

Person-Centered Support Plan

Support Plan Effective Date: 04/01/2025

Date of Support Plan Update: _____

About Me

Last Name	Wheeler	First Name	J	Nickname			
Date of Birth:	7/18/1983	Medicaid ID	8922574658	iConnect ID	82513	Legal Status	Legally Competent/Guardian Advocate Appt.
Living Setting	APD Licensed Facility – Small Group Home (Capacity 4-6)	Spoken Language	English	Alternate Communication			
Primary Diagnosis	G80.9 - Cerebral palsy, unspecified	Secondary Diagnosis		Other Diagnosis			

Where I Live

Street Address	5007 Riveredge Dr	City	Titusville	State	FL	Zip	32780
Email Address	wheelersu@gmail.com	Cell / Home Phone	(618)401-1339	Work Phone		Region	CENTRAL
Deliver my mail to	5007 Riveredge Dr	Mailing City	Titusville	State	FL	Mailing Zip	32780

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)
Keaton, Kenneth	FL WSC GROUP, INC.	brentkeaton@gmail.com	(321)317-5498

My Family, Friends, and Support System

Name	Relationship	Email	Phone
Wheeler, Su	Parent,Parent	wheelersu@gmail.com	1. (757)615-0697 2. (618)401-1339
Keaton, Kenneth	Case Manager,Case Manager	Brentkeaton@gmail.com	1. (321)317-5498 2. (321)317-5498

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

Name	Relationship	Email	Phone
Wheeler, Su	Parent,Parent	wheelersu@gmail.com	1. (757)615-0697 2. (618)401-1339
Keaton, Kenneth	Case Manager,Case Manager	Brentkeaton@gmail.com	1. (321)317-5498 2. (321)317-5498

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

Support Need	Funding Source
Medical and Dental (DentaQuest)	Medicaid

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Medicare 8CP9NK7RY38	Medicare
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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?			
Wheeler	Su	Parent,Parent	(757)615-0697	Y	<input checked="" type="checkbox"/>	N	<input type="checkbox"/>
Keaton	Kenneth	Case Manager,Case Manager	(321)317-5498	Y	<input checked="" 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)

JD will be 42 years old this July. He lives at home with his parents in Titusville, FL. JD was recently in a group home in Orlando, but believed it was not a good fit. He has temporarily moved back in with his parents, pending a new residential referral. He moved to Florida in 2020. He previously was in a group home in Illinois between 2014-2020. His daily routine consists of getting up at 8 am, bathroom, and personal hygiene. Mother does all transfers. They like to go out of the home daily to shop and see the sights. He does have a collapsible travel wheelchair for out in the community. Transfer assistance is necessary. JD likes to spend his day on his IPAD looking at the weather and learning about space launches. Sometimes, they eat out but they are usually home by 2 pm for snack and then dinner is at 5 pm. His Su (dob is 8/12/59) and John Wheeler (dob is 2/2/61.) Mr. Wheeler has congestive heart failure and back issues and transfers can be a challenge. JD wants to live in a group home again. He enjoyed the social aspect of it and is looking forward to finding a new group home.

JD's parents assist him with full hygiene care as he only has use of his left hand. He bathes before going to bed at night. He loves electronics. He is able to feed himself if the food is chopped into small bits. JD wears briefs for times when he cannot make it to the restroom; however, he rings a bell for his parents when he has to use the toilet and rarely has accidents. JD went to college for two years and took a variety of classes. He would like to do this again.

A QSI was completed on 11 2 2023 by Assessor Elizabeth Dale with Assessor Notes: "A QSI was completed with JD Wheeler and both of his parents Su (DOB: 7/12/59) and John)2/2/61). Dad has a hip surgery scheduled and is unable to physically assist with JD. Mom is petite, has osteoarthritis and has a difficult time with transfers. The family home has 3 stories, no elevator but there is a stair lift for each flight of stairs. The bathroom is not easily accessible. Mom is concerned with both of them falling and injuring themselves. JD has not had any major changes over the last year however he becomes tearful and wants to move out into a group home where he can have his own friends and activities." The scores are as follows: Functional 5, Behavioral 1, Physical 3 Overall Support Extensive 4.

How I get around in my community:

Family/Friend transit

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

JD enjoys fishing, being social, rocket launches, Disney shows, games shows, sports. He likes St. Louis Blues and the Cardinals. He likes the Bucks. He love electronics and spending time on his iPad.

Things I would like to change:

Wants to live in a group home and increase his circle of friends.

Things I want to stay the same:

JD wants to stay in close contact with his parents. He wants to live in the same area.

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

He moved to Florida in 2020. He previously was in a group home in Illinois between 2014-2020.

How I communicate and make choices and decisions:

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JD will take his time to understand. He can speak, write and will communicate with gestures. He looks to his parents for advice and counsel.

Employment

Job(s) I Have (for those who choose not to work, state N/A)	Hire Date(s)	Type of Job(s) I Have
Not interested in employment at this time.		

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 <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		

I was referred to Vocational Rehabilitation	Date of Referral to Vocational Rehabilitation	Outcome of Referral to Vocational Rehabilitation
Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>		

Date Phase 1 Job Stabilization Completed:	
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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)			
<input type="checkbox"/> Vision	14. Vision: JD wears glasses to correct his vision, no other concerns reported.	NA	
<input type="checkbox"/> Hearing	15. Hearing: No concerns.		
<input checked="" type="checkbox"/> Eating	16. Eating: Food is prepared and plates are made, food is cut up for JD so he can use a spoon with his left hand to eat as independently as possible. He drinks from cups with lids. Meals are supervised and physical assistance is provided to assist with scooping. JD has choked on foods but has been able to clear his throat independently.	Group home staff/Natural Supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Ambulation	17. Ambulation: JD has a manual chair that he relies on others to propel. He has a power chair that he can maneuver on his own. Help is given with settings and setting it up for use.	Group home staff/Natural Supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Transfers	18. Transfers: JD is dependent on others for all transfers (to and from bed, sitting chairs, bathroom, wheelchair).	Group home staff/Natural Supports	iBudget Waiver, Natural Supports

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<input checked="" type="checkbox"/> Toileting	19. Toileting: JD recognizes the need to use the bathroom and he is dependent on Mom to transfer him to the toilet. Physical help to clean up after a bowel movement. The bidet that was installed helps and Mom is present to turn it on.	Group home staff/Natural Supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Hygiene	20. Hygiene: JD is "total assistance" with his entire showering routine. He relies on others to set the water temperature and fully bathe his body and wash/rinse his hair. Physical assistance for facial hair, application of deodorant, drying off his body and for oral care.	Group home staff/Natural Supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Dressing	21. Dressing: JD helps choose what to wear for the day and he tries to help by lifting his legs to put on pants/shorts. He will try to push his arms through the holes of his shirts. JD is dependent on clothing adjustments.	Group home staff/Natural Supports	iBudget Waiver, Medicaid
<input checked="" type="checkbox"/> Communications	22. Communication: JD communicates verbally, he speaks slowly and listeners need to give him time to answer. The longer time you spend with him the easier it is to understand him. There are moments when Mom does not understand and she will ask follow up clarification questions or she may ask him to write it down.	Group home staff/Natural Supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Self-protection	23. Self-Protection: JD is aware of abuse and neglect but he may not recognize exploitation. He is with family at home and he stays with family when out in the community going to activities.	Group home staff/Natural Supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Ability to Evacuate (Home)	Ability to Evacuate: JD is dependent on others to get him to safety.	Group home staff/Natural Supports	iBudget Waiver, Natural Supports

Behavioral (Choose all that apply)

<input type="checkbox"/> Hurtful to Self/Self-injurious	NA		
<input type="checkbox"/> Aggressive/Hurtful to Others	NA		
<input type="checkbox"/> Destructive to Property	NA		
<input type="checkbox"/> Inappropriate Sexual Behavior	NA		
<input type="checkbox"/> Running Away	NA		

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<input type="checkbox"/>	Other Behaviors that May Result in Separation from Others.	NA		
Physical (Choose all that apply)				
<input type="checkbox"/>	Injury to Person Caused by Self-injurious Behavior	NA		
<input type="checkbox"/>	Injury to the Person Caused by Aggression to Others or Property	NA		
<input type="checkbox"/>	Use of Mechanical Restraints or Protective Equipment for Maladaptive Behavior	NA		
<input type="checkbox"/>	Use of Emergency Chemical Restraints	NA		
<input type="checkbox"/>	Use of Psychotropic Medications	NA		
<input checked="" type="checkbox"/>	Gastrointestinal Conditions (includes vomiting, reflux, heartburn, or ulcer)	37. Gastrointestinal Conditions: JD takes Tums daily to treat acid reflux.	Group home staff/natural supports	iBudget Waiver, Natural Supports
<input type="checkbox"/>	Seizures	NA		
<input type="checkbox"/>	Antiepileptic Medication Use	NA		
<input type="checkbox"/>	Skin Breakdown	NA		
<input checked="" type="checkbox"/>	Bowel Function	41. Bowel Function: JD has gastroparesis. He takes a combination of colace, Dulcolax soft chews, senna, and other otc stool softeners. Linzess is prescribed and is taken daily.	Group home staff/natural supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/>	Nutrition	42. Nutrition: JD is 5'5" and 85 pounds, BMI = 14.1 "Underweight" range according to the National Heart, Lung and Blood Institute. No prescribed diet. Medications: Linzess due to gastroparesis. JD will refuse food if he is not feeling well.	Group home staff/natural supports	iBudget Waiver, Natural Supports
<input type="checkbox"/>	Treatments	NA		

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<input checked="" type="checkbox"/>	Assistance in Meeting Chronic Health Care Needs	44. Assistance in Meeting Chronic Health Care Needs: JD takes Linzess to treat gastroparesis. Metoclopramide is given as needed. Tums is taken at night to treat acid reflux symptoms. JD takes Dulcolax chews, senna and colace as needed to treat constipation. He is dependent on others to administer medications and he will communicate pain and illness to others	Group home staff/natural supports	iBudget Waiver, Natural Supports
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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
<input checked="" type="checkbox"/> Requesting and Getting Help, if needed	JD has a button he uses at home to call his family for help.	Group home staff/natural supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Medication Management	His mother orders, prepares, and administers all medications.	Group home staff/natural supports	iBudget Waiver, Natural Supports
<input type="checkbox"/> Refusing Eating, Hygiene, or Supports			
<input type="checkbox"/> Substance Abuse			
<input checked="" type="checkbox"/> Handling Money/Finances	His mother is his payee and assists him with all financial transactions.	Group home staff/Natural supports	iBudget Waiver, Natural Supports
<input type="checkbox"/> Interactions with Strangers			
<input type="checkbox"/> Child/Adult Protective Services			
<input type="checkbox"/> Relating with Others			
<input type="checkbox"/> Home Safety			
<input type="checkbox"/> Community Safety			
<input type="checkbox"/> Internet Safety			
<input type="checkbox"/> Need for information or training on how to prevent abuse, neglect, and exploitation			
<input type="checkbox"/> Insufficient or Unstable Housing			

Needs/Risks Related to My Caregiver (For those living in the family home. Choose all that apply)

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<input checked="" type="checkbox"/> Caregiver Health Needs	His mothers birthdate is 8/12/59 and fathers birthdate is 2/2/61. His father has congestive heart failure and back issues. His mother has lifted and transferred JD his whole life and she stated that it is taking a toll on her body.	Group home staff/natural supports	iBudget Waiver, Natural Supports
<input checked="" type="checkbox"/> Limited Relief for Caregiver	Parents have no other family in area to assist with JD's care.	Group home staff	
<input type="checkbox"/> Caregiver Needing Additional Assistance			
<input type="checkbox"/> Aging Caregiver			

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 support	Parents currently back each other up for JD. If JD would need additional resources, WSC could be contacted to assist.	

What I Accomplished Last Year

My accomplishments last year:
<p>JD has caught 15 species of fish and is very proud of this. He likes to go to Disney frequently and go to Kennedy Space Center. He likes to give his family weather and sports reports daily. He is very focused on moving into a group home. WSC reviewed HIPPA, grievances, consumer responsibilities, program eligibility, consumer rights and choices (bill of rights), abuse, neglect and exploitation. Education of abuse, neglect and exploitation will be ongoing. Assessed JD's functional and physical limitations. Discussed preventative health care screenings. Reviewed COVID19 safety measures and precautions. Reviewed JD's budget for approved services, and monthly allocated units. Addressed JD's interest or concerns. Discussed person centered goals and outcomes and JD's rights and choices. Discussed right to vote and to actively participate in the community. JD has had a relatively good and healthy year.</p> <p>He currently does not have any caregivers and would like to focus on moving into a group home. He is given the opportunity to make adjustments in providers any time that he chooses. There is no reported history of abuse, neglect or exploitation. JD was provided safety training. He requires daily monitoring for safety due to his diagnoses. All of JD's health and safety needs require full focus practice by his service provider to ensure his continued level of care. JD will continue to receive all the supports he requires to maintain good health.</p>

Goals I worked on last year	Progress on each goal
JD wants to move into a residential habilitation home based upon his needs and preferences.	This goal was not met as JD was not certain he wanted to moved. He also went on a two-month trip. Upon returning he had issues with Medicaid eligibility.
JD wants to have a meaningful day activity to pursue his interests.	This goal was not met as JD went on a two-month trip. Upon returning he had issues with Medicaid eligibility.

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)
JD wants to move into a group home and attend an ADT for a meaningful activity.

Personal Goals

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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.
JD wants to move into a residential habilitation home based upon his needs and preferences.	RES HAB	Paid
JD wants to have a meaningful day activity to pursue his interests. He will require transportation to and from the ADT program.	ADT	Paid
Would like to increase his overall social skills. He will participate in activities.	ADT	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 I would like to learn more about?	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
My WSC provided information about abuse, neglect, and exploitation to me this year, and I know the reporting process and requirements.	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
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	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>

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:				
JD takes Linzess to treat gastroparesis. Metoclopramide is given as needed. Tums is taken at night to treat acid reflux symptoms. JD takes Dulcolax chews, senna and colace as needed to treat constipation. He is dependent on others to administer medications and he will communicate pain and illness to others				
Hospitalizations in the past year	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
Emergency Room Visits in the past year	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>
If yes, why did I go to the hospital or emergency room?				
Illness times 3				

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

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Medications	Dosage/Frequency	Purpose of Medication	Side Effects/Problems Experienced
Linzezz linaclotide CAPSULE, GEL ORAL 145 ug/1	3/mg (Milligram), Daily		
Metoclopramide Hydrochloride Metoclopramide Hydrochl SOLUTION ORAL 5 mg/5mL	5/mg (Milligram), 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?)

Dental/Eye/Physical and labs annually and prn

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 First: Dr. Miller	03/01/2025		
Dental: Country Club Dental	03/01/2025	Needs his wisdom teeth removed	Being referred to a special needs dentist for anesthesia.

Health Care Decision Maker Name	Role	Follow Up Activities
Wheeler, Su		

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.

Eyeglasses/manual wheelchair/ power wheelchair/lift

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

wipes, under pads and gloves

Personal Disaster Plan

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I have a Personal Disaster Plan Yes ☒ No ☐

Date Personal Disaster Plan Completed or Updated 10/27/2024

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 _____

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