SOUTH COMMUNITY INC
IDDT PROGRAM – CRISIS PLAN

CLIENT NAME: _____ CLIENT ID: _____ DATE DEVELOPED: _____

Instructions: Please complete this form, which was developed to provide you with an opportunity to declare your preference of service delivery in a time of crisis or other emergency where you may not be able to fully express your wishes. Please take your time reading the following pages, as the answers to the following questions will allow the IDDT team to best provide you with services during a period of crisis.

When I am feeling well, I am (describe yourself when you are feeling well):

The following symptoms indicate that I am no longer able to make decisions for myself, that I am no longer able to be responsible for myself or to make appropriate decisions.

When I clearly have some of the above symptoms, I want the *following people* to make decisions for me, see that I get appropriate treatment and to give me care and support:

I do not want the following people involved in any way in my care or treatment. List names and (optionally) why you do not want them involved:

Preferred medications:	Reason for preference:

Client initials: _____

Acceptable medications:	Reason for being acceptable:

Unacceptable medications:	Reason for being unacceptable:

Acceptable treatments and why:

Unacceptable treatments and why:

Home/Community Care/Respite Options:

Preferred treatment facilities and why:

Client initials: _____

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Unacceptable treatment facilities and why:

What I want from my supporters when I am experiencing these symptoms:

What I don't want from my supporters when I am experiencing these symptoms:

What I want my supporters to do if I'm a danger to myself or others:

Things I need others to do for me and who I want to do it:

How I want disagreements between my supporters settled:

Client initials: _____

Things I can do for myself:

I (give, do not give) permission for my supporters to talk with each other about my symptoms and to make plans on how to assist me.

Indicators that supporters no longer need to use this plan:

I developed and completed this document myself with the help and support of:

Client Date

Attorney (optional) Date

Witness Date

Witness Date

Adapted from SAMHSA by South Community Inc. (Dayton, Ohio)