

Planned Lifetime Assistance Network (PLAN) of Southwest Ohio Individual and Family Profile Form

Completed By: _____ Date _____

Relationship to Person with Disability _____

*This form is used for people facing a variety of situations concerning their relatives with disabilities. Skip items that do not pertain to your or your family member and add information that you believe important to PLAN as the long term care plan is developed. All information gathered is confidential.

Family Information

Father's Information:

Name _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Phone (h) _____ (w) _____

Date of Birth _____ Place of Birth _____

Social Security Number _____

Father's present health status _____

Degree of involvement with Person with Disability _____

Mother's Information:

Name _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Phone (h) _____ (w) _____

Date of Birth _____ Place of Birth _____

Social Security Number _____

Mother's present health status _____

Degree of involvement with Person with Disability _____

Information Regarding Person with Disability

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip _____ County _____
Phone (h) _____ (w) _____ Marital Status _____
Place of Birth _____ Social Security # _____

Step Parent/Sibling/Child/Other Involved Person Information

Name _____
Relationship to Person with Disabilities _____
Address _____
City _____ State _____ Zip _____
Phone (h) _____ (w) _____
Date of Birth _____ Place of Birth _____ SS # _____
Involvement with Disabled Person _____

Name _____
Relationship to Person with Disabilities _____
Address _____
City _____ State _____ Zip _____
Phone (h) _____ (w) _____
Date of Birth _____ Place of Birth _____ SS # _____
Involvement with Disabled Person _____

Guardian Information:

Name _____

Address _____

City _____ State _____ Zip _____

Phone (h) _____ (w) _____

Type of Guardianship _____

Guardian needs to be informed regarding the following issues: _____

Other Advocate Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone (h) _____ (w) _____

Advocate needs to be informed regarding the following issues: _____

Medical History and Care

Nature of Primary Disability _____

Primary and Other Diagnoses _____

Health Care Providers:

Psychiatric Services _____

Address _____

Phone _____ Contact Person _____

Frequency of Visits _____

Psychological Services _____

Address _____

Phone _____ Contact Person _____

Frequency of Visits _____

Physician _____

Address _____

Phone _____ Contact Person _____

Frequency of Visits _____

Dentist _____

Address _____

Phone _____ Contact Person _____

Frequency of Visits _____

Specialist 1 _____

Address _____

Phone _____ Contact Person _____

Seen For _____ Frequency _____

Specialist 2 _____

Address _____

Phone _____ Contact Person _____

Seen For _____ Frequency _____

Significant Family Medical History (parents, siblings, grandparents, etc.) _____

Individual Hospitalizations:

Date	Hospital	Reason

Medical History: Does the person w/ disabilities currently have or have a history of:

- Cardiac/Heart problems
- Seizures/Epilepsy
- Diabetes
- Skin problems
- Immune disorders
- Thyroid problems
- Blood pressure problems
- Hepatitis
- AIDS
- Sexually transmitted disease
- Allergies
- Tuberculosis
- Birth complications
- Drug or alcohol addiction or abuse
- Head injury
- Recent weight loss or gain
- Smoking
- Respiratory problems
- Complications at birth
- Cancer
- Bowel or bladder problems
- Circulatory problems

Describe any conditions checked above _____

Current Medications:

Medication Name	Dosage	When Taken	Prescribed For

Where does the person get medication? _____

How is medication paid for? _____

Who assists with monitoring medication? _____

Any routine lab/blood work needs? _____

Any known medication allergies? _____

Describe past or present difficulties in the following areas:

Vision/Hearing _____

Ambulation/Mobility _____

Communication _____

Nursing Needs _____

Nutrition _____

Behavioral Problems _____

A. Any triggers or antecedents? _____

B. Any effective ways to handle behavior problems? _____

Substance Abuse _____

Violent/Threatening Behavior _____

A. Any known antecedents/triggers? _____

B. Any effective ways to handle such behavior? _____

Suicide Attempts _____

Psychiatric Episodes _____

A. Any times of year episodes more frequent? _____

B. Any warning signs prior to episodes? _____

Other Medical/Psychiatric/Behavioral Information _____

Psychological Exam:

Date of last psychological exam _____

Examiner _____ Phone _____

Address _____

Results: FS IQ _____ Verbal _____ Performance _____

Instrument Used _____

Adaptive Behavior Rating _____

Instrument Used _____

Medical Insurers:

Primary Insurance

Secondary Insurance

Phone _____

Phone _____

ID # _____

ID # _____

Medicare Number _____

Medicaid Number _____

Other Provider Information

Casemanagement _____

Address/Phone _____

Contact Person _____

Residential Placement _____

Address/Phone _____

Contact Person _____

Vocational Placement _____

Address/Phone _____

Contact Person _____

Day Program _____

Address/Phone _____

Contact Person _____

Payeeship _____

Address/Phone _____

Contact Person _____

Social/Recreation _____

Address/Phone _____

Contact Person _____

Financial Information

Income Information:

Which of the following does the individual receive?	How much per month?
/ / SSI (Supplemental Security Income)	_____
/ / SSDI (Social Security Disability Income)	_____
/ / Social Security Survivors' and Dependents' benefits	_____
/ / Veteran's benefits	_____
/ / Other pensions/benefits income (specify)	_____
/ / Wages and other earned income	_____
/ / Food stamps	_____
/ / Other income (specify) _____	_____

Total Monthly Income \$ _____

Expenditure Information: How much does the person spend per month on:

Rent/Mortgage/Housing _____

Utilities _____

Phone _____

Food _____
Clothing _____
Personal Care _____
Recreation _____
Cable TV _____
Life Insurance Premium _____
Other Insurance _____
Credit Cards _____
Other obligations (specify) _____
Total Monthly Expenditures \$ _____

Does person qualify for a monthly Medicaid card? _____

Does person incur a monthly spend down? _____

Are applications for entitlements now pending? _____

When was application last reviewed? _____

At what age did person become disabled? _____

Does person re-determine with Department of Job and Family Services? _____

How often? _____

DHS Caseworker name _____ Phone _____

Account Information:

Checking Account 1 :Bank Name _____

Account Number _____

Checking Account 2: Bank Name _____

Account Number _____

Savings Account 1: Bank Name _____

Account Number _____

Savings Account 2: Bank Name _____

Legal Information

Family Attorney _____

Address _____

City _____ State _____ Zip _____

Phone _____

Financial Planner _____

Address _____

City _____ State _____ Zip _____

Phone _____

Is individual with disability named in parent/sibling wills? _____

Contact person for will developed _____

Is a trust established for the person with disabilities? _____

What type of trust? _____

Contact person for trust _____

Does the person have a guardian? What type? _____

Is there a power of attorney for the person? _____

Specify power of attorney _____

Does the person have burial arrangements? _____

Specify burial arrangements _____

Does person have a life insurance policy? List policy name, number, and agent.

Does the person have a will ? List attorney _____

Criminal Record Information:

Does the individual have a criminal record? _____

Describe charges, arrests, incarcerations or other legal problems _____

Any likely future legal problems? _____

Residential Information

Current Residence _____

Past Residences _____

Your or Family Member's Hope for Future Housing: _____

How well does person adapt to new situations/residences? _____

Work/Day Program Information

Present Work or Day Program _____

Past Work or Day Programs _____

Your or Family Member's Hope for Future Work or Day Program _____

Leisure/Socialization/Recreation

Current Activities/Hobbies (structured or unstructured) _____

Choices/Desires for Other Leisure/Social/Rec (immediate or future) _____

Education

Regular or Special Elementary and Secondary Education (specify type and where/when attended) _____

Higher Education (specify degrees held, where and when attended) _____

Current educational/training endeavors _____

Your or Family Member's Hopes for Future Education _____

Religion

Faith _____

Church Person Attends _____

Contact People _____

Your or Family Member's Hopes for Future Re: religion _____

Personal Relationships

Describe relationship with friends and family _____

Is person married, or have they ever been married? _____

Does the person have children? _____

Does the person have a girlfriend/boyfriend currently? _____

IS or HAS the person been sexually active? _____

Does person practice safe sex? _____

Does person have knowledge of safe sex practices? Describe _____

Your or Family Member's Hopes for Future Re: Relationships: _____

Personal Profile

Likes and Dislikes:

Food Likes _____

Dislikes _____

People Likes _____

Dislikes _____

Recreation Likes _____

Dislikes _____

Clothing Likes _____
Dislikes _____

Colors Likes _____
Dislikes _____

Any favorite restaurants, hairdressers, stores, or other places? _____

Other personal preferences of the person _____

Sleeping patterns _____

Does person spend time alone at home? _____

Describe optimal supervision for person (per day, per week, etc.) _____

Any specific fears or anxiety-provoking situations? Is there anything effective when allaying the person's anxiety?

How does person express/handle frustration or anger? Is there a particularly effective way to help person deal with frustration or anger?

Does person run away or wander? _____

Does person socialize? _____

Does person particularly like or dislike any family member or friend? _____

How does person celebrate birthdays or holidays? _____

Skills and Abilities Checklist

	<u>Independent</u>	<u>Needs Help</u>	<u>Total Assistance</u>
Self Care:			
Bathe/Shower	_____	_____	_____
Wash/Brush Hair	_____	_____	_____
Brush Teeth	_____	_____	_____
Dress appropriately	_____	_____	_____
Take medication	_____	_____	_____
Laundry	_____	_____	_____

Comments: _____

Independent Living:	<u>Independent</u>	<u>Needs Help</u>	<u>Total Assistance</u>
Tell time	_____	_____	_____
Get up/go to bed on time	_____	_____	_____
Use telephone	_____	_____	_____
Prepare meals	_____	_____	_____

Grocery shop	_____	_____	_____
Personal shopping	_____	_____	_____
Clean home/apartment	_____	_____	_____
Maintain home/apartment	_____	_____	_____
Use/arrange transportation	_____	_____	_____
Arrange/keep appointments	_____	_____	_____
Plan for nutritional needs	_____	_____	_____
Respond in emergency	_____	_____	_____
Make medical appointments	_____	_____	_____
Purchase clothing	_____	_____	_____

Comments: _____

Money/Resource Management:

Pay for items in community	_____	_____	_____
Pay bills on time	_____	_____	_____
Budget appropriately	_____	_____	_____
Make bank transactions	_____	_____	_____
Write checks for bills	_____	_____	_____
Keep accurate records/ balance checking accounts	_____	_____	_____
Conduct DHS re-determinations	_____	_____	_____
Coordinate spend down	_____	_____	_____
Serve as own payee	_____	_____	_____

Comments: _____

Vocational:

Apply for job _____

Maintain job _____

Seek appropriate employment _____

Read _____

Write _____

Discuss problems with employer _____

Comments: _____

Social/Rec/Leisure:

Make/keep friends _____

Seek out social activities _____

Participate in recreational activities _____

Seek out rec activities _____

Engage in hobby _____

Develop new hobbies _____

Describe an average daily schedule for your family member. Describe activities usually done on "days off" too

Quality of Life Information

Describe how you would like caregivers to treat matters like the following with your family member:

- 1. Home maintenance:**

- 2. Social skills:**

- 3. Decision Making:**

- 4. Relationships with opposite sex:**

- 5. Independence:**

- 6. Appearance:**

- 7. Integration with general population:**

- 8. Requests for help:**

PLAN Involvement Information

1. Ideally, how often would you like PLAN to “touch base” with or monitor your family member?

2. Do you have a preference regarding direct contact versus phone contact?

3. Do you have monthly parameters in mind regarding service billing (i.e., do you have a rough idea regarding how much you would spend per month on PLAN services)? PLAN can contact you regarding how regular monitoring could be conducted given the parameters you outline.

4. If your family member was experiencing a particularly difficult time, would you want PLAN to increase any service provided him/her given the circumstance? How would you like this to occur?

5. Would you want PLAN to appraise you of this or any other service/billing irregularities involved in caring for your family member?

6. How often would you like to be appraised on PLAN's involvement with your family member (e.g., weekly, monthly, bi-monthly, as needed, etc.)? How would like us to contact you (e.g., meet in person, phone, summary letter, etc.)?

7. Who should we contact in case of an emergency concerning your family member? (Include phone please)

8. If you have a supplemental needs trust set up for your family member, can it be arranged that PLAN bill the trust ongoing services?

9. If not, how can we arrange for ongoing services should something happen to your family member's primary contact person?

10. Is there anyone else you would like us to keep in contact with regarding your family member (either now or in the future)? Do you have ideas regarding how and how often you'd like them to be appraised of our work with your family member?

11. If something should happen to you, are there "one time" things would you want PLAN to take care of with respect to your family member (e.g., ensure that involved agencies are notified of family deaths, change of status paperwork with DHS/other

county offices, notification of any change of address that occurs with your family member, increased visits following a death or other catastrophic event, etc.)?

PLAN will update the information and services detailed in the Long Term Plan of Care in a personal meeting with you annually. If changes need to be made prior to the annual meeting, please call the PLAN office and notify them of such.

PLAN asks that you designate a person to be the contact for our involvement with your family member. PLAN will notify the person specified if there are issues or questions concerning a consumer and our work with them. The contact person will also be notified regarding the annual Long Term Plan of Care update.

Please specify your family contact person:

Name _____

Address _____

City/State/Zip _____

Phone _____

Please specify an alternate contact if person above is unable to serve as a contact:

Name _____

Address _____

City/State/Zip _____

Phone _____

Note: The alternate contact will be asked to specify an additional contact person unless arranged otherwise.

Personal Care Plan

Use the following array of services in conjunction with the PLAN Service Worksheet in your packet to begin to determine services your family member may need now and in the future. Samples of services appear as guides for you in each category: hopefully they will jog your memory regarding related services that your family member depends on.

When completing this section of the document, try thinking about a period of several days involvement with your family member. What are the services provide them routinely? How do you make sure that they're OK? What have you done in the past in order to ensure they maintain a certain quality of life? What are things you just know they'll need some assistance with or encouragement for? What do you generally follow up on in order to be sure it was completed by your family member? List what you normally do for them over the course of a proscribed period of time: you'll be surprised at what you come up with.

Next, try to determine what your family member might need NOW in the way of services (e.g., Is there anything they'd like to pursue in the way of a hobby or recreational activity? Do they need help completing job applications or eligibility forms?), what they may need in the NEXT FEW YEARS (e.g., Do they need assistance visiting potential apartments? Do they need to apply for entitlements?), and what they may need LONG TERM (e.g., Do they need someone who can help them refill medication? Make sure they're reminded to take it regularly? Ensure that their group home is clean and providing quality service?) Use the Service Worksheet to block those things out, then complete the Personal Care Plan below listing the frequencies and duration of services requested.

PLAN personnel will meet with you once this preliminary plan is completed in order to clarify questions, detail their plan to initiate services, and answer questions you may have. This plan will be updated at least annually, so don't worry that you need to get everything on paper the first time around. PLAN will be flexible in adding and removing ideas as you determine them, and responding with a plan to address needs as they arise. A brief phone call may be all that's needed to address something pressing or add a forgotten item to the service list.

Good Luck!

A. Benefits Coordination: (sample services)

- DHS re-determinations (food stamps, waiver eligibility, Medicaid)
- Contract representative payee services
- Coordination of monthly spend down
- Apply for entitlements
- Assist with eligibility snags
- Work with MH and MR/DD systems to ensure person's inclusion in appropriate systems (e.g., residential waiting lists, entry into MH system, adult service eligibility for MR/DD, etc.)
- Trouble shoot benefits problems

Advocate for services within MH and MR/DD systems

B. Trust Coordination: (sample services)

Attorney referral
"Designated Advocate" services
Receive trust disbursements and route to individual in specified ways
Financial planner referral

C. Medical/Dental/Psych Services: (sample services)

Accompany and monitor appointments
Schedule appointments
Remind person of appointments
Consult/problem solve with doctors regarding problems
Assist with prescription pick ups
Assist with/monitor refills
Monitor/coordinate/keep medical information

D. Social/Recreation/Leisure: (sample services)

Accompany to activities
Arrange/coordinate group social outings
Research/coordinate access to social/rec activities

E. Personal Services: (sample services)

Remind person of appointments
Set up medication daily or weekly
Administer medication
Remind person to take medication
Personal contact with person
Assist with grocery/personal shopping
Monitor/assist with personal hygiene
Routine checks and counsel back with parents
Companion services
Liaison with Case Manager
Monitor home cleanliness
Monitor/assist with pets
Transportation
Phone contact with person
Monitor/assist with laundry

F. Vocational/Day Program: (sample services)

Monitor vocational or day program, attend work meetings
Advocate for changes needed to accommodate needs/preferences
Liaison with vocational/day program provider

G. Residential/Work/Life Change: (sample services)

Research residential alternatives
Advise with regard to moving
Develop "home to own" transition plan
Assistance negotiating with employer
Assist with resume development, job applications
Assist with move
Research job opportunities
Trouble shoot job problems

H. Financial: (sample services)

Assist with budgeting

Coordinate trust disbursements
Act as designated advocate for trust (monitor receipts, make written requests to trust entities)
Balance/reconcile checking and savings accounts
Assist with paying bills/monitor bill payment

I. **Other Specialized Services:**

PLAN of Southwest Ohio, Inc.
Long Term Plan of Care for
