

Person-Centered Support Plan

Support Plan Effective Date: 09/01/2020

Date of Support Plan Update: 07/14/2020

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
Family	Natural Supports

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Med-Waiver	Medicaid
N/A	

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 21 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 21 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)

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Erick needs help to wash his face thoroughly, he also needs physical help to open and dispense toothpaste and brush his teeth at least three times a day. He needs physical help to shower with regulated water temperature and he needs help to apply soap, shampoo and to dry himself. He needs physical assistance to put on deodorant. Erick needs physical help to put on clothes, put on socks and his shoes as well to tie his shoes. He is not toilet trained and has bowel and bladder incontinence which requires the use of diapers regularly. Erick is on a special wheelchair and he requires a home health AID 24/7 days a week since he cannot complete his regular task for his daily living.

In the present, Erick needs to receive 10 hours a day of PCA. He needs assistance at home on a daily basis. As described above, he needs constant help and supervision that goes beyond what a normal adult his age will need and what a parent would be able to provide without assistance due to his physical limitation and chronic medical issues.

Services are essential for Erick to maintain stable routine and to help him function better in his environment and to help his mother to live her regular routine.

Erick is incontinent and needs consumable medical supplies of 200 units of diapers per month and 150 units of under pads per month; these items are being paid by Medicaid-Waiver. But he needs 1 unit of wipes per month x 12 months; attached is a RX for these items.

Erick needs an adult stroller; he has one but it is too old which is broken. His doctor and physical therapist have determined the type of stroller that he needs and would be requested through Medicaid State Plan. Erick needs to receive Physical Therapy Assessment, Occupational Therapy Assessment as his doctor requested. Erick needs 120 QH of Life Skills (community inclusion) to integrate into the community by visiting his friends, family, parks, grocery store, and most importantly visit his doctors.

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.

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
Functional (Choose all that apply)			
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

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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 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)

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:			

Physical (Choose all that apply)

Injury to Person Caused by Self-injurious Behavior			
Injury to the Person Caused by Aggression to Others or Property			

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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			
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 2019-2020, Erick continues to make progress toward achieving his support and services in place. The progress that was possible includes the Erick likes to continue to live with his mother at home, which is the most important person for him. Ercik has a close relationship with her mother, and she is his main caregiver.

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

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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"/>
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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

Allergies: (Including any reactions to any medications, substances, chemicals, etc.)

--

My critical health follow-up areas and preventative health plan: (How will I maintain my Health and Health Stability?)

--

My Health Care Contact Information: Include all doctors you see, any therapists, and anyone you have designated to act as your decision maker in health-related issues (health care surrogate)

Name	Date of Last Visit	Findings	Follow Up Activities

Health Care Decision Maker Name	Role	Follow Up Activities
Pastrana, Deisy	Mother and Legal Guardian	

Equipment and Supplies

Do I use any adaptive equipment, special equipment, glasses, hearing aids or need any adaptations made to my home?

Yes No If yes, please list below.

Erick has a standard wheelchair for his mobility.

Erick needs a hospital bed with frames to prevent her from falling.

Do I need any consumable supplies? Yes No If yes, please list below.

Diaper, Wipes, and under pads

Personal Disaster Plan

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I have a Personal Disaster Plan

Yes No

Date Personal Disaster Plan Completed or Updated

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

Signature Page

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Date Sent to Individual

Date Sent to APP

Date Sent to Individual _____ Date Sent to APD _____ Consumer Signature _____ Date _____

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
HTA		7/14/20	

This form contains additional information wherever there is a To see the text box place your cursor on or next to the .

Name: Erick Pastrana

Support Plan Effective Date: 9/1/2020

Person-Centered Support Plan – effective April 26, 2018

iBudget Florida HCBS Waiver Eligibility Work Sheet

Name: Erick Pastrana	SS#: 594-85-6677																									
Region: SOUTHERN	Support Plan Effective Date: 09/01/2020																									
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. <input type="checkbox"/> The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.																										
Option B. <input type="checkbox"/> 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. <input checked="" type="checkbox"/> 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.																										
<table border="1"> <thead> <tr> <th colspan="3">Handicapping Condition</th> <th colspan="2">Major Life Activities</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Ambulatory Deficits</td> <td><input type="checkbox"/> Behavior Problems</td> <td><input type="checkbox"/> Epilepsy</td> <td><input checked="" type="checkbox"/> Self Care</td> <td><input checked="" type="checkbox"/> Mobility</td> </tr> <tr> <td><input type="checkbox"/> Sensory Deficits</td> <td><input type="checkbox"/> Autism</td> <td><input type="checkbox"/> Spina Bifida</td> <td><input checked="" type="checkbox"/> Understanding and Use of Language</td> <td><input checked="" type="checkbox"/> Self Direction</td> </tr> <tr> <td><input type="checkbox"/> Chronic Health Problems</td> <td><input checked="" type="checkbox"/> Cerebral Palsy</td> <td><input type="checkbox"/> Prader-Willi Syndrome</td> <td><input checked="" type="checkbox"/> Learning</td> <td><input checked="" type="checkbox"/> Capacity for Independent Living</td> </tr> <tr> <td><input type="checkbox"/> Phelan-McDermid Syndrome</td> <td><input type="checkbox"/> Down Syndrome</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Handicapping Condition			Major Life Activities		<input type="checkbox"/> Ambulatory Deficits	<input type="checkbox"/> Behavior Problems	<input type="checkbox"/> Epilepsy	<input checked="" type="checkbox"/> Self Care	<input checked="" type="checkbox"/> Mobility	<input type="checkbox"/> Sensory Deficits	<input type="checkbox"/> Autism	<input type="checkbox"/> Spina Bifida	<input checked="" type="checkbox"/> Understanding and Use of Language	<input checked="" type="checkbox"/> Self Direction	<input type="checkbox"/> Chronic Health Problems	<input checked="" type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Prader-Willi Syndrome	<input checked="" type="checkbox"/> Learning	<input checked="" type="checkbox"/> Capacity for Independent Living	<input type="checkbox"/> Phelan-McDermid Syndrome	<input type="checkbox"/> Down Syndrome			
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II. Medicaid Eligibility:																										
A. Individual has a current Medicaid number. Medicaid # <u>7767058573</u>																										
B. Individual was referred for Medicaid eligibility on: The result was: Eligible <input type="checkbox"/> Ineligible <input type="checkbox"/> Date of Determination:																										
III. Eligibility Determination: Check the correct statement:																										
A. <input checked="" type="checkbox"/> Individual has met Level of Care Eligibility (I), has a Medicaid number (IIA), and is eligible for waiver services.																										
B. <input type="checkbox"/> 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): <u>Hugo B. Ortiz</u> Date: <u>7/14/20</u>																										
Agency: <u>SupernutriLife Planning & Care Inc.</u>																										
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. <input checked="" type="checkbox"/> 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. <input type="checkbox"/> I choose to receive institutional services and prefer services to be provided in an institutional setting.																										
Individual (Signature): <u>Erick Pastrana</u> Date: <u>7/14/20</u>																										
Legal Representative or Witness (Signature): <u>Xavier Pastrana</u> Date: <u>7/14/20</u>																										
Printed Name of Rep. or Witness: _____ Relationship: _____																										

* 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.