agency for persons with disabilities
State of Florida

Person-Centered Support Plan

Support Plan Effective Date: 05/01/2025

Date of Support Plan Update: 04/28/2025

About Me

Last Name	Ratner	First Name	April			Nickname	
Date of Birth:	8/3/1967	Medicaid ID	2278662023	iConnect ID	12527	Legal Status	Has Capacity
Living Setting	Family Home	Spoken Language	English			Alternate Communication	
Primary Diagnosis	F79 - Intellectual Disabilities, Unspecified	Secondary Diagnosis				Other Diagnosis	

Where I Live

Street Address	3170 Ocean Shore Blvd Apt 506	City	ORMOND BEACH	State	FL	Zip	32176
Email Address		Cell / Home Phone	(386)453-1333	Work Phone		Region	Northeast
Deliver my mail to	3170 Ocean Shore Blvd Apt 506	Mailing City	ORMOND BEACH	State	FL	Mailing Zip	32176

Best way to contact me: Cell or Home ☑ Work Phone ☐ Email ☐ Permission to leave a voice mail Message ☐

My Legal Representative(s)

#	First Name	Last Name	Primary Relationship	Multi Relationship	Main Phone	Cell Phone
1						

My Waiver Support Coordinator

Name	Agency (if applicable)	Email	Phone Number(s)
Rosario, Rocio	OVG, INC	RRosario@ovginc.net	(386)473-5784

My Family, Friends, and Support System

Name	Relationship	Email	Phone	
Harms, Sonia	Mother			2. (386)453-1333
Ratner, Bridgett	Sister			2. (386)453-1333

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

Name	Relationship	Email	Phone	
UF, Health	Other Healthcare Provider		1. (904)244-3094	
McDonald, Dr.	Other Healthcare Provider			
Health, Halifax	Primary Care Physician		1. (386)425-4822	
Quadrat, Dr. Otakar	Other Healthcare Provider		1. (386)255-5331	
Doughney, Kathleen Bridget	Other Healthcare Provider		1. (386)673-2442	
Dental Clinic, UF	Dentist		1. (727)394-6064	

Rosario Colon, Rocio	Case Manager,Case Manager		1. (386)473-5784	2. (386)473-5784

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

Support Need	Funding Source
Healthcare	Medicaid

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?
Harms	Sonia	Mother		Y ☑ N ☐
Ratner	Bridgett	Sister		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)

April lives with her mother and her sister on an apartment. April's family set up April's position bed on the living room. April's is on the CDC program, and her sister Briget is her provider. April's wakes up early at the morning and her sister Briget assist her with all her personal care and all April's daily living. April needs total assistance in all her activities. April's routine varies depending on the medical appointments and treatments. April has cancer and taking chemotherapy. April loves to go out to the community every day. April also, love to hear music and spending time with her family. Briget taking care of April all the time. April's mother has medical issues.
06-15-2025 April went to the Hospital. They are going to do a Brain Biopsy on 06-18-2025.
06-18-2025 The neurosurgeon cancelled the Biopsy because the April's platelets are low. They did a platelets transfusion. April went back home.
06-22-2025 April went to the Hospital. 06-23-2025. April had a Brain Biopsy.
08-25-2025 April had a brain surgery to remove a Tumor. April stay at the Hospital for a week.

How I get around in my community:

Family/Friend transit

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

April enjoys listening to music and spending time with her family. She enjoys going on car rides and out into the community. She also enjoys shopping and interacting with others. April likes the stickers, and she loves to go to buy at the store.

Things I would like to change:

April would like to be healthy and don't have to do chemotherapy.

Things I want to stay the same:

April would like to continue living with her family. April would like to go out to the community every day.

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

Person-Centered Support Plan

April was born in exploitation new and. Dx with mastectomy hydrocephalus at about 1 1/2 years of age. This caused the delay. April walked when she was 5 and accomplished her developmental milestones very late. She went mastectomy school and then ARC until she had a stroke at 50yrs of age. She had a stroke during her surgery for double mastectomy. In 2019 she was diagnosed with cancer again and was treated. She is currently in remission. In 2020 she was diagnosed with Metastatic cancer. In 2021 she continues to battle with cancer and is constantly in treatment. She has reacted well to the last round of treatment but continues to need constant assistance with multiple medical appointments. April does not have a history of abuse, neglect and exploitation. April's Brain Biopsy results reflect carcinoma from metastatic breast cancer. She will start to take targeted therapy and radiation.
06-15-2025 April went to the Hospital. They are going to do a Brain Biopsy on 06-18-2025.
06-18-2025 The neurosurgeon cancelled the Biopsy because the April's platelets are low. They did a platelets transfusion. April went back home.
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How I communicate and make choices and decisions:

April is non verbal and communicates via gestures. Her communication capacity has decreased since she had the stroke. Family members and people close to her can anticipate her needs. April will gesture and communicate via facial expressions.

Employment

Job(s) I Have (for those who choose not to work, state N/A)	Hire Date(s)	Type of Job(s) I Have
Choose not to work.		

I am interested in getting a job	I am interested in changing jobs	Type of Job I Want	Supports Needed to Succeed at Work
Yes ☐ No ☑ N/A ☐	Yes ☐ No ☐ N/A ☐		

I was referred to Vocational Rehabilitation	Date of Referral to Vocational Rehabilitation	Outcome of Referral to Vocational Rehabilitation
Yes ☐ No ☐ N/A ☐		
		Date Phase 1 Job Stabilization Completed:

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	April has an adequate vision.		
☐ Hearing	April has an adequate vision.		
☑ Eating	April is able to eat some finger foods. However, most of her meals need to be fed to her as she is unable to manage utensils appropriately. She also requires total assistance in preparing foods.	Personal support and family	iBudget Waiver, Natural Supports

☑	Ambulation	April uses a wheelchair propelled by her care giver. She is unable to use it on her own needs assistance from someone else.	Personal support and family	iBudget Waiver, Natural Supports
☑	Transfers	April requires total assistance to transfer. She is unable to carry her own body weight and change from a chair to a better bed to a chair.	Personal support and family	iBudget Waiver, Natural Supports
☑	Toileting	April requires total assistance with toileting. She is unable to let someone know when she needs to go to the bathroom and uses diapers. She needs to be changed every few hours to prevent skin breakdown.	Personal support and family	iBudget Waiver, Natural Supports
☑	Hygiene	April requires total assistance with personal hygiene and grooming. She is unable to complete any task independently and needs physical assistance for all tasks.	Personal support and family	iBudget Waiver, Natural Supports
☑	Dressing	April requires total assistance choosing her clothing and getting dressed. She physically cannot dress herself and would not know how to do it.	Personal support and family	iBudget Waiver, Natural Supports
☑	Communications	April is nonverbal and has a difficult time communicating her wants and needs. People know her best can anticipate her wants and needs. She often uses gestures when she wants something. It is very difficult to know when she is in pain or when she needs something.	Personal support and family	iBudget Waiver, Natural Supports
☑	Self-protection	April is unable to protect herself and has no sense of safety. She requires someone to be with her at all times to ensure her safety at home and in the community.	Personal support and family	iBudget Waiver, Natural Supports
☑	Ability to Evacuate (Home)	April is unable to evacuate. She would need total assistance to evacuate her home. April lives on the fifth floor of an apartment building and will require someone that is strong enough to carry her down the stairs in the elevator is not available.	Personal support and family. Emergency services.	iBudget Waiver, Natural Supports, Other Fire rescue
Behavioral (Choose all that apply)				
☑	Hurtful to Self/Self-injurious	April has a history of self-injurious behaviors and require someone to be with her at all times to ensure she does not hurt herself. She will pick at scabs or wounds.	Personal support and family	iBudget Waiver, Natural Supports

☐	Aggressive/Hurtful to Others	April don't have behaviors concern.		
☐	Destructive to Property	April does not have concern in this area.		
☐	Inappropriate Sexual Behavior	April does not have concern in this area.		
☐	Running Away	April does not have concern in this area.		
☑	Other Behaviors that May Result in Separation from Others.	April requires someone to be with her at all times to ensure her health and safety.	Personal support and family	iBudget Waiver, Natural Supports
Physical (Choose all that apply)				
☑	Injury to Person Caused by Self-injurious Behavior	April pics that broken skin and require someone to be with her at all times to ensure she does not hurt herself.	Personal support and family	iBudget Waiver, Natural Supports
☐	Injury to the Person Caused by Aggression to Others or Property	April does not have concern in this area.		
☐	Use of Mechanical Restraints or Protective Equipment for Maladaptive Behavior	April uses long sleeves to prevent picking at her skin.	Personal support and family	iBudget Waiver, Natural Supports
☐	Use of Emergency Chemical Restraints			
☑	Use of Psychotropic Medications	April takes medication.		
☐	Gastrointestinal Conditions (includes vomiting, reflux, heartburn, or ulcer)	April does not have history or diagnosis in this area.		
☐	Seizures	April does not have history or diagnosis in this area.		
☐	Antiepileptic Medication Use	April does not have history or diagnosis in this area.		
☑	Skin Breakdown	April is at risk of skin breakdown. She needs to be changed every several hours to prevent any damage to the skin. She also needs homes repositioning to prevent pressure sores.	Personal support and family	iBudget Waiver, Natural Supports
☑	Bowel Function	April requires bowel elimination medication.	Doctor, Personal Support, Family.	iBudget Waiver, Medicaid, Natural Supports

☑	Nutrition	April is on a special diet and requires someone to assist her choosing foods and making her meals.	Personal support and family	iBudget Waiver, Natural Supports
☐	Treatments	April receives chemotherapy on a regular basis. She requires someone to take her to chemotherapy and stay with her during the treatment.	Personal support and family	iBudget Waiver, Natural Supports
☑	Assistance in Meeting Chronic Health Care Needs	April requires total assistance in meeting healthcare needs. She requires assistance making medical appointments, attending medical appointments and interpreting medical information. She also requires total assistance to take her medication. April relies on her mother and sister to help her make healthcare decisions.	Personal support and family	iBudget Waiver, Natural Supports

Other Risks/Needs Related to Me (Choose all that apply)

Identified Need/Risk Area		Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
☑	Requesting and Getting Help, if needed	April cannot communicate effectively to request help when needed. Caregiver needs to know her well to be able to anticipate her needs.	Personal support and family	iBudget Waiver, Natural Supports
☑	Medication Management	April is unable to take her medication on her own and would not know what medication to take. She requires someone to administer all of her medication.	Personal support and family	iBudget Waiver, Natural Supports
☐	Refusing Eating, Hygiene, or Supports			
☐	Substance Abuse			
☑	Handling Money/Finances	April is unable to handle her own money or finances.	April's mother handles all of her finances.	Natural Supports
☑	Interactions with Strangers	April would be at risk when interacting with strangers. She requires someone to be with her at all times to help her interact appropriately and ensure her health and safety.	Personal support and family	iBudget Waiver, Natural Supports
☐	Child/Adult Protective Services			
☐	Relating with Others			

☑	Home Safety	April could not be home alone safely. She requires someone to be with her at all time to ensure her safety.	Personal support and family	iBudget Waiver, Natural Supports
☑	Community Safety	April require someone to be with her all at all times in the community to ensure her health and safety.	Personal support and family	iBudget Waiver, Natural Supports
☐	Internet Safety			
☐	Need for information or training on how to prevent abuse, neglect, and exploitation			
☐	Insufficient or Unstable Housing			
Needs/Risks Related to My Caregiver (For those living in the family home. Choose all that apply)				
☐	Caregiver Health Needs			
☐	Limited Relief for Caregiver			
☐	Caregiver Needing Additional Assistance			
☑	Aging Caregiver	April's mother is elderly and is unable to physically care for her.	Personal sports	iBudget Waiver

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)
Personal Supports, WSC	Family will call support coordinator to locate a group home if personal sports provider is unable to care for April.	

What I Accomplished Last Year

My accomplishments last year:
In the past year April has been healthier. April had all her services in place, and she was happy with her providers. April receives support coordination/consultant services and personal supports through the CDC program.

Goals I worked on last year	Progress on each goal
April would like to maintain healthy and safe.	April continues healthy and safe. April would like to continue with this goal.
April would like to maintain good hygiene and her environment clean.	April continues with a good hygiene and her environment is clean.
April would like to go out to the community every day.	April continues going out to the community all the time that the provider and the family can.
April wants to visit Disney with her family.	April wants to visit Disney with her family.

April does not go to Disney the last year, but she would like to continue with this 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)
April would like to continue living with her family and being the best health possible. April would like to have all her services in place. April would also like to get more into the community.

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.
April would like to maintain healthy with all her services and treatments.	Personal Support, Sister	Paid
April would like to be safe.	Personal Support, Sister	Paid
April would like to go out to the community safe.	Companion, Sister	Paid
April would like to have more Personal Support and Companion hours.	Waiver Support Coordinator/Companion.	

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 I would like to learn more about?	**Yes**	☐	**No**	☑
My WSC provided information about abuse, neglect, and exploitation to me this year, and I know the reporting process and requirements.	**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. If yes, complete the table.	**Yes**	☐	**No**	☑

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:

agency for persons with disabilities
State of Florida

Person-Centered Support Plan

April has a diagnosis of intellectual disability, breast cancer stage 2, high blood pressure, high cholesterol, arthritis and OCD. She has a history of breast cancer with a double mastectomy and Brocho 1 gene. April had a stroke during the mastectomy and now has high blood pressure. April picks and scratches as part of her OCD. April has Loop in the heart to monitor for a fib April needs IV sedation to sleep for any MRI or CT scan. IN 2022 April rejected the port. All Lymph nodes were removed. In December 2021 cancer was seen in PET scan and treatment began. 08-25-2025 April had a brain surgery to remove a tumor.

Hospitalizations in the past year	**Yes**	☐	**No**	☑
Emergency Room Visits in the past year	**Yes**	☐	**No**	☑

If yes, why did I go to the hospital or emergency room?

06-15-2025 April went to the Hospital. They are going to do a Brain Biopsy on 06-18-2025.
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My medication information (Current as of support plan meeting date)

Medications	Dosage/Frequency	Purpose of Medication	Side Effects/Problems Experienced
PRAVACHOL| PRAVASTATIN SODIUM|TABLET| ORAL|40|mg/1	40/mg (Milligram), Daily	Cholesterol	
Dexamethasone| Dexamethasone| TABLET|ORAL|2|mg/1	2/mg (Milligram), OTH (Other)	For fluid on swelling on Brain	
Enalapril maleate and hydrochlor|Enalapril maleate and h| TABLET|ORAL|5; 12.5|mg/1; m	5/mg (Milligram), Daily	High Blood Pressure	
Escitalopram Oxalate| Escitalopram Oxalate| TABLET, FILM|ORAL| 10|mg/1	10/mg (Milligram), OTH (Other)	Anxiety	
Anastrozole	1/mg (Milligram), Daily	Chemo	
Elepsia XR| Levetiracetam| TABLET, EXTE|ORAL| 1500|mg/1	500 mg/mg (Milligram), BID (2 times daily)		

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

NKA

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

April requires assistance with scheduling all healthcare appointments to ensure that she goes to all the different specialist and cancer treatments.

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
Dr. Doughney/Oncologist	09/23/2025	Chemo treatment and visit (Inmune therapy)	3 weeks

Dr. Quadrat/Cardiologist	08/04/2025	Check loop recorder and heart. Blood pressure and heart rate and good.	February 2026
Halifax health /PCP	08/05/2025	Routine checkup. No findings.	February 2026.
Gainsville Dental Clinic	08/27/2025	Routine checkup	3 months
Dr. Theodotou/ Neurosurge	09/09/2025	Follow up	October 16th, 2025

Health Care Decision Maker Name	Role	Follow Up Activities
Ratner, Bridgett		

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.**
Hospital bed, slider for ther tub, wheelchair.

Do I need any consumable supplies? Yes ☑ No ☐ If yes, please list below.
Diapers, wipes and pads.

Personal Disaster Plan

I have a Personal Disaster Plan Yes ☑ No ☐

Date Personal Disaster Plan Completed or Updated 04/28/2025

Voter Registration

YOU CAN APPLY TO RESISTER TO VOTE HERE: https://dos.fl.gov/elections/forms-publications/forms/ (Form DS-DE-77): See "National Voter Registration Act Preferencer Form/Application" (Department of State Form DS-DE-77), incorporated by reference in Rule 1S-2.048, Florida Administrative Code.

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** _____

agency for persons with disabilities
State of Florida

Person-Centered Support Plan

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