

## Person-Centered Support Plan

Support Plan Effective Date: 09/01/2021

Date of Support Plan Update: 07/05/2021

### About Me

Last Name	Pastrana	First Name	Erick	Nickname		Date of Birth	07/27/1999
		Medicaid ID	7767058573	iConnect ID	42962	Legal Status	Minor
Living Setting	Family Home	Spoken Language	Spanish			Alternate Communication	

### Where I Live

Street Address	2765 W 61st Pl Apt 101	City	HIALEAH	State	FL	Zip	33016
Email Address	deisypastrana62 @gmail.com	Cell/Home Phone	(786)712-5195	Work Phone		Region	Southern
Deliver my mail to	2765 W 61st Pl Apt 101	City	HIALEAH	State	FL	Zip	33016

Best way to contact me Cell/Home Phone|Permission to leave a voicemail message

### My Legal Representative(s)

#1

Last Name	First Name	Guardian/Legal Representative Type
Relationship		Other
Address	City	State Zip
Day Phone	Night Phone	Cell Phone
Email Address		

### My Waiver Support Coordinator

Name	Agency (if applicable)	Email	Phone Number(s)
Ortiz, Hugo	SUPERIOR LIFE MANAGEMENT CARE INC.	amortiz55@hotmail.com	(305)492-5929

### My Family, Friends, and Support System

Name	Relationship	Email	Phone
Pastrana, Deisy	Parent		1. (786)712-5193

### Other People Who Support Me or Work for Me (Teachers, Providers, Doctors, CDC+ Representative)

Name	Relationship	Email	Phone
Ortiz, Hugo	Social Worker, Case Manager, Social Worker		1. (305)989-0651 2. (305)492-5929

### Other Funding Sources for Supports (Vocational Rehab/Job Coach, Division of Blind Services, MSP Behavior Therapy)

Support Need	Funding Source
Natural Support his family, Personal Support	Other Med-Waiver

## Person-Centered Support Plan

Life Skills Level 1 (Community Inclusion) and Natural Support	Other Med-Waiver
Consumable Medical Supplies	Other Med-Waiver

### People Who Can Provide Information for My Support Plan (Doctor, Service Providers, Family, Friends)

Last Name	First Name	Relationship	Phone	Invite to Support Plan Meeting Y/N?
Pastrana	Deisy	Parent	(786)712-5193	Y <input type="checkbox"/> N <input type="checkbox"/>

### My Life

**My current day-to-day life:** (This is a "day in the life" description of me: where I live, if alone or with others, **my daily routines**, Services received during the day and/or night. List the housing information I was provided and where I choose to live in the future)

Erick is a 22 year-old boy who is non-verbal, he uses sounds, facial expressions, and body gestures in order to communicate his needs and wants. Erick is non-ambulatory. He uses a wheelchair in school and at home he sits in a rocker chair when he is not using a wheelchair. Erick is completely dependent on others for physical assistance with all of his activities of daily living. He is not toilet training.

Information provided by mother and Support Coordinator's observation of consumer

### How I get around in my community:

Family/Friend transit

### My interests, talents, abilities, strengths, preferences, and skills:

Erick is a 22 year-old boy who has been diagnosed with various conditions such as Cerebral Palsy, Microcephaly, Encephalopathy and Brain Atrophy. Erick lives with his natural family, mother and his grandparent who are very ill. At home he shares his room with his mother. He is very happy with his current living situation and his mother gives him the best support. Erick also loves listening to music and watching TV.

Erick is completely dependent on his mother or personal care assist for physical assistance with all of his daily activities. For example lifting and transferring Erick in and out of his wheelchair, bathing, grooming, and getting ready for school, also getting his meal ready. His daily routine begins early in the morning at 6:30 AM. He is awakened by his mother who gets him ready for all of his activities during the day and personal care skills. His mother prepares him breakfast, snacks, and lunch. He eats everything pureed and needs to be fed. He also prepares his bag with diapers and wipes. Then he is ready at about 8:15 AM which during this time he is being picked up by DCPS.

Erick attends Hialeah Gardens Senior High School from 9:00 AM to 3:00 PM, five days a week. He gets home around 2:30 PM and then by 4:30 PM he eats a snack. Later he takes a shower before dinner and then he has dinner around 6:30 PM, after he has dinner, he usually watches TV. He is going to bed around 9:00 PM. He sleeps the all night, but there are nights that he wakes up during the middle of the night, which he needs assistance 24/7.

### Things I would like to change:

Erick would like to graduate from high school and continue his education by attending ADT program where he can be involved in activities with people with the same age and medical condonation.

### Things I want to stay the same:

Erick wants to continue lives with his natural family mother and grandmother

Erick want to continue receive all his Therapies as possible

Erick's mother needs more assistance at home because she is not only Erick main caregiver; she has her mother whom suffered a terrible stroke and she needs to go to work.

### Important aspects from my personal history: (Medical, Social, Behavioral history)

## Person-Centered Support Plan

Erick is very happy with his current living situation, Erick is non-ambulatory and non-verbal, he is homebound uses a wheelchair as a means of mobility, he has no ability to use his lower body, uses a ramp in order to facilitate accessibility to go out, he also uses a hospitality electrical bed. He requires two people to transfer or to change position safely also to reposition his to prevent bed sores, he requires intensive assistance with all of his personal care skills. Erick is receiving 56 hours of personal care services. He needs to continue receiving his 56 hours of intensive PCA services. He requires lifting and transferring he is no ambulatory and requires intensive assistance with all his personal care skills. He also has severe spasticity hypertonicity and involuntary body movements making it difficult to transfer him in and out of his wheelchair.

Erick is completely dependent on others for physical assistance with all of his activities of daily living and personal needs such as lifting and transferring in and out of his wheelchair bathing, grooming and meal preparation and feeding. He is incontinent wears diaper and unable to recognize toileting needs and requires two people to assist him with these activities that are essential for his wellbeing, he won't be able to address his health issues himself. Since he is unable to recognize what he needs.

Erick needs adult Pull Ups medium 200 Units, one case of underpads and 600 units of adult wipes all of these supplies needs to be monthly basis. Please find Dr. Prescription and quote in this document.

Erick daily routine begins early in the morning he is awakened by his PCA and mother who assist him with all of his activities of daily living and personal care to transfer him from his bed to his wheelchair to the bathroom. He washes his brushes his teeth, combs his hair, once his personal hygiene tasks are complete, he is transferred back to his wheelchair to his bed. This is where his diapers are changed and he gets dressed by his PCA and again he is transferred back into his wheelchair and then his PCA prepares his breakfast he needs everything to be prepared and requires full assistance with feeding needs constant physical assistance and mealtime intervention to eat safely after breakfast he is transferred to his bed for diaper change if he has a bowel movement.

Erick is attending to Hialeah Senior High School, he is in 12 grade. Erick can manipulate toy objects appropriately with his hands during his classes with maximum assistance, his teacher gives him computer games with sounds and music to stimulate him. Erick most of the time likes to hold something in his hands. When he is not holding something, he puts his hands in his mouth and throw-up. When his mother tells him not to put his hands in his mouth, he stops from doing. Most of the time, Erick is a happy child and is always smiling. Erick is non-verbal and non-ambulatory. His mother transfers him from the wheelchair into the bed, changes his diapers and gives his medications.

Erick needs to receive 40QH P/D x 365 = 14600 Units of Personal Support (PS) per year his personal supports assist Erick with the daily routine like clean disinfect his room, bathroom, and common areas, change his bed linens and pick up the dirty clothes, do his laundry and fold. His assistance with serving meal and feeding, he requires to be changed frequently because he is incontinent. Erick is non-ambulatory; he uses a customized wheelchair for mobility. He is not able to wheel himself from one place to another and needs assistance to transfer from one sitting area to another. His personal support needs to help Erick with transferring and lifting him from /to his wheelchair. Sometimes his personal care takes him out in his wheelchair.

Erick needs Life Skills Level 1 Community inclusion (Companion), this service will allow him to participate in social engagements (church, movies, etc.) or helping with his errands (grocery shopping, or trips to the pharmacy). Erick needs Life Skills Level 1 community inclusion (Companion) will be provided during the week to go to the doctors' appointments or weekends Saturdays and Sundays to go to the church, go to the movies, visit his friends and go to the parties. Erick needs 520Q P/M x 12 = 6240 units of Life Skills Level 1 during the year.

Erick needs medical services to be provided by his current primary care physician and specialists, funded by Medicaid as needed. Erick also needs his medications funded by Medicaid and purchased at the pharmacy of the parent's choice.

For Erick to maintain good dental hygiene, he needs to continue receiving adult dental care, provided by the dentist of the parent's choice and funded by Medicaid.

Erick needs to continue to receive the services of his mother who is acting as his main care giver and will be his legal guardians.

Erick's wheelchair is heavy, and his mother cannot take him out to outings. Erick needs a lighter stroller so that his mother can take him out to the mall and to other places in the community. Please find quote for Erick's DME.

Erick continues to count with a strong natural supports: he counts with his mother who are very supportive to his needs, his mother can promote Erick community inclusion and his access to generic supports such as parks, malls, restaurants, church, beach, school friends, local store and dental services.

### How I communicate and make choices and decisions:

Erick, is nonverbal, unable to grasp, needs to be feed and is totally dependent on another person for all of his activities of ADL's and IADL's, he is fully assisted by his mother or by his PCS. His mother is a single mother and needs to take care of Erick's grandmother; every morning he needs assistance with his activities of daily living: changing his diapers, brushing his teeth, preparing breakfast that consists of rice milk two or three slices of bread and a cup of cereal, he needs physical assistance to cut his food and to feed himself.

## Person-Centered Support Plan

### Employment

Job I Have	Job I want (for those who choose to not work, state N/A):	Supports needed to reach my employment goals:			
I choose not to Work					
I tried to access services from Vocational Rehabilitation		Yes <input type="checkbox"/> No <input type="checkbox"/>			
The outcome of my VR referral					

### Other Services Needed for Health and Safety

This Information is captured in the QSI. Identify: A) Areas of critical needs/potential risk to the health/safety of myself or others B) The specific issue, how it is addressed or where to find this information C) The service/support to address need D) The source of funding

Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
<b>Functional (Choose all that apply)</b>			
Vision			
Hearing			
Eating	Consumer required constant assistance for his meal, he eat pured food, his food needs to be prepared with special dedication to obtain his calories to maintain some level of oral eating	Personal Support staff and Natural support (mother)	iBudget Waiver
Ambulation	Independently uses a power wheelchair as a mean of mobility requires assistance	Personal Support staff and Natural support (mother)	iBudget Waiver
Transfers	Needs Physical Assistance of one person to transfer or to change positions	Personal Support staff and Natural support (mother)	iBudget Waiver
Toileting	Consumer is incontinent, he needs two person to move for his hygiene.	Personal Support staff and Natural support (mother)	iBudget Waiver
Hygiene	Requires maximum and/or physical assistance.	Personal Support staff and Natural support (mother)	iBudget Waiver
Dressing	Totally dependent on staff for dressing and selection of clothes	Personal Support staff and Natural support (mother)	iBudget Waiver
Communications	Limited communication abilities and does not have sufficient communicate needs	Personal Support staff and Natural support (mother)	iBudget Waiver
Self-protection	Special precautions, Person requires close supervision at or accompaniment of a competent adult	Personal Support staff and Natural support (mother)	iBudget Waiver
Ability to Evacuate (Home)	Totally dependent on assistance from others for emergency evacuation of a building.	Personal Support staff and Natural support (mother)	iBudget Waiver

### Behavioral (Choose all that apply)

## Person-Centered Support Plan

Hurtful to Self/Self-injurious			
Aggressive/Hurtful to Others			
Destructive to Property			
Inappropriate Sexual Behavior			
Running Away			
Other Behaviors that May Result in Separation from Others. List "Other" behaviors:			
<b>Physical (Choose all that apply)</b>			
Injury to Person Caused by Self-injurious Behavior			
Injury to the Person Caused by Aggression to Others or Property			
Use of Mechanical Restraints or Protective Equipment for Maladaptive Behavior			
Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
Use of Emergency Chemical Restraints			
Use of Psychotropic Medications			
Gastrointestinal Conditions (includes vomiting, reflux, heartburn, or ulcer)			
Seizures			
Antiepileptic Medication Use			

## Person-Centered Support Plan

Skin Breakdown			
Bowel Function			
Nutrition			
Treatments			
Assistance in Meeting Chronic Health Care Needs			

### Back-up Plans for My Critical Needs/Risks(in case my primary supports are not available)

Service/Support	Back-up Plan	Specific Strategies (as needed)

### What I Accomplished Last Year

My accomplishments last year:	
During the year 2020-2021, Erick could make progress toward achieving his support and services in place. The progress that was possible includes the Erick likes to continue living with his mother Ms. Daysi Pastrana who is his main care giver. For Erick Ms. Pastrana is the most important person, Erick continues to have good relationship with his mother Ms. Daysi Pastrana. During this year Erick visit his Doctor on April 12, 2021 not hospitalization	
During the year 2020-2021, continues integrated in the community by going to his church, public library, parks and visit his friends and family his mother side. His Waiver Support Coordinator help Erick's mother to fill up his Legal Guardian forms and submitted to Legal Aid office and is still in the process.	
Erick would like to maintain good and stable health. With the help of his mother Ms. Daysi, Erick has been able to keep all doctor appointments and maintain stable health. He continues to be under the care of her primary physician and specialist.	
Erick and his main care giver Ms. Daysi Pastrana express their satisfaction and contentment with could make during the last year.	

Goals I worked on last year	Progress on each goal
Erick wants to continue lives with his natural family mother and grandmother	His mother Mrs. Daisy Pastrana will continued provided security home
Erick want to continue receive all Therapies as possible	Medicaid State plan will continue provides him all of his Therapies as needs.
Erick's mother needs more assistance at home because she is not only Erick main caregiver; she has her mother with a terrible stroke.	iBudget Program will provide Respite Care to help Erick's mother in her heavy routine.

### My Personal and Future Plans

What I Want in the Next Few Years: (Supports, accomplishments, dreams, desires, interests, or activities I want in my life in the next few years)
During the year 2021-2022 Erick continues to make progress toward achieving his support and services in place. The progress that was possible includes that Erick would like to continue to live with his mother at home, which is the most important people for him. Erick has a close relationship with her mother, and she is his main caregiver. He would like to continue to receives his services to improve his daily activities.

### Personal Goals

## Person-Centered Support Plan

The most important things I want to achieve this coming year. Identify goals/desired outcomes and be as specific as possible.	What service will help me?	Paid or Non-Paid. If non-paid, provide name and relationship.
Erick wants to continue lives with his natural family mother and grandmother	Naturel Support and Personal Support	Paid
Erick wants to integrate in the community and the future continue he education.	Life Skill Level 1 ( community inclusion ) and ADT program	Paid
Erick want to continue receive all Therapies as possible	PT and OT assessment, which determines his treatment plan	Paid

### Personal Rights: (not related to guardianship)

Signatures on the last page indicate that the individual or their Legal Representative are aware of the individual's personal rights and the Bill of Rights for Persons with Developmental Disabilities.

Is there a right in which I would like to learn      Yes  No

Do I have restrictions on my rights? This might include limited restrictions such as not being able to lock my bedroom door with a key,

restricted visitation, inflexible schedule, limited food or environmental access, etc.      Yes  No  If yes, complete the table.

Right Limited	Reason (the assessed need for the restriction and what less intrusive methods were tried but did not work out)	What is being done to help me obtain my full rights?	When will it be reviewed to determine ongoing effectiveness, or to terminate restriction?

WSC, initial as assurance that the interventions and supports cited above will not be harmful

Safety Plan Required and Attached (if applicable)

Yes  No

### My Health

Important health history about me:			
Erick has been diagnosed with various conditions such as Cerebral Palsy, Microcephaly, Encephalopathy and Brain Atrophy.			
Hospitalizations in the past year	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	
If yes, why I was hospitalized?			

### My medication information (Current as of support plan meeting date)

Medications	Dosage/Frequency	Purpose of Medication	Side Effects/Problems Experienced

## Person-Centred Support Plan

<b>Equipment and Supplies</b>			
<p>Do I use any adaptive equipment, special equipment, glasses, hearing aids or need any adaptations made to my home? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please list below.</p> <p>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, please list below.</p> <p>Eric has a standard wheelchair with frames to prevent her from falling.</p> <p>Eric needs a hospital bed with frames to prevent him from falling.</p> <p>Diaper, Wipes, and Under Pads</p>			
<b>Personal Disaster Plan</b>			
<p>I have a Personal Disaster Plan <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If yes, please list below.</p> <p>Date Personal Disaster Plan Completed or Updated</p>			

## Person-Centered Support Plan

### Signature Page

I have participated in the development of this plan. I have been informed of my due process rights under Florida Statutes 120 and acknowledge that I may appeal any portion of this plan. I understand that if my needs change, an update to this plan may be needed. I also understand that I may request to change something in my plan throughout the support plan year. Supports should be identified according to my needs or the needs of my family, regardless of the availability of funding. Supports and services needed to meet my needs will be sought from my personal resources, community resources, and government resources. When government resources are necessary, they shall be provided based on the availability of funds. My Support Coordinator reviewed the Bill of Rights for Persons with Developmental Disabilities with me and I understand my personal rights.

Date Sent to Individual

Date Sent to APD

Consumer Signature

Date

Witness Signature (if needed)

Date

Legal Representative Signature

Date

Waiver Support Coordinator Signature

Date

### Signature of Support Plan Meeting Participants:

Relationship	Signature	Signature Date	Date Copy Sent

## iBudget Florida HCBS Waiver Eligibility Work Sheet

Name: Erick Pastrana SS# \*: 594-85-6677Region: 11 Support Plan Effective Date: 09/01/2021**I. Level of Care Eligibility:**

The individual is an APD client with a Developmental Disability who meets one of the following criteria and is eligible to receive services provided in an ICF/DD. Check the criteria that are met.

Option A.  The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.

Option B.  The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has at least one of the following handicapping conditions OR the individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

Option C.  The individual is eligible under the category of Autism, Cerebral Palsy, Down Syndrome, Prader-Willi Syndrome, Spina Bifida, or Phelan-McDermid Syndrome and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.

**Handicapping Conditions**

- Ambulatory Deficits
- Sensory Deficits
- Chronic Health Problems
- Phelan-McDermid Syndrome

- Behavior Problems
- Autism
- Cerebral Palsy
- Down Syndrome

- Epilepsy
- Spina Bifida
- Prader-Willi Syndrome

**Major Life Activities**

- Self Care
- Understanding and Use of Language
- Learning

- Mobility
- Self Direction
- Capacity for Independent Living

**II. Medicaid Eligibility:**

- A.  Individual has a current Medicaid number. Medicaid # 7267058573  
 B.  Individual was referred for Medicaid eligibility on \_\_\_\_\_ (MM/DD/YY)

The result was: Eligible  Ineligible  Date of Determination: \_\_\_\_\_

**III. Eligibility Determination:** Check the correct statement.

- A.  Individual has met Level of Care Eligibility (I), has a Medicaid number (IIA), and is eligible for waiver services.  
 B.  Individual has not met the Level of Care Eligibility in I and/or II and, therefore, is not eligible for waiver services.

Support Coordinator (Signature): Hugo B. Ospiziano Date: 7/5/2021

Agency: Superior Life Management Inc

**IV. Choice:** Only to be completed at the time of initial Waiver enrollment and every 365 days thereafter. I have received an explanation of home and community-based services.

## (CHOOSE ONE OF THE FOLLOWING)

- A.  I have been offered waiver services, and I choose to receive community-based supports and services. I understand that I have a choice of enrolled eligible providers.
- B.  I choose to receive institutional services and prefer services to be provided in an institutional setting.

Individual (Signature): N/A Date: N/A

Legal Representative or Witness (Signature): X D. Palmer Date: 7/5/2021  
 Printed Name of Rep. or Witness: Daisy Pastrana Relationship: Mother & Legal Next

\* Federal law requires the collection of your social security number as a condition of eligibility for Medicaid benefits under 42 U.S.C. 1320b-7 and the agency will collect, use, and release the number for administrative purposes as authorized under law.

Signatur Page

I have participated in the development of this plan. I have been informed of my due process rights under Florida Statutes 1420 and acknowledge that I may appeal any portion of this plan. I understand that if my needs change, an update to this plan may be needed. I also understand that I may request to change something in my plan throughout the support plan year. Supports should be identified according to my needs or the needs of my family regardless of the availability of funding. Supports and services needed to meet my needs will be sought from my personal resources, community resources, and government resources. When government resources are necessary, they shall be provided based on the availability of funds. My Support Coordinator reviewed the Bill of Rights for Persons with Developmental Disabilities with me and I understand my personal rights.

Date Sent to Individual

Date Sent to APD

Date Sent to APD \_\_\_\_\_

### Consumer Signature

Witness Signature (if needed)

Legal Representative Signature

Waiver Support Coordinator Signature

Signature of Support Plan Meeting Participants:

Relationship	Signature	Signature Date	Date Copy Sent
President		7/5/2021	
Vice President			
Secretary			
Treasurer			
Board Member			
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To see the text box place your cursor on or next to the **i**.

Support Plan Effective Date: 9/1/2021

Name: Erick Pastrana

Person-Centered Support Plan - effective April 26, 2018

**Agency for Persons with Disabilities**  
**Consent to Obtain or Release**  
**Confidential Information**

Individuals

Name: Erick Pastorm

Date of Birth

7/27/1999

**Permission for Obtaining Record Information.** I hereby give my permission and consent to the Agency for Persons with Disabilities or its representative to obtain the specified protected health information on the above named consumer from agencies, individuals and institutions identified below OR

**I hereby request the specified protected health information on the above named consumer be sent to me OR**

**Permission for Release of Information.** I hereby give my permission for the Agency for Persons with Disabilities or its representative to discuss matters related to my services or goals or to release protected health information to the following person, agency or institution.

The information requested below will be used/disclosed for the following purposes:

<input checked="" type="checkbox"/> Medical Reports	<input checked="" type="checkbox"/> Social Service Reports
<input checked="" type="checkbox"/> Academic Records and Plans	<input checked="" type="checkbox"/> Speech and Hearing Reports
<input checked="" type="checkbox"/> Habilitation Plans/Support Plans	<input checked="" type="checkbox"/> Physical Therapy Reports
<input checked="" type="checkbox"/> Psychological Reports	<input checked="" type="checkbox"/> Occupational Therapy Reports
<input checked="" type="checkbox"/> Other (Please specify):	

Name, address, or fax # of individual or agency from whom information is to be obtained:

Name, address, or fax # of individuals or agencies to whom information is to be provided:

- Hugo B Pastorm / Supervisor Life Manager Care Inc.  
11411 SW 195 Terrace Doral FL 33177
1. I understand that information may only be re-released with my approval except as required by law. However, I understand that if the receiver of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
  2. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.
  3. I understand that I may revoke this authorization in writing at any time by contacting my support coordinator, except when the requested information has already been sent, based on this authorization.
  4. I certify that I understand the above statements either personally or through my legal representative.
  5. I also understand that this form is valid for no longer than 90 calendar days unless otherwise indicated.  
 I understand that I may specify that it be for a shorter period of time.

Expiration date: 7/5/2022

HP Pitino

Signature of Client or Legal Representative

Daisy Pastorm *Legal Mother* 7/5/2022

Printed Name/Relationship to client

Date

This authorization has been signed by a personal representative (above) on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here: