

Cross System Crisis Plan

TODAY'S DATE		CLIENT'S NAME		DATE OF BIRTH	
MENTAL HEALTH AGENCY				TELEPHONE NUMBER	
MENTAL HEALTH AGENCY CASE MANAGER OR THERAPIST				TELEPHONE NUMBER	
LEGAL REPRESENTATIVE / NSA NAME (Specify relationship)				TELEPHONE NUMBER	
RESIDENTIAL SUPPORT AGENCY NAME			TELEPHONE NUMBER	ON-CALL NUMBER	
DDA CASE MANAGER/SOCIAL WORKER				TELEPHONE NUMBER	
MH and Medical Diagnosis (DSM-5TR)		CONTRACT THERAPIST FOR CPP PARTICIPANTS ONLY		TELEPHONE NUMBER	
		DOC OR JUVENILE REHABILITATION CONTACT		TELEPHONE NUMBER	
		FAMILY CONTACT		TELEPHONE NUMBER	
		GENERAL PHYSICIAN / PRESCRIBER		TELEPHONE NUMBER	
		MH CRISIS OR WISe TELEPHONE NUMBER			
COMMUNICATION <input type="checkbox"/> Nonverbal <input type="checkbox"/> Picture System <input type="checkbox"/> Sound or Gestures <input type="checkbox"/> Other Device: <input type="checkbox"/> Verbal <input type="checkbox"/> Processing delays:			PREFERRED LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
LEAST RESTRICTIVE ALTERNATIVE <input type="checkbox"/> Yes; expires: <input type="checkbox"/> No		LRA MONITORING AGENCY		TELEPHONE NUMBER	
Challenges					
VISION / HEARING			SENSORY		
MOBILITY			EATING / SWALLOWING CONCERNS		
Contact for Updated Medication List (Agency name or staff title if residential provider)					
NAME				TELEPHONE NUMBER	
Risk Issues (For each box checked, include a brief description of the risk in the box below)					
<input type="checkbox"/> Allergies (Food, Medication, Other) <input type="checkbox"/> Medical Conditions <input type="checkbox"/> Suicidal Ideation / Gestures <input type="checkbox"/> Aggression <input type="checkbox"/> Legal Issues <input type="checkbox"/> Other:		<input type="checkbox"/> Eludes Supervision <input type="checkbox"/> Sexual <input type="checkbox"/> Fire Setting <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Self-Injurious Behavior			

RISK ISSUE NOTES

Symptom / Behavior Description	Action: (Briefly list triggers to avoid; when and who should be called; scripts; for what purpose)

Signatures (Client, legal representative if applicable, DDA plan author)		Plan Expiration Date:	
SIGNATURE	DATE	PRINTED NAME	TELEPHONE NUMBER

Other Contributors to the Plan			
PRINTED NAME	ROLE	PRINTED NAME	ROLE

Review and Update (if plan requires significant revision, new plan must be developed)		
COMMENTS / CHANGES	DATE	SIGNATURE