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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  | |  | | --- | | **Helpful & Emergency Information** 24-hour Toll-Free Help Line: 1-844-MFP HELP (1-844-637-4357) | | | | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  | |  |  |  | | --- | --- | --- | | |  | | --- | | **Information about me** | | | | **My Name:** |  | | **My Date of Birth:** |  | | **My Address:** |  | | **Land Phone Number:** |  | | **Mobile Phone Number:** |  | | | | | |  |
|  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | **Significant Medical conditions/issues** | | | | | **Disability/Disease/Condition:** | **Emergency/Relocation issues/Concerns:** | **Other comments:** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | | | | | | |  |
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|  |  |  | |  |  |  |  |  | | --- | --- | --- | --- | --- | | |  | | --- | | **Providers and people who support me** | | | | | | |  | | --- | | **Type:** | | |  | | --- | | **Name:** | | |  | | --- | | **Office Phone:** | | |  | | --- | | **Cell Phone:** | | | Service Coordinator/Case Manager |  |  |  | | Primary Care Physician |  |  |  | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | |  | | --- | | **Provider Agencies** | | | | | | | **Agency Name:** | **Agency Phone Number:** | **Agency After-Hours Phone:** | **Service Provided:** | **Schedule:** | |  |  |  |  |  | |  |  |  |  |  | | | |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | **Friends and family who can help in an emergency** | | | | | **Name:** | **Phone Number:** | **Can help with:** | |  |  |  | | | | | | |  |
|  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | |  | | --- | | **Medical Equipment & Assistive Technology** | | | | | | | **Item:** | **Company Name:** | **Company Phone Number:** | **Necessary to bring in case of evacuation?** | **What I can use as back-up for this item:** | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | | | | | | |  |
|  |  |  |  |  |  |  |  |  |
|  |  | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | **Places I can go in case of emergency** | | | | | **Name:** | **Phone Number:** | **Address:** | |  |  |  | | | | | | |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  | |  |  |  |  | | --- | --- | --- | --- | | |  | | --- | | **Resources in my community** | | | | | **Resource Type:** | **Description:** | **Phone Number:** | |  |  |  | |  |  |  | |  |  |  | | | | |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  | |  |  | | --- | --- | | **911 form completed and submitted on:** | **\_\_\_\_\_\_\_\_\_** | | |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  | |  |  | | --- | --- | | I participated in developing this plan on: | \_\_\_\_\_\_\_\_\_ | | |  |  |  |  |  |
|  |  |  | |  | | --- | | *My service coordinator/case manager informed me about ways I can report suspected abuse and/or neglect as part of this discussion. I understand that I am responsible for alerting my service coordinator/case manager if my situation changes and my plan needs to be updated.*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Participant Signature)* *(Date Signed)*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Guardian Signature)* *(Date Signed)*    *Reviewed:* \_\_\_\_\_\_\_\_\_ *Reviewed:* \_\_\_\_\_\_\_\_\_ *Reviewed:* \_\_\_\_\_\_\_\_\_ | |  | | | | | |  |