

A Plan for *

***'s Plan**

Date of the 1st plan

Dates the plan was changed

What do you hope that this plan will help accomplish for your *?

Who helped with this plan? (Who gave you information)

Facilitators:

• *	•	•
•	•	•
•	•	•

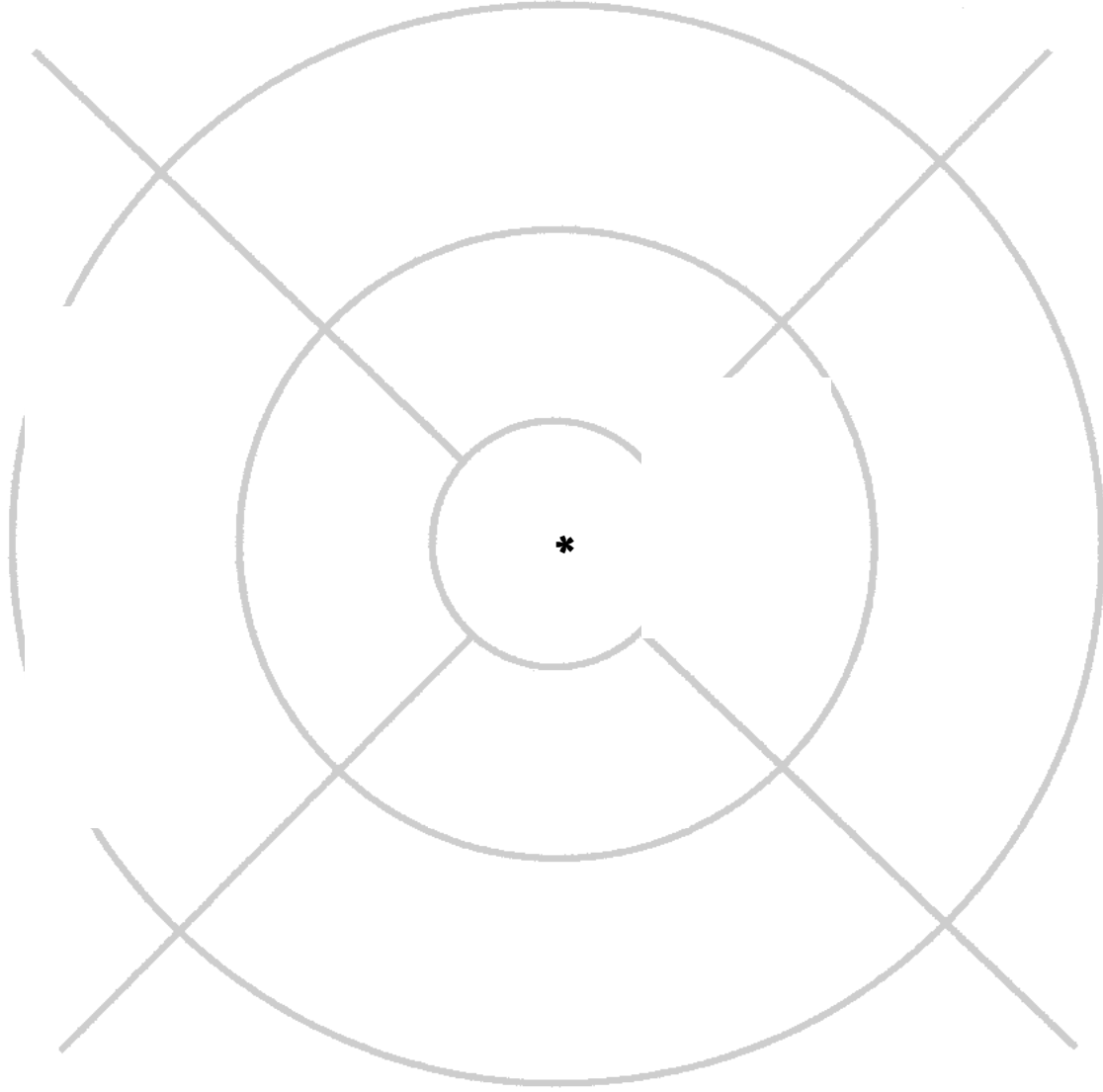
Who do you still need to talk to? (Are there others who can help you get more information?)

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A Plan for *

People Map for *

Family



**People
who
support *
at work,
school,
training**

**People
whose
job is to
support *
at home
and other
places**

A Plan for *

What is Important to *

What do you want other people to know about the things that are important to *?
Who are the people that are most important to *? What does * do with them? What
are the things that * has to do (and things * needs to have) if * is going to be
happy?

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A Plan for *

What are the characteristics of people who support * best?

If you were going to pick a new person to work with * (e.g. case manager, staff in a home) what would you look for? What do the people that * likes to work with have in common? Have there been people that * couldn't work with? What do they have in common?

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New Things We Have Learned

A Plan for *

What Others Need to Know
or Do to Support *

If * is going to have the things that are important to *, and stay healthy and safe, what do people need to know? What do they need to do? How does * need to be supported at home, at work, or out in the community?

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A Plan for *

What Other People Need to Know or Do to Help * Stay Healthy and Safe

Does * have medical conditions or mental health issues that other people should know about? Are there times when * needs help in managing medical or mental health?

	New Things We Have Learned
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EMERGENCY BACK UP PLAN

In case the primary caregiver becomes unavailable what is your emergency back up plan? Who do we contact 1st, 2nd, 3rd? What are their names, addresses, phone numbers and e-mail addresses? Please be sure these individuals are aware that they will be included in the Essential Lifestyle Plan as an emergency backup.

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1. NAME: _____
ADDRESS: _____
CITY, STATE & ZIP: _____

PHONE #'s: HOME: _____ CELL: _____ WORK _____
(With Area Code)

E-MAIL ADDRESS: _____
COMMENTS: _____

.....

2. NAME: _____
ADDRESS: _____
CITY, STATE & ZIP: _____

PHONE #'s: HOME: _____ CELL: _____ WORK _____
(With Area Code)

E-MAIL ADDRESS: _____
COMMENTS: _____

.....

A Plan for *

3.

NAME: _____
ADDRESS: _____
CITY, STATE & ZIP: _____

PHONE #'s: HOME: _____ CELL: _____ WORK _____
(With Area Code)

E-MAIL ADDRESS: _____
COMMENTS: _____

Two Minute Drill

Imagine that you are supporting * and you have an emergency that means you suddenly have to leave. The person who will "fill in" has arrived and you have two minutes to give advice, suggestions, or tips about supporting *- What would you say?

**Things others need to know to help you
stay healthy and safe**

Please check if any of the following conditions exist for you:

- A diagnosis of seizures or epilepsy, or medication is taken for seizures**
- You have had a seizure in the past 5 years**
- You are at risk for Aspiration and/or Dehydration**
- You cough or choke while eating or drinking**
- Someone else puts food or fluid into your mouth**
- You have chronic chest congestion, frequent pneumonia, rattling when breathing, persistent cough, or chronically use cough/asthma medication**
- You eat/drink too rapidly or stuff food into your mouth that may cause choking**
- You have extreme food/ liquid seeking behavior that may cause you injury**
- Food or fluid falls out of your mouth (Including someone who regularly drools)**
- You regularly refuse liquids**
- You routinely need/use assistance to get drinks or to receive fluids**
- You are at risk for Constipation**
- You routinely take bowel medications (not including fiber)**
- You required a suppository or enema for constipation within the past year**
- You had trouble moving your bowels, complained of pain with BM, or had BM that is hard and small within the past year**

Staying Healthy and Safe, con't:

- You have an ostomy or tube (g-tube, catheter, colostomy, etc.)
- You have been diagnosed with GER (gastro esophageal reflux)
- You complain of chest pain/heart burn or have small, frequent vomiting
- You have unusual burping (burping that is very frequent or wet)
- You have allergies that others should know about
- You have diabetes
- You engage in aggressive or self-injurious behavior
- You engage in property destruction that could result in injury
- You engage in other behavior(s) that requires intervention
- You engage in pica
- You currently have a mental health condition or illness
- You require help to take prescribed medication(s)
- Other: _____

Staying Healthy and Safe, con't:

If you checked a box on previous page, what do others need to know or do to help you stay healthy and safe with regard to the condition(s)?

Do you have a health, safety and/or behavioral issue not addressed through the previous questions in this section?

What helps you feel healthy and safe? (people, places, things they need to do, things others should know or do)

___ I do not currently have any identified medical conditions

A Plan for *

Things to Figure Out

What are the things that you are still trying to “figure out?” What are the things about *, or the supports that * gets that you don’t understand or where you need more information? What are the things that are getting in the way?

•	New Things We Have Learned
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A Plan for *

What is Happening in *’s Life - The Upside and Downside

Look at what is working and not working, makes sense and doesn't make sense in your life <i>right now</i> . Think about ...	What does * think - * perspective
<ul style="list-style-type: none"> Where you live 	<ul style="list-style-type: none"> What doesn't work, doesn't make sense, the downside
<ul style="list-style-type: none"> What you do during the day 	
<ul style="list-style-type: none"> Who you spend time with 	
<ul style="list-style-type: none"> The services that you receive to help you stay healthy/safe 	
<ul style="list-style-type: none"> Issues with medication - how it works, side effects 	
<ul style="list-style-type: none"> What you do for fun 	
<ul style="list-style-type: none"> Other parts of your life 	

A Plan for *

What is Happening in *’s Life - The Upside and Downside

Look at what is working and not working, makes sense and doesn't make sense in *’s life <i>right now</i> . Think about ...	What others think - their perspective	What doesn't work, doesn't make sense, the downside
<ul style="list-style-type: none"> • Where * lives • What * does during the day • Who * spends time with • Services received to help * stay healthy/safe • Issues with medication - how it works, side effects • What * does for fun • Other parts of * life 	<ul style="list-style-type: none"> • • • • • • • • • • • • • 	<ul style="list-style-type: none"> • • • • • • • • • • • • •

A Plan for *

To Do List, Goals, Action Planning

What can you do to make sure things that are working, continue, or change those things that are not working? What can other people do to keep things that are working and to change those things that are not working?

Desired Outcome:

Discussion/Justification

What needs to be done	How often	How long?	Who is responsible?	By when?

Review of Desired Outcome:

Date:

Comments:

A Plan for *

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