# CRISIS PREVENTION AND INTERVENTION PLAN

| Date of Initial Crisis Plan (mm/dd/yyyy): | Date of Last Revision (mm/dd/yyyy): | Medicaid ID #: | Record #: |
|---|---|---|---|
| Name: | | Date of Birth (mm/dd/yyyy): | |
| Address: | | Telephone Number: | |
| Clinical Home/First Responder: | Emergency Phone #: | Alternate Phone #: | |
| LME-MCO: | LME-MCO Phone #: | County: | |

## Living Situation

| Living Situation (Stable, Unstable): | If "Unstable" Describe: |
|---|---|

In a crisis, assistance will be needed in the following areas (if not applicable, leave blank)

| Children (if yes, indicate ages): | Pets (Yes/Blank): | Transportation (Yes/Blank): | Other (Describe the type of assistance needed): |
|---|---|---|---|

Explain what help will be needed:

## Employment (In a crisis, assistance will be needed to contact my employer)

| Assistance will be needed (Yes/No): | Contact Name: | Contact Phone #: |
|---|---|---|

Please inform them:

| Communication | Preferred Language | |
|---|---|---|
| Method (Verbal, Nonverbal, Picture System, Gestures, Sound/Gestures, Other Device): | Preferred Language (English, Spanish, Sign Language, Other): | If "Other", specify: |

## Legally Responsible Person

| Guardian Appointed (Yes/No): | Legally Responsible Person Name: | Contact Phone #: |
|---|---|---|

## Insurance

| Type of Insurance: | Name of Company or Payer (If Type is Private or Other): | Policy Number/Member ID: |
|---|---|---|

## Diagnoses

| DSM Code: | Diagnosis: | Diagnosis Date (mm/dd/yyyy): |
|---|---|---|
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## Current Medications (Update/revise anytime there is a change)

| Medication Name: | Dose: | Frequency: | Reason for Change: | Date: | Prescribing MD: | Pharmacy: |
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## Allergies (Medication(s) and reaction - Update/revise anytime there is a change)

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## Poorly Tolerated Medications (Medication(s) and reaction - Update/revise anytime there is a change)

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## Medical/Dental Concerns

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