Manitoba

Community Living disABILITY Services
My Support Plan

Date Completed:_____

Date Reviewed (if applicable):_____

Completed by:_____

MY INFORMATION

Name:		**Birthdate:**	
Address:		**Telephone:**	
Type of Residence:		**Move In Date:**	
House Manager or Supervisor:			

Legal Status:

☐ **Independent:** ☐ **Property** ☐ **Personal Care**

How is the individual supported to make their own decisions?

☐ **Substitute Decision Maker** ☐ **Property** ☐ **Personal Care** ***or***

☐ **Committee** ☐ **Property** ☐ **Personal Care** ***or***

☐ **Power of Attorney**

Name:
Address:
Phone:
Expiry Date:
What powers have been appointed?

MHSC:		**PHIN:**		**SIN:**	
EIA:		**Treaty:**		**Other:**	

Next of Kin: **Name:**

Address:

Phone:

CSW: **Name:**

Address:

Phone:

EIA: **Name:**

Address:

Phone:

Other Support: **Name:**

Address:

Phone:

Date of Last Person-Centred Plan: **On File:** ☐ **YES** ☐ **NO**		**Date of Last Financial Plan:** **On File:** ☐ **YES** ☐ **NO**	

My Employment, Day Program or School

Name of Employer/Program:

Address:

Phone:

Type of Employment/Program:

Supervisor:

Date Started:

Transportation:

GETTING TO KNOW ME

My Strengths and Interests

Daily Routine

Important People to Me

My Communication Skills

IMPORTANT INFORMATION ABOUT MY HEALTH

Medical Professionals

Physician: **Phone:** **Address:** **Last Appointment:** **Next Appointment:**	**Dentist:** **Phone:** **Address:** **Last Appointment:** **Next Appointment:**
Audiologist: **Phone:** **Address:** **Last Appointment:** **Next Appointment:**	**Ophthalmologist:** **Phone:** **Address:** **Last Appointment:** **Next Appointment:**

Neurologist: **Phone:** **Address:** **Last Appointment:** **Next Appointment:**	**Psychiatrist:** **Phone:** **Address:** **Last Appointment:** **Next Appointment:**
Pharmacy: **Phone:** **Address:** **Fax:**	**Other:**

My Health Profile

My Medical History

Medications I Take

Medical Administration Record (MAR) Required ☐ **N/A** ☐ **YES** ☐ **ON FILE**

Medical Protocols

Seizure Protocol Required ☐ **N/A** ☐ **YES** ☐ **ON FILE**

PRN Protocol Required ☐ **N/A** ☐ **YES** ☐ **ON FILE**

Health Care Plan/Nurse Delegation Plan ☐ **N/A** ☐ **YES** ☐ **ON FILE**

Other _____ ☐ **N/A** ☐ **YES** ☐ **ON FILE**

Allergies/Allergic Reactions

IMPORTANT INFORMATION FOR MY PERSONAL CARE AND FINANCES

Physical Capabilities and Mobility

Equipment Requirements

Physical Therapy and Occupational Therapy

Occupational Therapy Assessment Required ☐ **N/A** ☐ **YES** ☐ **ON FILE**

Date _____

Details:

Physical Therapy Assessment Required ☐ **N/A** ☐ **YES** ☐ **ON FILE**

Date _____

Details:

Eating, Diet, and Nutrition

Relevant Plans/Protocols Required ☐ **N/A** ☐ **YES** ☐ **ON FILE**

Bathing

Toileting

Other Personal Care Routines

Dressing

Oral Care

Skin Care

Sleep

Financial

SUPPORTING MY SAFETY AND INDEPENDENCE

Supporting Independence at Home

Individualized Support Plan Required ☐ N/A ☐ YES ☐ ON FILE

Supporting Independence in the Community

Community Access Plan Required ☐ N/A ☐ YES ☐ ON FILE
Missing Persons Protocol Required ☐ N/A ☐ YES ☐ ON FILE

Challenges to Supports

Behaviour Support Plan Required ☐ N/A ☐ YES ☐ ON FILE
Restrictive Practices/Restraint Plan Required ☐ N/A ☐ YES ☐ ON FILE

In Case of Emergency

Crisis Plan Required ☐ N/A ☐ YES ☐ ON FILE

SIGNATURE RECORD

Signing below indicates that you have read the attached Support Plan and understand its contents.

It is your responsibility to ensure you have all the information you need to fully understand how support is provided to an individual.

Date: _____ Initials:_____ Signature: _____

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