agency for persons with disabilities
State of Florida

Agency for Persons With Disabilities
Support Plan/ Support Plan Update
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Support Plan Development Date:			**Support Plan Effective Date:**		
Support Plan Updates:	First:	**Second:**		**Third:**	**Fourth:**
Name:			**Legal Status:**		
DOB:		SSN:	**Guardians Name:**		
Medicaid #:			**Guardian Type/Area:**		
Residential Address:			**Guardian's Phone:**		
			Guardian's Address:		
Phone: **Home:**		**Work:**			
Home District:			**Residence/ Level of Care Codes**		
District of Residence:			**Foster Care/ Small Group Care Codes**		
Support Plan Written By:				**Intense**	**Moderate**	**Minimal**
Name of Support Coordinator			**Group Home And Residential Habilitation Center:**		
			A	**B**	**C**	D	E
			ICF/DD Level of Care:		

Personal Attributes (interest, talents, attributes, gifts, strengths, preferences, and communication style). How would you describe yourself to others? What things are you good at doing? What type of activities do you most enjoy? Who provided the information?

Future View (personal goals for the future (3-5 years). Things you want different in your life in the next 3-5 years. Where do you eventually see yourself living and working? What will you be doing for fun?

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Life Area	**Present situation** (in the life areas of home, daily activities/work/school and personal/social). **Include a brief functional description of : (1) capabilities, (2) daily activities, (3) interactions with others, (4) valued roles, (5) community opportunities, (6) supports and services currently being received (both paid and unpaid), (7) issues or concerns (health, challenging behaviors or situations) the person is experiencing, (8) any changes the person wants in their present situation, and (9) important relationships in the person's life. Also include a brief summary of personal goals achieved in the past year and/or the status toward completion. (Add additional pages if needed). This summary will serve as the annual report.**

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Health Summary: Describe any health concerns and how it impacts on the person. What health concerns do you have? Describe the preventative health services that are needed to stay healthy.
(Attach additional pages and/or reports if needed.)

Who helps you manage your health care?		**Relationship:**		**Phone:**	

Assistive or Adaptive Equipment:		**Yes**		**No**	

Identify glasses, dentures, equipment, etc. What adaptive equipment do you use and what is it used for?

Medications:		Yes, list below		No

Identify all meds: The name and dosage schedule, purpose and any problems/side effects being experienced. Any r problems, e.g., drowsiness, rashes, etc?

Current as of:	

Medication Name	Dosage and schedule	Purpose or Diagnosis	Problems/ Side Effects Noted

Note: Pages A, B, and C should be completed by the Support Coordinator Prior to the Support Plan Meeting.

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Personal Goals for Upcoming Year: What do you want to accomplish this year? What are the most important things you want to see happen in your life?	***Support/Services Needed:** Include all natural, generic, community and paid supports. Identify the type of service and who is responsible. (include only those services needed to accomplish personal goals.)
Other supports/Services Needed: Routine services that are not specifically related to the accomplishment of personal goals but are essential supports/services needed to ensure that the person's health and safety are maintained.	**Who will take the Lead?** Identify the person who will take the lead on scheduling appointments or other type of actions needed.

NOTE: Support coordinator has overall responsibility to coordinate the provision of all supports and services. Support coordinator is identified as responsible in situations in which the coordinator has a definite role/ specific task the coordinator is responsible for completing.

Name:	
Support Plan Effective Date:	

Individual/Guardian Consent: I have participated in the development of the plan and I agree to the contents. I have been informed of my due process rights under Florida Statutes 120 and that I may appeal any portion of this plan. I understand that the purpose of this plan is to identify my or my family's strengths, needs, preferences, and resources to help promote a positive quality of life. I understand that if my needs change, an update to this support plan may be needed. Supports should be identified according to my or my family's needs regardless of the availability of funds. Supports and services needed to meet my needs will be sought from my personal resources, community resources and government resources. When government resources are necessary, they shall be provided based on the availability of general revenue funds.

Individual's Signature:	**Date:**		**Date Copy Sent:**	
	Date Copy Sent to Area:			
Legal Representative's Signature:	**Date:**		**Date Copy Sent:**	
Printed Name and Telephone Number:	**Relationship (parent, guardian advocate, POA)**			

Signature of Support Plan Participants			
Relationship	**Name /Address/Program (if applicable)**	**Date of Signature**	**Date Copy Sent:**

Signature of Support Plan Participants: Enter the relationship, and the name(s)/address/program (if applicable) of the individual(s) who are invited by the person and participated in the development of the support plan, and the date the support plan was signed. Provide the date the support plan was provided/mailed to the participant.