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|  |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **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**[ ]**  Nonverbal**[ ]**  Sound or Gestures**[ ]**  Verbal | **[ ]**  Picture System**[ ]**  Other Device: | PREFERRED LANGUAGE**[ ]**  English**[ ]**  Spanish | **[ ]**  Sign Language**[ ]**  Other:  |
| **[ ]**  Processing delays:  |
| LEAST RESTRICTIVE ALTERNATIVE[ ]  Yes; expires:  [ ]  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)** |
| **[ ]**  Allergies (Food, Medication, Other) [ ]  Eludes Supervision[ ]  Medical Conditions [ ]  Sexual[ ]  Suicidal Ideation / Gestures [ ]  Fire Setting[ ]  Aggression [ ]  Substance Abuse[ ]  Legal Issues [ ]  Self-Injurious Behavior[ ]  Other:  |
| 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 | ROLE | PRINTED NAME | TELEPHONE NUMBER |
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| **Other Contributors to the Plan (Signature not required)** |
| PRINTED NAME | ROLE | PRINTED NAME | ROLE |
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| **Review and Update (if plan requires significant revision, new plan must be developed)** |
| COMMENTS / CHANGES | DATE | SIGNATURE |
|  |  |  |