



## An easy-to-use, customizable plan for people who want to create a Psychiatric Advance Directive or Mental Health Crisis Plan



ASAP\* Guidebook & Plan Developed and Written by  
Lauren Rieser Shawl, M.S.  
Mental Health Association of Southeastern Pennsylvania

ASAP\* Project Concept Development by  
Jeffrey Draine, Ph.D.  
University of Pennsylvania School of Policy and Practice

### EMERGENCY CONTACT INFORMATION for

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_

In the event of an emergency situation in which I cannot communicate clearly on my own behalf, please contact the person(s) named on the reverse side of this card.

### MENTAL HEALTH ADVANCE DIRECTIVE

I, \_\_\_\_\_, have created an Advance Self-Advocacy Plan which is to be used as an advance directive concerning my mental health care. If I am hospitalized, please contact the person(s) named on the reverse side of this card.  
My date of birth: \_\_\_\_\_

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Developed by the Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities  
Funded by the National Institute on Disability and Rehabilitation Research



## ADVANCE SELF-ADVOCACY PLAN\*

The ASAP\* is an easy-to-use, customizable plan for people who want to create a Psychiatric Advance Directive or Mental Health Crisis Plan in order to maintain a voice in their mental health care and personal choices during times of illness or hospitalization.

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Please note that the Advance Self-Advocacy Plan (ASAP)\* forms do not constitute legal advice. State laws vary and it is possible that part or all of this document will not be effective in your state. It is recommended that you consult a lawyer or legal resource before you assume that you're Advance Self-Advocacy Plan will be legally valid in your state as an advance directive.

EMERGENCY CONTACTS
Name: _____
Phone: _____
<input type="checkbox"/> Above person is my Mental Health Care Representative
Name: _____
Phone: _____

EMERGENCY CONTACTS
Name: _____
Phone: _____
Name: _____
Phone: _____

# ADVANCE SELF-ADVOCACY PLAN

## FACILITY (HOSPITAL) INSTRUCTIONS

### Checklist

<input type="checkbox"/>	People Who Have a Copy of Your ASAP -----	5
<input type="checkbox"/>	Self- Assessment/Mental Wellness -----	6
<input type="checkbox"/>	Wellness and Recovery Techniques -----	6
<input type="checkbox"/>	Symptoms and Helpful Actions -----	6
<input type="checkbox"/>	Previous Hospitalizations -----	7
<input type="checkbox"/>	Treatment Facility Preference -----	8
<input type="checkbox"/>	Preferences about Doctors -----	8
<input type="checkbox"/>	Experimental Studies -----	8
<input type="checkbox"/>	Drug Trials -----	8
<input type="checkbox"/>	Electroconvulsive Therapy (ECT) -----	9
<input type="checkbox"/>	Seclusion and Restraint -----	9
<input type="checkbox"/>	Religious Preferences -----	9
<input type="checkbox"/>	Dietary Preferences -----	9
<input type="checkbox"/>	Street Drugs -----	10
<input type="checkbox"/>	Discharge Concerns -----	10
<input type="checkbox"/>	Medications -----	11
<input type="checkbox"/>	Notifications -----	13

## MAKING YOUR ASAP A LEGAL DOCUMENT

<input type="checkbox"/>	Statement of Intent, Witness, Notary -----	15
<input type="checkbox"/>	Additional Instructions -----	16

## PERSONAL INSTRUCTIONS SECTION

<input type="checkbox"/>	Notifications -----	19
<input type="checkbox"/>	Home Needs and Mail -----	20
<input type="checkbox"/>	Pets -----	20
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<input type="checkbox"/>	Job -----	22
<input type="checkbox"/>	School -----	22
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<input type="checkbox"/>	Planning Tips & Additional Resources -----	27
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## ABOUT THE ADVANCE SELF-ADVOCACY PLAN (ASAP)

The Advance Self-Advocacy Plan is a simple tool to tell others how you want to be treated in case your mental health takes a turn for the worse sometime in the future. It helps you discover what you need to handle and recover from a psychiatric crisis and provides a way to address those needs, both in and out of the hospital.

Your ASAP is designed to keep you in the center of your care, even during times that you have difficulty communicating your needs to others. And because this planning process helps you to identify and better understand your needs, you can sometimes avoid a crisis altogether.

To ensure that the ASAP is relevant and useful, it was created with extensive input from people who have used mental health services and who have been hospitalized in psychiatric facilities. Behavioral health service providers also contributed important information to better help them to assess and implement the plan developer's needs. As a result of the input, contributions and feedback from many sources, important topics that are not addressed in other mental health advance planning documents were included in the ASAP.

**Your ASAP can be used as a legally-binding psychiatric advance directive.** + The form on page 15 of your Advance Self-Advocacy Plan can be used to inform crisis response and in-patient facilities that *they need to provide mental health treatment and care as you have directed in your ASAP.*

+Please note: Some states still do not recognize Psychiatric Advance Directives while others might require some modification of this form in order for it to be used as a legal document. See Resource #1 on page 25 for state-specific information about psychiatric advance directives.

The **ASAP GUIDEBOOK** was developed as a companion for this ASAP planning tool. We recommend that anyone interested in creating an Advance Self-Advocacy Plan use the Guide-book to get a better sense of what to consider as they make their own plan.

## AN IMPORTANT NOTE ABOUT THE NUMBERS ON YOUR ASAP PLANNING SHEETS:

The ASAP is designed so that you can customize the page numbers of your personal plan. Most people will not need to use every ASAP planning sheet that is offered; you only need to include those pages that are relevant to your particular situation. (For example, if you do not have dependent children, you would not include ASAP pages 21, 22, or 23 in your plan.)

The number in parentheses at the bottom center of each page corresponds to the Table of Contents.



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Personal Plan p. # 1



There is also a blank space after the words “**Personal Plan p. # \_\_\_\_**” on the bottom right of each planning sheet where you can fill in your own numbers. After completing your personal ASAP, you can customize the page numbers for your plan by filling in the new, correct page number in that blank space for each of your planning sheets.

## ADVANCE SELF-ADVOCACY PLAN (ASAP) FOR:

\_\_\_\_\_ (print name clearly)

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Updated: \_\_\_\_\_ Signed: \_\_\_\_\_

**I have appointed a Mental Health Care Representative (Proxy):** Yes \_\_\_\_\_ / No \_\_\_\_\_

See Finances section for details (page 19).

[It is recommended that copies of your Advance Self-Advocacy Plan be given to trusted family members, friends and any people or agencies involved with your general health and mental health care, such as your primary care doctor, psychiatrist, therapist, case manager or mental health service provider.]

**The following people have been given a copy of my Advance Self-Advocacy Plan or have access to my personal copy.**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address and/or Phone Number(s): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address and/or Phone Number(s): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address and/or Phone Number(s): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address and/or Phone Number(s): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address and/or Phone Number(s): \_\_\_\_\_



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**SELF-ASSESSMENT**

**MENTAL WELLNESS** - This is what I'm like when I'm feeling well:

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**SYMPTOMS, TRIGGERS and HELPFUL ACTIONS:** If I experience a trigger (see Guidebook) and/or start to have uncomfortable symptoms or behaviors, the following actions can help me to feel more comfortable and possibly avoid a mental health crisis:

If I experience this (see below):

This action will help me to feel better:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**WELLNESS AND RECOVERY TECHNIQUES** - While in the hospital, I want to be permitted to use the following wellness techniques to help with my recovery:

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Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**PREVIOUS HOSPITALIZATIONS** – My history and preferences regarding hospitalization include the following:

I have been admitted to a psychiatric or crisis response facility before \_\_\_\_\_ Yes \_\_\_\_\_ No

This is how I have felt and reacted when I was hospitalized in the past:

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The following aspects about being in the hospital make me feel uncomfortable:

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The hospital staff can take the following steps to reduce my anxiety and help me feel more comfortable about being in the hospital:

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If I am feeling suicidal, the best thing staff can do to reduce the intensity of this feeling is this:

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Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**MY REQUESTS REGARDING FUTURE IN-PATIENT HOSPITALIZATION ARE AS FOLLOWS:**

(IT'S BETTER TO INITIAL YOUR RESPONSE RATHER THAN JUST PLACING A CHECK IN THE APPROPRIATE SPACE.)

**TREATMENT FACILITIES – My choices of treatment facilities are as follows:**

If my psychiatric condition is serious enough to require hospitalization, I would prefer to receive this care in this/these facilities:

Facility #1: \_\_\_\_\_ City/State: \_\_\_\_\_

Facility #2: \_\_\_\_\_ City/State: \_\_\_\_\_

I DO NOT wish to be admitted to the following facilities for psychiatric care (give reason if possible).

Facility: \_\_\_\_\_

Facility: \_\_\_\_\_

**TREATING PHYSICIAN/DOCTOR – My choice of a treating physician is:**

1st Choice of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

2nd Choice of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

I DO NOT wish to be treated by the following physicians: (optional)

Name of Physician: \_\_\_\_\_ Name of Physician: \_\_\_\_\_

**EXPERIMENTAL STUDIES – Hospital staff might approach you about participating in experimental studies.**

Initial your preference below:

\_\_\_\_\_ I DO NOT want to be approached about participating in experimental studies.

\_\_\_\_\_ I am willing to participate in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks.

**DRUG TRIALS – Hospital staff might approach you about participating in drug trials.** Initial your preference below:

\_\_\_\_\_ I DO NOT want to be approached about participating in drug trials.

\_\_\_\_\_ I am willing to participate in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks.



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**ECT — These are my preferences regarding electroconvulsive therapy (ECT):**

\_\_\_\_\_ I agree to the administration of electroconvulsive therapy if my treating physician believes that the potential benefits to me outweigh the possible risks.

\_\_\_\_\_ I DO NOT agree to the administration of electroconvulsive therapy.

**SECLUSION AND RESTRAINT — These are my preferences regarding the use of Seduction and/or Restraints:**

I have one or more of the following **risk factors**; therefore seclusion or restraint should not be used as it could prove dangerous to my emotional and/or physical health:

- |  |  |
|--|--|
| <input type="checkbox"/> Pregnancy             | <input type="checkbox"/> Seizure disorder                                |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Abuse history: physical/emotional, sexual, rape |
| <input type="checkbox"/> Head or spinal injury | <input type="checkbox"/> Other _____                                     |

\_\_\_\_\_ I DO NOT want restraint used during my hospitalization except as a last resort when all other possible safety interventions have been attempted.

\_\_\_\_\_ I DO NOT want seclusion used during my hospitalization except as a last resort when all other possible safety interventions have been attempted.

If it is determined that seduction or restraint is absolutely necessary, (1) such treatment needs to be ordered by my treating physician and (2) I must be monitored, and the need for this measure assessed, at intervals of 15 minutes or less as per the “Rules and Regulations” Section of the Federal Register.

Staff can minimize use of restraint and seduction by doing — or letting me do — the following:

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**RELIGIOUS REQUIREMENTS/PREFERENCES:**

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**DIETARY REQUIREMENTS/PREFERENCES:**

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Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**STREET DRUGS — Without admitting to or denying current use of street drugs, I offer the following information:**

A. This is the drug (or drugs) I am or was most likely to use: \_\_\_\_\_

\_\_\_\_\_

B. I feel and behave this way after taking this drug (or drugs): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

C. When I arrive at the hospital or crisis unit, I would be comfortable letting medical staff know – *in confidence* – whether I have taken a street drug (initial response). \_\_\_\_ Yes \_\_\_\_ No

**DISCHARGE CONCERNS — I will have to face the following difficult issue(s) when I am discharged; I would like to work on resolving these concerns during my hospital stay.**

If I have not already done so, I would like to fill out this section of my Advance Self-Advocacy Plan as soon as I am able so that I can inform hospital staff about my discharge concerns.

**Discharge Concern:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date of Concern: \_\_\_\_\_

**Resolution to Problem:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Discharge Concern:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ Date of Concern: \_\_\_\_\_

**Resolution to Problem:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICATIONS — These are my preferences regarding medications:**

**A. I agree to administration of the following medication(s):**

<u>Name of Medication</u>	<u>Dose</u>	<u>Medication is current as of date below</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Optional) Physician Verification: _____	Date: _____
--	-------------

**(Optional) These above medications have been prescribed by:**

Dr. \_\_\_\_\_ Doctor Phone # \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone # \_\_\_\_\_

**B. The following medication(s) must be avoided:**

Name of Medication	Reason (optional)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- MEDICATIONS Section Continued on Next Page -





Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**NOTIFICATION — In the event my psychiatric condition is serious enough to require hospitalization, I wish for the following people to be notified:**

**A. Primary Support Person: I request that the person named below is the first person notified about my hospitalization.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

If I lack the capacity to give consent to mental health treatment, I give my Primary Support Person full power and authority to make mental health care decisions for me as my mental health care representative (proxy). This includes the right to consent, refuse consent or withdraw consent to any mental health care, treatment, service or procedure consistent with any instructions and/or limitations I have stated in this Advance Self-Advocacy Plan, which may also be used as an advance directive. If I have not expressed a choice in this advance directive, I authorize my representative to make the decision that (s)he determines is the decision I would make if I were competent to do so.

I give permission for my Primary Support Person to serve as my legal mental health care representative (proxy) as detailed in the statement above.

\_\_\_\_\_  
(signature)

I DO NOT give permission for my Primary Support Person to serve as my legal mental health care representative (proxy).

\_\_\_\_\_  
(signature)

**B. Alternate Primary Support Person:** If the person named above is unable or unavailable to serve as my Primary Support Person, I hereby appoint and request immediate notification of my alternate Primary Support Person, who is named below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

I give permission for my Alternate Support Person to serve as my legal mental health care representative (proxy) as detailed in the statement above.

\_\_\_\_\_  
(signature)

I DO NOT give permission for my Alternate Support Person to serve as my legal mental health care representative (proxy).

\_\_\_\_\_  
(signature)

**C. I request that my primary care physician and/or other health care/mental health care professional(s) be notified and consulted concerning my care as soon as possible:**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**NOTIFICATION continued:**

**D. I request that staff of the Community Mental Health Program where I am a client be notified:**

Program Name \_\_\_\_\_

Phone #: \_\_\_\_\_ City/State: \_\_\_\_\_

Primary Counselor or Case Manager: \_\_\_\_\_

**E. The following people may also be notified. I have indicated whether or not I give them permission to VISIT me in the hospital:**

		<u>Visiting Privileges</u>	
		YES	NO
<b>Name:</b> _____			
Phone # _____	Relationship: _____		
<b>Name:</b> _____		YES	NO
Phone # _____	Relationship: _____		
<b>Name:</b> _____		YES	NO
Phone # _____	Relationship: _____		
<b>Name:</b> _____		YES	NO
Phone # _____	Relationship: _____		

**I DO NOT want the following people notified of my hospitalization under any circumstances:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

**ADDITIONAL NOTIFICATION NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## STATEMENT OF INTENT

I, \_\_\_\_\_, being of sound mind, willingly and voluntarily execute this health care advance directive to assure that, if I should be found to lack capacity to consent to my own mental health treatment, my choices regarding treatment will be carried out despite my inability to make informed decisions for myself.

In the event that a guardian or other decision maker is appointed by a court to make mental health care decisions for me, I intend that this document take precedence over all other means of determining my intent while competent.

To the extent, if any, that this document is not valid under state law, it is my desire that it be considered a statement of my wishes and that it be accorded the greatest possible legal weight and respect.

This document will become active and take effect upon the following two conditions:

- (1) It has been determined that I do not have the capacity to make my own mental health treatment decisions and it shall continue in effect only during that incapacity; and
- (2) Determination of my capacity must be made by my designated physician or a psychiatrist and one other mental health treatment provider, who have examined me.

Name (Please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SIGNATURE AND STATEMENT OF WITNESSES** (Each witness must be 18 or older, not related to me by blood, marriage or adoption and not a provider of my mental health care.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed this document in my presence.

**WITNESS 1:** Name (Please print): \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**WITNESS 2:** Name (Please print): \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTARY ACKNOWLEDGEMENT:** State of \_\_\_\_\_ County of \_\_\_\_\_

On \_\_\_\_\_, 20\_\_\_\_, before me the undersigned Notary Public personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person(s) whose name(s) is/are subscribed to the above Declaration for Mental Health Treatment as the Declarant and/or Witnesses for the purposes expressed therein. I attest that he/she/they appear to be of sound mind and not under or subject to duress, fraud, or undue influence.

Notary Public \_\_\_\_\_

My Commission Expires: \_\_\_\_\_







## Personal Instructions Section

for the



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**ADVANCE SELF-ADVOCACY PLAN (ASAP) FOR:**

\_\_\_\_\_ (print name clearly)

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Signed: \_\_\_\_\_

Updated: \_\_\_\_\_ Signed: \_\_\_\_\_

**- PERSONAL INSTRUCTIONS -**

**My Request Regarding Care for My Personal Responsibilities Are As Follows:**

(IT'S BETTER TO INTIAL YOUR RESPONSES RATHER THAN JUST PLACING A CHECK IN THE APPROPRIATE SPACE.)

On the following pages I am providing information about how my personal responsibilities should be handled in the event that I am temporarily unable to take care of them. I have named the Support Person(s) I would like to take care of each responsibility in my absence.

**NOTIFICATIONS:**

\_\_\_\_\_ I give permission for **ALL** Support People named on the following pages to be notified of my condition.

\_\_\_\_\_ **ONLY** Support People who are named below may be notified of my condition.

Name and Phone Number(s) or Address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**HOME NEEDS: If I am temporarily unable to care for my home, I request that the following items be handled by the Support Person(s) named below:**

Name of Support Person: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Home Needs: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**MAIL: If possible, I would like my mail handled as follows:**

Please ask \_\_\_\_\_ to:

(Contact's name and phone number)

- personally collect my mail in my absence
- have delivery stopped until I return home
- other \_\_\_\_\_

**PETS: If I am temporarily unable to care for my pets, I request that they be cared for by the Support Person(s) named below as follows:**

Name of Support Person \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Pets Support Person #2, Veterinarian or Boarding Facility contact information:

\_\_\_\_\_

**Pet #1 - Name:** \_\_\_\_\_ **Type of Animal:** \_\_\_\_\_

Care & Feeding Information \_\_\_\_\_

\_\_\_\_\_

**Pet #2 - Name:** \_\_\_\_\_ **Type of Animal:** \_\_\_\_\_

Care & Feeding Information \_\_\_\_\_

\_\_\_\_\_

**Pet #3 - Name:** \_\_\_\_\_ **Type of Animal:** \_\_\_\_\_

Care & Feeding Information \_\_\_\_\_

\_\_\_\_\_



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCES:** *If you want or need to have someone else take care of your financial responsibilities, you will need to either (1) appoint someone to have power-of-attorney authority over your financial affairs or (2) give a trusted friend or family member your bank account (and possibly social security) information so that they can make these payments for you.*

The person named below is my representative payee who already takes care of my finances. If I am hospitalized for more than \_\_\_\_ day(s), I agree to have him/her notified: \_\_\_\_ Yes \_\_\_\_ No

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**If I am temporarily unable to care for my finances, I have given the Support Person(s) named below the necessary information to care for the following payments until I am able to do so.**

Name of Support Person \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Alternate Support Person \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**RENT OR MORTGAGE PAYMENTS**

Name of landlord, rental or mortgage company: \_\_\_\_\_

Phone / Mailing address: \_\_\_\_\_

On the \_\_\_\_ day of the month, I pay the following amount: \$ \_\_\_\_\_

**BILL PAYMENTS**

<b>Type of Bill</b> (water, electric, phone, etc.)	<b>Account Number</b>	<b>Due on this day</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

*Note: It can be difficult to find contact information about your job and/or school when you are not feeling well.  
Get it and fill it in NOW... before you need it!*

**EMPLOYMENT INFORMATION:**

Company: \_\_\_\_\_

Name of Supervisor: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Personnel Director: \_\_\_\_\_

Personnel or Human Resources Dept. Phone #: \_\_\_\_\_

If I am unable to take care of this myself, I would like the following Support Person to contact my school about my employer on my behalf:

Name of Support Person: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

**SCHOOL INFORMATION:**

School: \_\_\_\_\_

Address (city & state): \_\_\_\_\_

School's Main Phone: \_\_\_\_\_

Counseling Office and/or Office of Disability Phone: \_\_\_\_\_

Financial Assistance/Loan/Grant/Scholarship Office Phone: \_\_\_\_\_

Name and contact information (phone/email address) of counselor, teacher, or other people at school who should be notified if you are absent:

\_\_\_\_\_  
\_\_\_\_\_

If I am unable to take care of this myself, I would like the following Support Person to contact my school about my absence on my behalf:

Name of Support Person: \_\_\_\_\_

Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**CARING FOR MY CHILDREN:**

If I am temporarily unable to care for my child/children, please immediately contact my child’s/children’s other parent or other close family member (named below) to take charge of their care.

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Under **NO** circumstances should my child/children be given to, or placed in the custody of, the following person (people):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

It’s a good idea to identify more support people to act as back-up caregivers in case the first person you name is not available when you need this type of assistance. If you can think of other people who could be contacted to care for your child/children in your absence, list them in order of preference and/or indicate your first, second and third choices.

**Please Note:**

- It’s important to ASK each person on your list if he/she is willing to accept this responsibility if necessary and, if possible, sign your plan on page 23 under his or her name.
- It’s a good idea to share ASAP pages 21—23 with your chosen caregivers so that they are aware of your preferences and have important information about each of your children.



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

In the event that I am temporarily unable to take care of my children AND my children's other parent is unavailable, unwilling or not allowed to have temporary custody, please contact these support people (in the order indicated) to care for my children:

Support Person's Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Signature: \_\_\_\_\_

Support Person's Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Signature: \_\_\_\_\_

Support Person's Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Signature: \_\_\_\_\_

**RESPIRE CARE INFORMATION:** In the event that I am temporarily unable to take care of my children AND no other adult of my choosing is available, willing or allowed to have temporary custody, please contact one of these respite care facilities to care for my children:

Name of Organization: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Name of Organization: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_



Plan Creator: \_\_\_\_\_ Initials \_\_\_\_\_ Date: \_\_\_\_\_

**Important information about my child or each of my children:**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **School and Grade:** \_\_\_\_\_

**Medical condition(s) and medication(s):** \_\_\_\_\_

\* **Personality and/or other information:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **School and Grade:** \_\_\_\_\_

**Medical condition(s) and medication(s):** \_\_\_\_\_

\* **Personality and/or other information:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **School and Grade:** \_\_\_\_\_

**Medical condition(s) and medication(s):** \_\_\_\_\_

\* **Personality and/or other information:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Birth Date:** \_\_\_\_\_ **School and Grade:** \_\_\_\_\_

**Medical condition(s) and medication(s):** \_\_\_\_\_

\* **Personality and/or other information:** \_\_\_\_\_

\*such as favorite color, foods, TV programs, games or video games, best friend(s), etc.





## PLANNING SUPPORT MATERIALS

Here are some things to keep in mind as you create your plan:

- Work on your plan (or parts of your plan) when you are feeling fairly well.
- You do not need to complete every section of the plan in order for it to be useful. However, you want to make sure that you fill out information for those areas that are most important to you.
- Think carefully about the information you include and perhaps discuss your choices and decisions with people who can contribute to the plan that you create. Be as specific as you can when writing down your preferences so that others will know exactly what you want.
- If it's helpful, make use of Plan Contributors: If you need help thinking about or getting information for your plan, you can ask your **Plan Assistant(s), Plan Supporter(s) and Mental Health Professionals** to assist you.
- **Don't be discouraged if you don't have all the information at your fingertips...** write down whatever you DO know and make a note of what you need to find out. You can use the ASAP **"Find It" Sheet** located at the end of the guidebook to keep track of the information you need find and add to your ASAP.

### - ADDITIONAL RESOURCES -

National Resource Center on Psychiatric Advance Directives:  
<http://www.nrc-pad.org/index.php>

Bazelon Center for Mental Health Law (Template/Forms for completion, FAQs):  
<http://www.bazelon.org/issues/advancedirectives/index.htm>

Mental Health America (formerly National Mental Health Association) Psychiatric Advance Directive Toolkit:  
<http://www1.nmha.org/position/advancedirectives/index.cfm>

The Advocacy Center for Persons with Disabilities (PAD Toolkit):  
<http://www.advocacycenter.org/AdvanceDirectives/advancedirectives.htm>

National Disabilities Rights Network:  
<http://www.napas.org/issues/advdir/default.htm>







## My Support People: Emergency Contacts in case of mental health crisis:

Name: _____ Relationship* _____ Phone Numbers: Home: _____ and/or Work Phone: _____ Cell Phone: _____ Address: _____ Type of assistance requested: _____ _____	Name: _____ Relationship* _____ Phone Numbers: Home: _____ and/or Work Phone: _____ Cell Phone: _____ Address: _____ Type of assistance requested: _____ _____
Name: _____ Relationship* _____ Phone Numbers: Home: _____ and/or Work Phone: _____ Cell Phone: _____ Address: _____ Type of assistance requested: _____ _____	Name: _____ Relationship* _____ Phone Numbers: Home: _____ and/or Work Phone: _____ Cell Phone: _____ Address: _____ Type of assistance requested: _____ _____
Name: _____ Relationship* _____ Phone Numbers: Home: _____ and/or Work Phone: _____ Cell Phone: _____ Address: _____ Type of assistance requested: _____ _____	Name: _____ Relationship* _____ Phone Numbers: Home: _____ and/or Work Phone: _____ Cell Phone: _____ Address: _____ Type of assistance requested: _____ _____

