## Needs Assessment & Individual Support Plan

## Assessment date:

**Planning date:**

**Plan of care start date**:

**Source of information (name & relationship):**

**Service recipient Name**: **Client ID#**:

**Address**: **Phone Number**:

**DOB**: **Gender**: **Waiver Code**:

**Residential Type**: **County**: **Legal Status**:

Person Responsible for Health & Safety: Case Manager:

Name:

Address: **Supervisor:**

Phone:

**Diagnosis**:

Axis I:

Axis II:

Axis III:

**Primary Care Physician**: Address: Phone:

Hospital: Pharmacy:

**Private Insurance**: Policy Number: Policy Holder:

Address:

Phone:

Contact:

**SSI**:  **SSA**:  **Representative Payee**  YES  No

### Name:

### Address:

### Phone:

**Medicaid**  **Number: C940185 001**

**Medicare**   **Number**:

**Tribal Benefits**  **Tribe: None/Not applicable Degree: Roll No.:**

**V.A. Benefits**

**Trusts established to provide care: Name:**   **Trustee:**

**Benefits Coordinator:**   **Phone #:**

## Social Summary/Developmental History

My developmental history, including my gestational history, approximate age when my delays or difficulties were first noted or diagnosed, and age when my developmental milestones were met:

Important events in my life, including my residential history such as where and with whom I lived, when and how long I lived in each location and my waiver history including services I received, length of time I received the services and benefits of the services:

My educational and employment history, including date I completed/graduated from high school or highest grade I completed, where I previously attended school, and services I received in school, my employment history such as where I have worked, positions I have held and length of time at each job:

**Person-Centered Assessment**

What I did last year:

I like to spend time with:

The best ways to approach me for the first time:

The ways I calm myself:

Things that are extremely important to me:

Things I never want in my life:

What I do for fun:

What works:

What doesn’t work:

What happens when things don’t work:

**Person-Centered Vision**

My long-term goals for the future:

What I want to accomplish within the plan year and who will help me:

**Medical History and Comments {include diagnosis(es)}:**

## General Health

Seizures Tube Feeding Frequent Hospital Admissions

Catheter Care Oxygen Frequent Physician/Nurse Visits

Ostomy Care Diabetic Heart Condition

Trach. Care Skin Breakdown Assistance with Ambulation

Swallowing Issues Positioning Needs Allergies

Suctioning Date of last dental visit:

If \_\_\_\_\_\_\_requires paid supports (include family members who are paid to fulfill this role) to complete medical appointments, name the primary Health Care Coordinator and back-up:

AND Is \_\_\_\_\_\_\_\_ cooperative with medical services/treatments?

How and/or by whom are health needs met?

Describe Mealtime Assistance Plan if applicable or plan to return to oral consumption:

Describe any needs for therapies or treatments:

Is there a current physician’s order/prescription for any waiver nutrition, nursing, speech, OT, PT, audiology service or nutritional supplements?  Yes  No  Not applicable

DISCUS/AIMS needs:

**Medical**

1. Does \_\_\_\_\_\_\_\_ have any unresolved medical issues? YES  NO

If YES, please explain:

2. Has \_\_\_\_\_\_\_\_\_ had a change in health status during the last year? YES  NO

If YES, please explain:

3. Does \_\_\_\_\_\_\_\_ receive any therapies through the school? YES  NO  NA

If YES, please explain:

4. Medications (prescription and over-the-counter):

How and/or by whom are \_\_\_\_\_\_\_\_\_ medication administration needs met?

Does DDSD-funded staff assist in any way with administration of meds for \_\_\_\_\_\_\_\_\_? Yes No

If yes, go to question a. below. If no, skip to question 5.

a. Does \_\_\_\_\_\_\_\_\_\_\_ want to participate in the administration of medications and require paid supports to do so? If no, skip to 4b.  YES  NO

If yes, can \_\_\_\_\_\_\_\_\_\_ understand and follow label directions?

properly identify the medication?

take at correct time?

take the correct dosage?

administer own medications without supervision?

demonstrate ability to address problems including asking staff for help?

If all 6 of these items can be completed, \_\_\_\_\_\_\_\_\_\_\_\_\_may self-administer medications without supports and is an ultimate user of his/her medication(s).

If any of these 6 items cannot be completed, \_\_\_\_\_\_\_\_\_\_\_\_ requires supports to self-administer medications. IMSP (include outcome as well):

b. Modifications to the medication administration responsibilities of staff are needed.  YES  NO

If yes, IMSP (include outcome as well):

5. Psychotropic Medications

1. A psychotropic medication is a drug used to treat a mental disorder, or any drug prescribed to stabilize or improve mood, mental status or behavior. Does \_\_\_\_\_\_\_ receive one or more psychotropic medication(s)?  Yes  No

If yes, list the medication(s), start date(s), and psychiatric diagnosis(es) or specific target behavioral symptoms (if a medication is prescribed as needed (PRN), include that designation as well), then go to question B:

If no, skip the rest of the psychotropic medication section completely, go to question 6 Health Related Service Tasks.

1. A protective intervention plan is required when a psychotropic medication is used for the sole purpose of controlling behavior. A medication is used for behavioral control when prescribed without a confirmed psychiatric diagnosis appropriate for the medication. This includes PRN psychotropic medication. Does \_\_\_\_\_\_\_\_\_\_\_ take a medication(s) to control behavior?  Yes  No

If no, skip to question C.

If yes, does the HTS administer the psychotropic medication?  Yes  No

If yes, has a protective intervention plan been developed?  Yes  No

If yes: Date PIP was written/revised:

Date PIP was approved by the team:

Date PIP submitted to agency HRC:

Date PIP submitted to SBRC:

If PRN medication, date form 06HM067E submitted:

Complete an addendum if PIP not written/revised, approved or submitted to HRC and/or SBRC at the time of the initial/annual planning meeting.

1. For all psychotropic medication use, identify:

Specific method for collecting data:

Method for reporting data to prescribing physician (who, frequency, etc.):

Has a psychotropic medication reduction been attempted?  Yes  No

If yes, date and results:

If no, explain:

6. **Health-related service tasks** performed by community services worker(s):

The service recipient's Team has identified the following health-related tasks and agrees that these tasks may be performed by community services workers upon completion of appropriate individual specific training:

**Nutrition**:

instilling medications through a gastrostomy tube or jejeunostomy tube

instilling nutrition through a gastrostomy tube or jejeunostomy tube

maintenance of the gastrostomy tube or jejeunostomy tube site

fluid support, including documentation of intake and output

blood glucose monitoring

urine dip stick glucose monitoring

**Hygiene:**

stoma care

ostomy bag care

wound care, non-sterile dressing changes

oral care requiring suctioning

**Elimination**:

application of external catheter

administration of enema

stool and urine collection

**Health and safety needs:**

pulse oxygen reading for data collection and reporting of signs and symptoms or concerns to a health

professional

suctioning of the opening of a tracheostomy tube

administration of oral metered dose inhalers

administration of nebulizers

non-sterile catheterization

oxygen administration

chest physiotherapy and positioning for postural drainage

vagal nerve stimulator activation

Other (describe):

For each box checked, the Team should ensure that all needed health-related task outcomes and action steps are included in the Plan. Training requirements and timeframes should be included in the Staff Training section of the IP. There must be a specific order from the physician acknowledging staff can complete the task(s).

Does \_\_\_\_\_\_\_\_\_require any medical supplies?

If yes, describe (also include applicable toileting program outcome?

## Assistive Technology/Architectural Modifications:

1. Does the home accommodate the person’s accessibility needs?  YES  NO

If NO, please explain:

2. Are architectural modifications needed?  YES  NO

If YES, please explain:

3. Does the person have unmet Assistive Technology needs?  YES  NO

If YES, please explain:

## COMMUNICATION SKILLS

Evaluate the following areas according to the scale below, and place an X inside the appropriate box.

**0. No Assistance Needed**

**1. Some Assistance/Supervision Needed**

**2. Cannot do at all**

**0 1 2**

Making sounds or gestures to get the attention of others.

**0 1 2**

Communicating wants and Needs.

**0 1 2**

Responding when name is called by looking at person speaking.

**0 1 2**

Indicating “yes” or “no” in response to a simple question.

**0 1 2**

Communicating basic needs by speaking or signing.

**0 1 2**

Ability to dial 911 in the event of an emergency

**0 1 2**

Can independently contact their caregiver.

**0 1 2**

Ability to read and write.

**0 1 2**

Answering and using the telephone to contact others

**0 1 2**

Responding appropriately to most common signs, or symbols, etc. (ex. STOP,

MEN, WOMEN, DANGER)

COMMENTS SECTION: (Indicate if person uses sign language, gestures, requires interpreter, adaptive equipment, etc.)

How and/or by whom are communication needs met?

## SKILLS of Daily Living

Evaluate the following areas according to the scale below, and place an X inside the appropriate box.

**0. No Assistance Needed**

**1. Some Assistance/Supervision Needed**

**2. Cannot do at all**

**0 1 2**

**Dressing**. Includes getting out clothes, putting them on, fastening them, and putting on shoes.

**0 1 2**

**Bathing/Grooming/Personal Hygiene**. Includes running the water, taking the bath or shower and washing all parts of the body, including hair; combing hair, washing face, shaving, brushing teeth

**0 1 2**

**Toileting.** How well can you manage using the toilet? Independence includes adjusting clothing, getting to and on/off the toilet, and keeping yourself clean and dry*.* If accidents occur and person manages it alone, count as **NO assistance.** If reminders are needed, count as **Some assistance/ supervision.**

**0 1 2**

**Eating.** Includes eating, drinking from a cup/glass, ingesting food through mouth, chewing and swallowing.

**0 1 2**

**Shopping/Errands**. Shopping for food and other things you need. Does not include getting to/from store. Includes making lists, selecting needed items, reading labels, reaching shelves, completing the purchase, etc.

**0 1 2**

**Preparing Meals**. Making sandwiches, cold or preparing simple meals, TV dinners, etc., (Does not refer to quality of nutritional content.)

**0 1 2**

**Laundry.** Using detergent, getting items in/out of washer or dryer, starting and stopping the machine, or otherwise washing and drying, sorting, folding, putting away, etc

**0 1 2**

**Housekeeping and Cleaning**. Includes dusting, vacuuming, sweeping, general home maintenance, yard work, etc. Does not include laundry

**0 1 2**

**Operating Home Appliances**.Using home devices such as TV, toaster, microwave, coffee maker, etc.

How and/or by whom are daily living needs met?

## Mobility and Community Access

Evaluate the following areas according to the scale below, and place an X inside the appropriate box.

**0. No Assistance Needed**

**1.** **Some Assistance/Supervision Needed**

**2. Cannot do at all.**

**0 1 2**

**Community Transportation Ability**. Arranging and using local transportation or driving to places beyond walking distance, to get to places you need to go.

**0 1 2**

**Mobility**. Moving about, even with a cane or walker or using a wheelchair. Independence refers to the ability to walk or move yourself short distances. (Does not include stairs; may refer to a history of falling.)

**0 1 2**

**Transferring.** Including getting in/out of chair, bed, sofa, tub, vehicle, etc.

**0 1 2**

**Stairs.** Ability to use stairs safely.

**0 1 2**

**Participating in recreation/leisure in community.** Taking part in recreation/leisure in community settings, such as bowling on a team, participating in an exercise class, etc

How and/or by whom are mobility and community access needs met?

## Work, School, or Day Programming

Evaluate the following areas according to the scale below, and place an X inside the appropriate box.

**0. No Assistance Needed**

**1.** **Some Assistance/Supervision Needed**

**2. Requires physical assistance/close supervision**

**0 1 2**

**Accessing a work, school or day program.** Can they access a work, school or day program.

**0 1 2**

**Supports required during work, school or day programming.** What level of support do they need to be successful in work, school, or day programming? Are they independent, do they require intermittent support, or one to one support?

**0 1 2**

**Learning and using skills.** Identify the level of assistance needed to learn and use skills.

**0 1 2**

**Interacting with others at work, school or day programming.**  Does the person require behavioral supports and/or interventions to be successful in this environment?

**0 1 2**

**Ability to participate.** Refers to their ability to participate in a meaningful day program

How do they spend their day? On average how many total hours a week is the person involved in either a work, school or day program? Who provides necessary assistance?

Any adult day services or DDSD funded vocational service must be a waiver service on the plan of care.

## Protection and Advocacy

Evaluate the following areas according to the scale below, and place an X inside the appropriate box.

**0. No Assistance needed.**

**1. Some Assistance/Supervision Needed**

**2. Cannot do at all.**

**0 1 2**

**Advocating for Self.**  Indicating personal preference, including wants and needs; and support requests; participating in advocacy groups.

**0 1 2**

**Managing Money and personal finances.** Refers to only your own money. Paying bills, balancing checkbook, counting change, staying within available financial resources, etc.

**0 1 2**

**Protecting self from exploitations.** Identifying when someone is attempting to exploit and then taking action to prohibit the exploitations.

**0 1 2**

**Obtaining legal services or help from others.** Contacting help from authorities and attorneys for legal service.

How and/or by whom are Protection and advocacy needs met?

## Assessment of Risk

Evaluate the following areas according to the scale below, and place an X inside the appropriate box.

**0. Never**

**1.** **Rarely**

**2.** **Frequently**

**0 1 2**

**Is the service recipient hurtful to self?** Injures own body—for example, by hitting self, banging head, scratching, cutting or puncturing, biting, rubbing skin, pulling out hair, picking on skin, biting nails, or pinching) **If so describe:**

**0 1 2**

**Is the service recipient hurtful to others?** *Causes physical pain to other people or to animals—*by hitting, kicking, biting, pinching, scratching, pulling hair, or striking with an object. **If so describe:**

**0 1 2**

**Is the service recipient destructive to property?** *Deliberately breaks, defaces or destroys things –* for example, by hitting, tearing or cutting, throwing, burning, marking or scratching things. **If so describe:**

**0 1 2**

**Does the service recipient have problems, which interfere with community inclusion?** by clinging, pestering or teasing, arguing or complaining, picking fights, laughing or crying without reason, interrupting, yelling/screaming and/or inappropriate touching. **If so describe:**

**0 1 2**

**Does the service recipient present any other unusual issues? If so describe:**

**0 1 2**

**Does the service recipient have elopement issues?** leaving the home, school or work site, and/or waking in the middle of the night and leaving while the care givers are asleep. **If so describe:**

**0 1 2**

**Has the service recipient had any mental health hospitalizations during the past year?** Admission to a mental health facility. **If so describe:**

**0 1 2**

**Has the service recipient had any involvement with law enforcement? If so describe:**

**0 1 2**

**Does the service recipient have any restrictive or intrusive procedures essential for safety?** Physical management, any limitations placed on the service recipient’s access to goods, services, and activities. **If so describe:**

How and/or by whom are the risks addressed?

**If HTS staff must use restrictive procedures, protective intervention planning is required.**

**Ensure any physical, emotional, medical, financial or legal safety, or community participation risks are described and addressed in the Plan (including outcomes/action steps derived from the risk assessment or PIP, as well as timeframes to evaluate the effectiveness of the PIP). If a restrictive PIP is needed, identify the name of the person who wrote the PIP and indicate the date of the PIP Team Review:**

# Assessment of Caregiver Support

1. Does\_\_\_\_\_\_\_\_\_\_ reside in his/her own home (not a family or relative home)? YES NO

2. If \_\_\_\_\_\_\_\_\_\_\_\_ lives alone answer the following questions below, if not go to question #3:

A. Does the home require safety devices such as an anti-scald device, non-skid material on floor, etc.?

B. What precautions, if any, are needed for storage of toxic substances or other dangerous products?

C. Who is responsible for home maintenance?

D. What support is necessary to provide for the \_\_\_\_\_\_\_\_\_\_\_\_ safety (number of hours of supervision needed

per day, type of supervision/support needed?)

3. Does the hts live in the same home as \_\_\_\_\_\_\_\_\_\_\_?

4. Is the hts related to \_\_\_\_\_\_\_\_\_\_\_\_?

1. If the hts is related to \_\_\_\_\_\_\_\_\_\_\_\_, what is the relationship?

5. Level of staff support needed for safety during recreational water activities?

6. If DDSD-funded staff assists with bathing or showering: what level of staff support is needed for water safety in the home/bathing?

7. If the service recipient lives with others, please list household members and indicate if he/she also receives DDSD waiver services.

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| Household Members | Relationship to Service recipient | Age |
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8. Does the primary caregiver (s) have any health problems that limit his/her ability to provide care to the service recipient? YES  NO

If YES, please explain:

9. Does the primary caregiver work outside the home?  YES  NO

If yes - \_\_\_\_\_\_\_ hours per day. List days per week:

10. How is needed care provided while caregiver is working?

11. If the primary caregiver(s) is suddenly unable to assist \_\_\_\_\_\_\_\_\_\_, who will take his/her place (i.e. back-up plan)?

12. Is there anything that makes it difficult for the caregiver to manage the care?

13. Does anyone besides the primary care giver provide unpaid assistance to the service recipient at least once a month?  YES  No

If yes, list their relationship to \_\_\_\_\_\_\_\_\_\_, their names and frequency of care (hours and days):

14. Can \_\_\_\_\_\_\_\_\_\_ be left alone safely?  YES  NO

If yes, for what length of time, and under what conditions?

**Legal Issues, Finances & Guardianship**

Describe any refusal of services by a legally competent adult or legal guardian:

A copy of DHS Publication No. 05-40, OKDHS Hearing: Requesting a fair hearing, hearing procedures, and appeals from hearing decisions, was provided to \_\_\_\_\_\_\_\_\_\_. The forms acknowledging explanation of Choice of Services; Choice of Providers; How to Report Abuse, Neglect and Exploitation; and Right to Request a Fair Hearing were reviewed and signed by \_\_\_\_\_\_\_\_\_\_\_.

Describe any advanced health care directive (such as a living will):

Describe any burial policy \_\_\_\_\_\_\_\_\_\_\_ has:

Does \_\_\_\_\_\_\_\_ have a representative payee or guardian with authority over finances?  YES  NO

If yes, name:

Does \_\_\_\_\_\_\_\_\_\_ manage any of his/her finances?  Yes  No

If yes, does the service recipient require any assistance to safely manage personal funds?

If yes, what kind of assistance does the service recipient require to safely manage personal funds?

Does this person have a spending program?  YES  NO If yes: \_\_\_\_\_\_\_\_ receives $\_\_\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_.

Answer this question only for adults: does \_\_\_\_\_\_\_\_\_\_ have a bank card (ATM or debit)?  Yes  No If so, name of the person who is responsible for it:

Does the team agree \_\_\_\_\_\_\_\_\_\_ should have limited access to his/her personal funds?  YES  NO Do not consider funds that are managed by a financial guardian or representative payee.

If yes: Plan to remove this restriction (including dates to review the plan):

AND: Has the team addressed whether \_\_\_\_\_\_\_\_\_:

Is able to recognize currency and coins and their value?

Loses money regularly?

Leaves money lying around?

Gives money away?

Has the ability to make change or knows when to wait for change?

Shows responsible behavior regarding his/her money, paying bills on time, writing checks only when he or she has sufficient funds and saving or planning for special items?

Understands his or her responsibility to pay room and board expenses?

Understands budgeting so money will last all month?

Responsibility for timely reporting all income changes, earned and unearned, and resource status to the Social Security Administration and the OKDHS county office for SSI, Medicaid, Supplemental Nutrition Assistance Program benefits (food stamps) or other benefits, and for assisting with routine case reviews is assigned to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_ current guardianship status is \_\_\_\_\_\_\_\_\_\_\_\_. Complete this section only for persons age 17 ½ and older.

The last guardianship assessment/review was completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Based on those findings, \_\_\_\_\_\_\_\_\_\_  has  does not have capacity to give informed consent.

1. Has \_\_\_\_\_\_\_\_\_ capacity to give informed consent changed since the last review?  Yes  No

2. Has \_\_\_\_\_\_\_\_\_\_ life changed in any way that would necessitate a change in guardianship status, such as increased need for medical consents or Adult Protective Services involvement?  Yes  No

3. Does \_\_\_\_\_\_\_\_ currently have a guardian?  Yes  No

If yes, list names of all appointed guardians:

If yes, is the guardian a volunteer guardian through TARC?  Yes  No

If yes, does the guardianship and guardian(s) meet \_\_\_\_\_\_\_\_\_\_ needs?  Yes  No

If no, explain and describe plan to remedy the situation:

4. Not including guardians, is there a person in this \_\_\_\_\_\_\_\_ life who actively advocates for him/her, but is not paid to do so?  Yes  No

If yes, does advocacy meet \_\_-\_\_\_\_\_\_\_\_\_\_ needs?  Yes  No

Name of advocate:

If no, explain and describe plan to remedy the situation:

5. If guardianship or volunteer advocacy has been recommended but has not been established, describe current status, such as waiting for court date or agency searching for match.

## Service Summary of Previous Year

1. What was achieved last year as a result of the services provided?

2. The person’s needs’ can be met by a combination of natural/informal supports, other available programs, and the In Home Supports Waiver:  Yes  No

If no, please explain in detail including why their needs can’t be met, a description of the services needed, including frequency and duration.

### Referrals for Services

Case Management action in response to consumer’s request for in home care.

**Referral Date of Referral Contact Person Phone Number**

School based services, if under 21

Public transportation

Personal Care Services

Dept. of Rehabilitative Services

EPSDT Services, if a child, under 21

Medical services available in State plan

Benefits available through private insurance

Benefits available through Tribal Assistance

HUD or local housing authority

D-Dent or dental clinic

Emergency services

Home delivered meals (Meals on Wheels etc)

Volunteer Services

Mental Health or Substance Abuse Services

Special Needs Day Care

Other – List:

Comments:

## Services Plan

Include additional justification for any services requested, including professional services(nutrition, nursing, speech, OT, PT, audiology, family counseling, psychological, etc.):

List the services requested through the In-Home Supports Waiver. Include the frequency, duration, expected outcome, and end date of the service prescribed.

**Service Start date End date Frequency Duration Total Units**

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**Outcomes, action steps & responsible persons**:

**Self-Direction of Services**

Service recipient elects to self-direct all or a portion of the IHSW budget.          Yes    No

If yes, complete this section:

Dollar amount of budget the person intends to self-direct: \_\_\_\_\_\_\_\_\_\_ minus $70 administrative fee per month X number of months the person plans to self-direct = \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If the service recipient elects to self-direct hts, the hts cannot be a parent (including step-parents), siblings (including half-siblings and step-siblings) or any person who resides in the same home as the service recipient.

**Case Management**

**Case management services are provided by DDSD to assist in gaining access to needed services. Case management services include assessment, support and service planning, monitoring and coordination, and reassessment.**

At a minimum, case management face-to-face monitoring services are provided monthly semi-annually. Other monitoring services provided as needed include other contacts with service recipient, family members, guardian, advocates, and providers; observation of the provision of services; review of progress; assessment of needs; planning; referral activities; and monitoring.

The DDSD Case Manager provided a copy of the DDSD HCBS Waiver Overview document to \_\_\_\_\_\_\_\_\_\_\_\_\_\_ which includes information on how to report abuse, neglect and exploitation.

The following forms were provided, reviewed and signed:

1. OCA GR-3

2. HIPAA 2 - Privacy Notice (one time only)

3. HIPAA 3 – Release of Information (as needed)

**Staff Training**

If applicable, the following forms were provided, reviewed and signed:

1. DDS-37 – Certificate of Competency

2. DDS-38 – Family Member’s Statement

3. All staff, regardless of certificate of competency, must successfully complete: first aide training, CPR, and medication administration training, if the staff member administers medication or assists the individual with self-administration.

In addition to the general and job specific training requirements defined in policy for direct support staff, the following individual-specific in-service training requirements are required to work with \_\_\_\_\_\_\_\_\_\_\_\_\_.   The team specifies the required time frames for completion of each identified training.  If time frames are not identified in the Plan, the required training must be completed before working with \_\_\_\_\_\_\_\_\_\_\_\_.   The team also identifies the person responsible for providing the training, by name.

**Back-up Plans**

In the event the home becomes temporarily uninhabitable or some other emergency occurs, the service recipient will relocate to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

If staff is not available, \_\_\_\_\_\_\_\_\_\_\_\_\_ needs will be met as follows:

Cc: Central Files

All providers of a service

Service Recipient/Guardian