agency for persons with disabilities
State of Florida

Person-Centered Support Plan

Support Plan Effective Date: 06/01/2021

Date of Support Plan Update: 05/19/2021

About Me

Last Name	Phan	First Name	Matthew	Nickname		Date of Birth	10/12/2000
		Medicaid ID	9546104302	iConnect ID	76505	Legal Status	Incompetent, Guardian Available
Living Setting	Family Home	Spoken Language	English	Alternate Communication			

Where I Live

Street Address	15160 SW 116th Ter	City	Miami	State	FL	Zip	33196
Email Address	marthahiep@yahoo.com	Cell/Home Phone		Work Phone		Region	SOUTHERN
Deliver my mail to	15160 SW 116th Ter	City	Miami	State	FL	Zip	33196

Best way to contact me

My Legal Representative(s)

#1

Last Name	Nguyen	First Name	Martha	Guardian/Legal Representative Type			Legal Representative
Relationship	Parent			Other			
Address	15160 SW 116 Ter	City	MIAMI	State	FL	Zip	33196
Day Phone		Night Phone	(786)781-9839	Cell Phone			
Email Address	marthahiep@yahoo.com						

My Waiver Support Coordinator

Name	Agency (if applicable)	Email	Phone Number(s)
Flores, Yadi	FLORES YADI	agoranorthoffice@gmail.com	(305)450-4274

My Family, Friends, and Support System

Name	Relationship	Email	Phone	
Nguyen, Martha	Legal Representative,Parent	marthahiep@yahoo.com	1. (786)781-9839	

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

Name	Relationship	Email	Phone

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

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Support Need	Funding Source
Matthew will receive personals support from Medicaid State plan	Medicaid
Matthew will receive REspite care support from Medicaid waiver	Other 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?

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)

Matthew Phan is a 20-year-old man diagnosed with Autism Spectrum Disorder, Macrocephaly and Monoplegia. He became an APD client on 01/15/2020 and is currently a category 7. Consumer latest QSI dated on February 21, 2021 with score of Functional-4; Behavior-6 Physical-2 with an Overall-5.Matthew was receiving Medicaid through DCF, but when he turned 18, he lost it. Right now, he only has a shared of cost with a deductible of $1514 dollars every month, she is cannot afford that amount every month. He applied for SSI at the SSA office, but was denied because of his immigration status, he needs to become a USA citizen to be eligible for SSI. Matthew lives with his mother and his 22-year-old sister. Matthew's father passed away 2 ½ years ago. Matthew was very close to his father and he was a constant source of support for him. Due to the father death, mother was forced to work and be the financial support of the family. His mother works at home for MHFI Inc. from 9AM to 1PM. His sister is a full-time student at FIU, and her hours range from 8:00 AM to 6:00PM, 3 times a week and from 8:00 AM to 4:00PM, 2 time a week. Also, Matthew's sister works after school at Strive America doing Transcript for Doctors from 4:00PM to 8:00PM biweekly. Matthew's mother states that Matthew needs assistance and prompts for feeding, bathing, toileting and dressing. He requires substantial physical assistance and supervision in the mealtime, because he is very picky about his food if he doesn't like the texture, he has a gag reflex and he get nauseous and tries to vomit. He is continent but due to he cannot control the movement of his hands, requires assistance to complete his hygiene actives like toileting, wiping and bathe. Matthew's mother helps him choose his clothes and helps him dress as well. He can express his wants and needs, but his vocabulary is limited. He answers with a word or two. Mother states that he shows difficulties in expressing himself when he is in pain. Matthew's mother says she is very concerned that he is not receiving any of his therapies and his behavior is been getting worse. He lately has been scratching, hitting his head and ear until bleeding. She states that last year, he went to the emergency room (ER) because he hit his ear so hard that he started to bleed. In addition, one time he escaped from the house and she got the police help her to find him. Also, she says that when he starts beating himself, she needs the help of her daughter to hold him down and not hurt himself. Matthew's mother says she is very concerned that he is not receiving any of his therapies and his behavior is been getting worse. He lately has been scratching, hitting his head and ear until bleeding. She states that last year, he went to the emergency room (ER) because he hit his ear so hard that he started to bleed. In addition, one time he escaped from the house and she got the police help her to find him. Also, she says that when he starts beating himself, she needs the help of her daughter to hold him down and not hurt himself.

How I get around in my community:

Family/Friend transit

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

Things I would like to change:

he will like to receive from waiver respite care, and personal support .

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Things I want to stay the same:

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

How I communicate and make choices and decisions:

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 tried to access services from Vocational Rehabilitation	Yes	☐	No	☐
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			
	Ambulation			
	Transfers			
☑	Toileting			
☑	Hygiene			
☑	Dressing			
☑	Communications			
☑	Self-protection			
☑	Ability to Evacuate (Home)			
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: 3			
Physical (Choose all that apply)				
☑	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			

	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:

The following information was gathered from Matthew's QSI and information provided by Matthew's mother.
Matthew's mother states that Matthew needs assistance and prompts for feeding, bathing, toileting and dressing. He requires substantial physical assistance and supervision in the mealtime, because he is very picky about his food if he doesn't like the texture, he has a gag reflex and he get nauseous and tries to vomit. He is continent, does not use diapers. Due to Matthew's unable to control the movement of his hands, he requires assistance to complete his hygiene actives like toileting, wiping and bathing. Matthew's mother helps him choose his clothes and helps him dress as well. He can express his wants and needs, but his vocabulary is limited. He answers with a word or two. Mother states that he shows difficulties in expressing himself when he is in pain.

Mother states that Matthew doesn't recognize danger and he requires a competent adult in case of emergency events. Matthew requires a one to one close supervision. In addition, report shows that consumer exhibits maladaptive behavior like self-injury, hits himself hard in his face, scratches his hands, face and legs, he is aggressive to others, pushes, punches and pokes others, he breaks things like toys, doors, and everything close to him when he gets mad or anxious, he talks himself, he is repetitive, pacing around and acting in ways that are socially disruptive to others. To control his behaviors, he takes one psychotropic medication and requires people to physical restrain him for more than 15 seconds because he is very strong: his mom declared that while restraining him to hard in one event she had injured her elbow. Mother also stated that sometimes, she and her daughter give up on him from being too strong for them.

Matthew's mother stated she is very concerned that he is not receiving any of his therapies and his behavior is getting worse. Lately Matthew has been scratching, hitting his head and ear until bleeding. She states that last year, he went to the emergency room (ER) because he hit his ear so hard that he started to bleed. In addition, one time he escaped from the house and the police was involved to help find him. Also, she says that when he starts beating himself, she needs the help of her daughter to hold him down to not hurt himself.

Due to Matthew does not have Medicaid and her deductible is too high. Mother is requesting via crisis enrollment process the following services: WSC services to help coordinate services, Personal Support services to assist with personal care activities and Behavioral Services pending final approval to ensure consumers well being.

Goals I worked on last year	Progress on each goal

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)

Personal Goals

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.

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 more? **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:				
Hospitalizations in the past year	**Yes**	☐	**No**	☑

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
pcp	05/24/2021	alvaro Dandond	
neurologist	02/05/2020	Dr. Pensirikul	yearly follow up

Health Care Decision Maker Name	Role	Follow Up Activities

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.**

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

Personal Disaster Plan

I have a Personal Disaster Plan Yes ☐ No ☐

Date Personal Disaster Plan Completed or Updated

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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