INDIVIDUAL SUPPORT, CRISIS PREVENTION AND INTERVENTION PLAN
Family version
PART I - FACE SHEET

Demographics	
Name:	DMR/DMHAS Region:
Date:	S.S.#:
D.O.B.:	Telephone #:
Address:	

Living Situation (check appropriate box):

___ lives with parents/guardian
___ lives with spouse/partner
____ lives alone
____ other (specify)

describe:

	Diagnosis		***Insurance***
Axis I		**Medicaid #**	
Axis II		**Medicare #**	
Axis III		**Private Ins. #**	
Axis IV		**Other**	
Axis V		**Other**	

Current Medication (both prescription and over the counter)

As of **:** ____/____ /____

medication	***dose***	***frequency***

Medical/Dental Conditions

Communication Style - Primary Language

Strengths/Skills/Interests

Circle of Support/PROVIDERS

Type	***agency***	***Name***	***Address***	***phone #***
Guardian				
family contact/ friend				
Residential Program				
Work Program				
Case manager				
Individual Clinician				
Primary Physician				
Psychiatrist				
Therapist				
Neurologist				
MH Team				

PART II - GENERAL GUIDELINES

Describe general patterns of behavior, personality traits, etc. that are part of who the individual is: (i.e. has a good sense of humor; skills, interests, does best when given "space", ways to develop rapport, etc.):

Describe what life is like at home and the environment in which the individual lives:

Describe factors that create increased stress for the individual (i.e., anniversaries, holidays, noise, change in routine, anticipation of a planned event, fatigue, inability to express medical problems or to get needs met, etc.):

Describe situations and/or behaviors that have historically led to crisis service use and/or hospitalization for this individual:

Describe alternatives that have been effective in keeping the individual out of crisis. Have alternative services i.e. respite and diversion to hospitalization been used effectively?

PART IV - DISPOSITION RECOMMENDATIONS

Specify what options have been most successful in the past; whether the individual has been to respite and does well there, which hospital is the hospital of choice, if necessary, etc.

PART V - BACK-UP PROTOCOL

Describe the systems prevention and intervention back-up protocols to support the individual (who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible. Protocol should be initiated to prevent crisis at *earliest signs of difficulty*.

Outline specific protocols under which the mental health crisis team or other emergency supports will be accessed. Who should be called in case of a behavioral health emergency? How can they be reached? What will happen when family member contacts them? BE AS SPECIFIC AS POSSIBLE include contact names, phone numbers, hours of operation, etc. Protocol should be initiated to prevent crisis at *earliest signs of difficulty*.

PART VI - SIGNATURES/APPROVALS

NAME:

CIRCLE OF SUPPORT SIGNATURES		
	Signature	***date***
Individual (OPTIONAL)		
Family member/friend		
DMR/DMHAS Case Manager		
Psychologist		
Psychiatrist		
Primary medical provider		
Day/Voc Program rep.		
Advocate		
Neurologist		
Respite program rep.		
Mental Health Crisis Team representative		
Other		

ADMINISTRATIVE APPROVAL		
	Initials	***date***
DMR Administrator		
Mental Health Crisis team administrator		