisions of law.
 - c. The record or any part thereof may be disclosed to a qualified researcher, a staff member of the facility where the client resides, or an employee of the agency when the administrator of the facility or the director of the agency deems it necessary for the treatment of the client, maintenance of adequate records, compilation of treatment data, or evaluation of programs.
 - d. Information from the records may be used for statistical and research purposes if the information is abstracted in such a way to protect the identity of individuals.
 - 2. The client, if competent, or the client's parent or legal guardian if the client is incompetent, shall be supplied with a copy of the client's central record upon request.
- (j) Each client residing in a residential facility who is eligible to vote in public elections according to the laws of the state has the right to vote. Facilities operators shall arrange the means to exercise the client's right to vote.

Developing the Personal Rights section

42 CFR 441.301(c)(4)(vi)(F) states that the support plan must “Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- a) *Identify a specific and individualized assessed need.*
- b) *Document the positive interventions and supports used prior to any modifications to the person-centered service plan.*
- c) *Document less intrusive methods of meeting the need that have been tried but did not work.*
- d) *Include a clear description of the condition that is directly proportionate to the specific assessed need.*
- e) *Include a regular collection and review of data to measure the ongoing effectiveness of the modification.*
- f) *Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.*
- g) *Include informed consent of the individual.*
- h) *Include an assurance that interventions and supports will cause no harm to the individual.”*

If the individual has a specific limitation on one of their rights, such as limited access to food, fill out the table in the Personal Rights section of the support plan by providing the following information:

1. Explain the specific right being limited.
2. List the reason for the limitation and what less intrusive methods were tried prior.
3. Explain what is being done to help them obtain their full rights.
4. Input when it will be reviewed for effectiveness and termination.

My Health

Use this section to document important information about the individual's health. Include any diagnoses, history of medical complications, surgeries or hospitalizations, and medication trials.

The sources for this information include the most recent QSI, current Medical Case Manager reports (if applicable), past support plans, nursing or physician care plans, and progress notes. When there are gaps in information, or if anything does not seem clear, conversations or face-to-face meetings may be required to get an accurate picture of the individual's health.

Personal Disaster Plan

WSCs should assist individuals in planning for an emergency or disaster. Indicate whether the individual has a personal disaster plan in place and the date it was completed or updated. WSCs may use the APD Personal Disaster Plan template. Review and update the plan annually or as needed.

The following is a copy of the suggested Personal Disaster Plan that you can find on the APD website under Support Coordination forms.

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living, and other Staff and Caregivers
(Can be used for individuals living in licensed residential facilities)

Name: _____ Address: _____
Ph#: _____ Roommate(s): _____
Emergency Contact/Relationship/Ph.# _____
SC/Ph#: _____ SLC/Ph.# _____ Other/Ph.#: _____

This Personal Disaster Plan should be updated annually, or as living situations change.

Most recent update: _____

Copies of Disaster plan to be provided to:

- _____ Consumer
- _____ Support Coordinator
- _____ Supported Living Coach
- _____ Personal Supports Provider
- _____ Other _____

For Tropical Events:

- In the case of a tropical event, always check local news for any evacuation information. To know your local evacuation zone, contact your local County Emergency Management Office: <https://www.floridadisaster.org/counties/>

PLAN A: My Personal Plan to Shelter in Place: My first choice will always be to shelter in my own home unless County Emergency Management mandates evacuation, or the emergency situation makes me feel that I may not be safe if I remain in my home. This is my plan to shelter in place:

- I have the following supplies reserved in my home for emergencies:
- 3-day supply of water (1 gallon/day for each person in my home; water replaced every 6 months)
 - 3-day supply of nonperishable food that requires little/no cooking and little/no water to prepare.
 - Battery-operated radio and extra batteries.
 - Flashlight for each person in the home and extra batteries.
 - First aid kit with bandages, cleansing agent, antiseptic, gloves, sunscreen, over-the-counter meds, etc.
 - Sanitary supplies including toilet paper, hand sanitizer, bleach, personal hygiene items, garbage bags.
 - Duct tape, precut plastic sheeting to cover ducts and all openings in interior room designated for shelter in event of a chemical or biological threat.

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
and other Staff and Caregivers

(Can be used for individuals living in licensed residential facilities)

- Other tools/supplies: disposable cups, plates and utensils; multipurpose utility tool; hand held can-opener; whistle; matches/lighter; rain gear; complete change of clean dry clothing; bedding/sleeping bag; charged cell phone and charger; cash; pet supplies; games, books, entertainment supplies.
- I maintain at least a 3-day supply of my prescription medication at all times, in the event of a potential disaster. The contact information of the person who will help me fill my prescriptions to obtain at least a two-week supply is:
Name: _____ Phone: _____
- I have a waterproof container that has copies of my identification, emergency contact information, insurance papers, list/proof of valuables; evacuation communicator, disaster plan, updated medical and prescription information, bank and credit card information, Social Security information and other important documents.
- I am dependent on the following special dietary supplies, durable medical equipment and/or consumable medical supplies:

- I will use the following interior space in my home to shelter in the event of a tornado, chemical or biological threat or similar emergency: _____
- The contact information of the person who helps me to ensure that all the above has been completed, all equipment is in working order, and that all personal information is current on a quarterly basis is:
Name: _____ Phone: _____
- If I need assistance as I shelter in my home, this person(s) will remain with me in my home:
Name: _____ Phone: _____

PLAN B: My Personal Plan When I Must Evacuate My Home: If I must evacuate my home during an emergency or disaster, I am prepared to follow this plan:

- Please see "Go Kit" on page 4.
- Please see "Pets" on page 5.
- I will evacuate to one of these locations if I can evacuate within the area:
 - First Choice
Name: _____ Address: _____
Phone Number: _____
 - Second Choice: If circumstances prevent me from evacuating to my first choice, I will evacuate to
Name: _____ Address: _____
Phone Number: _____

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
and other Staff and Caregivers

(Can be used for individuals living in licensed residential facilities)

- I have transportation arranged to get to both my first and second choices for both of my in-area and out-of-area evacuation destinations. The contact information for the person who has committed to assisting me in evacuating is:
Name: _____ Phone: _____
- If I need assistance when I evacuate, this person(s) will remain with me for the duration of my evacuation:
Name: _____ Phone: _____

PLAN C: My Personal Plan If I Must Go to a Shelter or Medical Facility: I understand that shelters operated by County Emergency Management and the Health Department are available but should only be used as a last resort and as a back-up to My Personal Sheltering Plans A and B. Note: Shelters may be crowded, noisy, lack privacy and may be especially challenging for persons with behavioral health needs. However, if circumstances make it necessary for me to go to a shelter or medical facility; this is my plan:

- I have determined what type of shelter or medical facility that I will need to go to (a general population shelter, a special needs shelter, or a medical facility.)
- This person helped me determine where I need to go:
Name: _____ Phone: _____
- Transportation: I have identified how I will get to my designated shelter.
- I will need to use transportation arranged and provided by County Emergency Management and have confirmed this with them.
- I will be transported by this person/company:
Name: _____ Address: _____
Phone Number: _____

General Population Shelter

- I will be able to go to a general population shelter because I do not need the type of care and supervision that is provided in a special needs shelter.
- The name and location of the general population shelter that I will go to is:
Name: _____ Address: _____
Phone Number: _____

Special Needs Shelter

- I will need to go to a special needs shelter because I need electricity for life supporting medical equipment, or basic nursing care, or oxygen therapy, or observation/monitoring by a healthcare professional, or assistance with medication and no one to assist me, or a chronic condition that requires assistance from a healthcare professional, or special medical requirements that do not require hospitalization or another special need that cannot be accommodated in a general population shelter. My condition may warrant a caregiver to go with me to a Special Needs Shelter to care for me while I shelter there.

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
and other Staff and Caregivers

(Can be used for individuals living in licensed residential facilities)

- I understand that there are eligibility criteria that I must meet to have access to a special needs shelter. I have submitted pre-registration to my County Emergency Management if I need or suspect I may need to shelter in either a special needs shelter or a medical facility or if I need transportation to evacuate to a shelter.
- This person submitted my preregistration on this date:
Name: _____ Phone: _____
Date: ____/____/____
- I received confirmation from my County Emergency Management regarding my pre-registration shelter assignment. Yes _____ or No _____
 - The County Emergency Management has assigned the following special needs shelter or medical facility address as follows:
Name: _____ Address: _____
Phone Number: _____
- I will need to use transportation arranged and provided by County Emergency Management and have confirmed this with them.
- I will be transported by this person/company:
Name: _____ Address: _____
Phone Number: _____
- If I evacuate to a special needs shelter, this person(s) will remain with me for the duration of my evacuation:
Name: _____ Phone Number: _____

Medical Facility

- I will need to go to a medical facility because my special medical requirements exceed what can be provided in a special needs shelter. The contact information of the facility is:
Name: _____ Address: _____
Phone: _____

"Go Kit"

- I have an easy-to-carry "Go Kit" prepared that contains or can be readily packed to contain the following supplies that I have reserved in my home and will take with me to the shelter: at least a 7-day supply of meds; Items required for special diet; a 3-day supply of water and non-perishable food and snacks; personal hygiene essentials; first aid kit; battery-operated radio and extra batteries; flashlight and extra batteries; cash; cell phone and charger; bedding/sleeping bag; at least one complete change of clean dry clothing; glasses; hearing aids; durable and consumable medical supplies; waterproof container that has copies of all of my important documents; multipurpose utility tool; whistle; matches/lighter; rain gear; games, books, entertainment supplies.
- This person will help make sure my "Go Kit" is readied if I need to go to a shelter:
Name: _____ Phone Number: _____

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
and other Staff and Caregivers

(Can be used for individuals living in licensed residential facilities)

Pets

- I have a plan for my pet(s). My pet will either go to the designated pet shelter in my county or I have arranged for this person/veterinarian to take care of my pet(s) for me:
Name: _____ Address: _____
Phone: _____
- My pet(s)'s supplies and papers will be sent along with my pets.

My Personal Commitment to Disaster Preparedness:

- I understand that I have a personal responsibility for disaster preparedness and I am committed to working in a proactive manner with County Emergency Management and the people who support me to follow my Personal Plan for Disaster Preparedness.
- I have received training and information from this person about my personal responsibility for preparing for all types of disasters including hurricanes, tornadoes, wildfires, earthquakes, floods, chemical and biological spills/ attacks, nuclear power accidents, terrorist attacks, etc. from this person:
Name: _____ Phone Number: _____
- I review/practice/drill on this plan with this person _____ on at least a quarterly basis.
- I will call this person _____ at one of these numbers: _____
or _____ within 2 hours or as soon as possible after an emergency has passed to report on my health/safety status and needs.

Consumer Signature/Date

Support Coordinator Signature/Date

Personal Supports Signature/Date

Personal Supports Signature/Date