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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 | | | |
|  | | | | |  | |  | | | |