agency for persons with disabilities
State of Florida

Person-Centered Support Plan

Support Plan Effective Date: 09/01/2025

Date of Support Plan Update:

About Me

Last Name	Williams	First Name	Hunter			Nickname	
Date of Birth:	3/29/2005	Medicaid ID	9466825321	iConnect ID	76234	Legal Status	Has been Adjudicated Incapacitated
Living Setting	Family Home	Spoken Language	English			Alternate Communication	Smart Phone
Primary Diagnosis	F79 - Intellectual Disabilities, Unspecified	Secondary Diagnosis	F84.0 - Autism			Other Diagnosis	ADHD, Depression, Autistic disorder

Where I Live

Street Address	1741 Black Maple pl	City	Ocoee	State	FL	Zip	34761
Email Address	kwilliams33012@cfl.rr.com	Cell / Home Phone	(407)791-5230	Work Phone		Region	CENTRAL
Deliver my mail to	1741 Black Maple pl	Mailing City	Ocoee	State	FL	Mailing Zip	34761

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	Katrina	Williams	Legal Representative	Caregiver|Florida Court Appointed Guardian or Guardian Advocate		

My Waiver Support Coordinator

Name	Agency (if applicable)	Email	Phone Number(s)
Massay-Brank, Karen	MASSAY-BRANK KAREN	KmassayB1@outlook.com	

My Family, Friends, and Support System

Name	Relationship	Email	Phone	
Williams, Katrina	Legal Representative,Caregiver,Florida Court Appointed Guardian or Guardian Advocate	kwilliams33012@cfl.rr.com	1. (407)791-5230	

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

Name	Relationship	Email	Phone	
Williams, Katrina	Legal Representative,Caregiver,Florida Court Appointed Guardian or Guardian Advocate	kwilliams33012@cfl.rr.com	1. (407)791-5230	

Impower, Central Florida	Psychiatrist,HIPAA Authorized Person,Psychiatrist			

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

Support Need	Funding Source
Medical	Medicaid
Psychotherapy	Behavioral Health (DCF), Medicaid State Plan (AHCA), Natural Supports
Dental	
College	Adult Protective Services (DCF), Other Paid education for children for adoptive parents
On the job training	Vocational Rehabilitation (DOE)
Lungs specialist	Medicaid State Plan (AHCA)

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?			
Williams	Katrina	Legal Representative,Caregiver|Florida Court Appointed Guardian or Guardian Advocate	(407)791-5230	Y	☐	N	☐
Impower	Central Florida	Psychiatrist,HIPAA Authorized Person| Psychiatrist		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)

Hunter is a 20-year-old young man who currently lives with his adoptive parents in the Ocoee area of Orange County Florida. Hunter and his parents are requesting placement in a group home, as his adoptive parents are aging and have their own health issues. Hunter would like to have his own apartment in the future. Hunter would like to improve his independent living skills before trying to live on his own. Hunter stated that he requires supervision to use most of the kitchen appliances. Hunter uses an alarm to wake up at 7am, then he completes his ADLs with some prompting in order to be on time to get on the Lynx door to door bus between 8:30-9am.to get to school for his college classes. Hunter packs his lunch on the days that he had college classes which end around 3:15pm. Hunter get on the Lynx bus by 4pm and arrive home around 4:30pm. Hunter receives tutoring before class and on days that he doesn't have classes. Hunter stated that he tried to be responsible and make the call for the bus ride and was not able to do it properly, so, his mother continues to do it for him.
After school Hunter does his homework, has dinnar, and does his ADLs, prepares for bed around 8:30pm.

How I get around in my community:

Family/Friend transit, Share-A-Ride

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

He said he is talented and interested in technology, he has the ability to play video games, he is good at organizing and keeping his surrounding neat and clean.

Things I would like to change:

Self development . I want to be able to follow directions without delays

Things I want to stay the same:

I want to continue college

agency for persons with disabilities
State of Florida

Person-Centered Support Plan

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

I am adopted and lives with my adopted parent. I have ADHD and autism.

Rights
Hunter has been educated about his rights through verbal conversation. Pedro chooses to exercise his right to privacy, communication, personal possessions, and others daily. Pedro has been educated on the Grievance Procedures and understands who to contact if he feels he is not being treated fairly or respected. He has also been educated on HIPAA, due process, provider choices, and the WSC backup system. He understands that in the event WSC is unavailable another certified WSC will be available to assist him.
Health and Health Care needs
Hunter was informed and educated on his health and healthcare needs (medication, side effects, and preventive health). He is current with all his medical appointments, and annual exams. Hunter chooses to cooperate with his healthcare providers. He is educated on his right to choose his doctors and healthcare providers. He requires complete assistance to make his appointment and transportation to all of his doctors visits.
Safety and safety needs and skills
Hunter was educated on his safety and safety needs and skills (natural disasters, community, environmental, and home safety). He requires assistance with decisions regarding his safety. He could easily be influenced in the wrong. Mother stated he once blocked her and her husband out of his phone location. and was talking to a girl whom mother stated was and continues to be a bad influence on him.
Hunter takes medications but he is unable to state the name of the medication, nor does he know for what purpose he is taking the medication. He also has no knowledge of the side effects. He was educated on this information and continues to be reminded to take his medication.

How I communicate and make choices and decisions:

I verbally communicate my choices and desires when making decisions

Employment

Job(s) I Have (for those who choose not to work, state N/A)	Hire Date(s)	Type of Job(s) I Have
I had about 5 different placement and some of which I work the same place multiple times but WBLE training program with VR since middle school. I also attended UCF CART		Prevocational Training
Restaurant cleaning dish washing which he did previously back in middle school		Prevocational Training
		Prevocational Training

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	☐	Game development and simulation	VR back in middle school

I was referred to Vocational Rehabilitation						Date of Referral to Vocational Rehabilitation	Outcome of Referral to Vocational Rehabilitation
Yes	☑	No	☐	N/A	☐		He has had five different on the job training placement. He was completed two of them and three of them was cut short due to him taking unauthorized breaks to be on his phone.
							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	Color blind	Ophthalmologist Natural Supports Group Home	iBudget Waiver, Medicaid, Natural Supports
☐	Hearing	No problem		
☐	Eating	No problem		
☐	Ambulation	No problem		
☐	Transfers	No problem		
☐	Toileting	No problem		
☑	Hygiene	Requires assistance with prompting to complete hygiene tasks.	Natural Supports Group Hoome	iBudget Waiver, Natural Supports
☑	Dressing	Due to his color blindness, he requires assistance with matching clothes.	Natural Supports Group Home	iBudget Waiver, Natural Supports
☑	Communications	Mother has to answer some questions for him due to him not knowing how to answer the certain questions even with visuals	Natural Supports Group Home	iBudget Waiver, Natural Supports
☑	Self-protection	The use of access Lynx door to door service as he requires supervision to remain safe.	Natural Supports Group Home	iBudget Waiver, Natural Supports
☑	Ability to Evacuate (Home)	Does not know what to do to case of an emergency	Natural Supports Group Home	iBudget Waiver, Natural Supports
Behavioral (Choose all that apply)				
☐	Hurtful to Self/Self-injurious	No problems		
☐	Aggressive/Hurtful to Others	No problems		
☐	Destructive to Property	No problems		
☐	Inappropriate Sexual Behavior	No problems		
☑	Running Away	Leaving worksite to meet up with someone in the past year. Did not show up for classes or tutoring to hangout with the same person	Natural Supports Group Home	Medicaid, Natural Supports
☑	Other Behaviors that May Result in Separation from Others.	psychotropic medication for control of behavior or psychiatric symptoms.	Psychotherapy Natural Supports Group Home	iBudget Waiver, Medicaid, Natural Supports
Physical (Choose all that apply)				
☐	Injury to Person Caused by Self-injurious Behavior	No problems		

☐	Injury to the Person Caused by Aggression to Others or Property	No problems		
☐	Use of Mechanical Restraints or Protective Equipment for Maladaptive Behavior	No problems		
☐	Use of Emergency Chemical Restraints	No problem		
☑	Use of Psychotropic Medications	On medication to control behaviors	Natural Supports Medicaid Group Home	iBudget Waiver, Medicaid, Natural Supports
☐	Gastrointestinal Conditions (includes vomiting, reflux, heartburn, or ulcer)	No problems		
☐	Seizures	No problems		
☐	Antiepileptic Medication Use	No problems		
☐	Skin Breakdown	No problems		
☑	Bowel Function	Takes doculax daily	Natural Support Group Home	iBudget Waiver, Natural Supports
☑	Nutrition	BMI is below national recommendations but no medical issues	Natural Supports Group Home	iBudget Waiver, Natural Supports
☐	Treatments	No problems		
☑	Assistance in Meeting Chronic Health Care Needs	He requires assistance with making and meeting his medical appointments and follow ups.	Natura Supports Group Home	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	He said he would not ask for help if he needs if	Natural Supports Group Home Medicaid School	iBudget Waiver, Medicaid, Natural Supports, Public Schools
☑ Medication Management	Requires assistance with taking his medication	Natural Supports Group Home	iBudget Waiver, Natural Supports
☐ Refusing Eating, Hygiene, or Supports			

☐	Substance Abuse			
☑	Handling Money/Finances	Requires guidance with handling money	Natural Supports Group Home	iBudget Waiver, Natural Supports
☑	Interactions with Strangers	May need continued education on stranger danger	Natural Supports Group Home	iBudget Waiver, Natural Supports
☑	Child/Adult Protective Services	Former foster child now adoptive family	APD Waiver service placement into a reshab	iBudget Waiver
☐	Relating with Others			
☑	Home Safety	Needs assistance with use of kitchen appliance	Natural Supports Group Home	iBudget Waiver, Natural Supports
☑	Community Safety	At risk of being exploited doesn't comprehend danger	Natural Supports Group Home	iBudget Waiver, Natural Supports
☑	Internet Safety	Requires restrictions, parental control	Natural Supports Group Home	iBudget Waiver, Medicaid
☑	Need for information or training on how to prevent abuse, neglect, and exploitation	Continued education on abuse, neglect, and exploitation	Natural Support WSC Group Home	iBudget Waiver, Natural Supports, Public Schools
☐	Insufficient or Unstable Housing			
Needs/Risks Related to My Caregiver (For those living in the family home. Choose all that apply)				
☑	Caregiver Health Needs	Caregivers, adoptive parents are again and dealing with their own health issues		
☐	Limited Relief for Caregiver			
☐	Caregiver Needing Additional Assistance			
☐	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)
Group Home will provide for any needed back-up.		

What I Accomplished Last Year

My accomplishments last year:
New to the waiver

Goals I worked on last year	Progress on each goal
New to the waiver	

My Personal and Future Plans

agency for persons with disabilities
State of Florida

Person-Centered Support Plan

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)
I want to transfer to independent living in the future.

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.**
I want to live in a safe group home	Res-hab	Paid
I want to complete my certification in college		Non-Paid Name: -----, ---- Relationship: Circle of Supports
I want assistance with learning independent living skills including money management	Res Hab	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**	☐	**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:				
Autism disorder, ADHD				
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?

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

Medications	Dosage/Frequency	Purpose of Medication	Side Effects/Problems Experienced
Focalin| dexmethylphenidate hydr|CAPSULE, EXT| ORAL|30|mg/1	30/mg (Milligram), Daily		
REMERON| MIRTAZAPINE| TABLET, FILM|ORAL| 15|mg/1	15/mg (Milligram), Daily		
Lexapro| ESCITALOPRAM OXALATE|SOLUTION| ORAL|5|mg/5mL	5/mg (Milligram), Daily		
Intuniv|guanfacine| TABLET, EXTE|ORAL| 2|mg/1	1/mg (Milligram), Q4H (Every 4 hours)		
SYMBICORT| Budesonide and Formoter|AEROSOL| RESPIRATORY|160; 4.5|ug/1; u	2 puffs/mcg (Microgram), Daily		
Vyvanse| lisdexamfetamine dimesy|CAPSULE| ORAL|40|mg/1	1/gm (Gram), Daily		

Allergies: (Including any reactions to any medications, substances, chemicals, etc.)
environmental allergies no food allergies

My critical health follow-up areas and preventative health plan: (How will I maintain my Health and Health Stability?)
Follow up as needed with PCP, dental, and Psych

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		Annual psyical	
Dental:			
Psychiatrist			
Pulmonologist			
Neurologist			

agency for persons with disabilities
State of Florida

Person-Centered Support Plan

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.
Glasses

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 09/19/2025

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** _____

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

agency for persons with disabilities
State of Florida

Person-Centered Support Plan

Agency for Persons with Disabilities
Support Plan/ Support Plan Update Page __ of __

Name: Hunter Williams

Support Plan Effective Date: 09/01/2025

Safety Plan:

Summary of Historical Events: Previous sexual encounter with young brother at age 7 and 5 in foster care. At risk of online interaction with the wrong people in the community.

Special Considerations:

a) If there is a court order, indicate what it requires: N/A

b) If there is a Probation Officer, identify who, their location, contact numbers and any other court requirements:N/A

c) If required, identify where the person must register locally as a “sex offender”: N/A

General Precautions and Preventative Measures

a) Identify any triggers, high-risk situations, environmental and personal stressors that might lead to re-offending: Staying in the same room with his brother or other vulnerable person may give him Idea to reofend

b) What predatory “grooming” behaviors are known: None

c) Limitations on access to media (TV, movies, printed material, video games, internet or cell phone) if any and why: Controlled

d) Identify “avoidance” or preventative behaviors that need to be trained or be prompted in risky situations: Own personal room and with known camera for his or anyone else's safety

e) The level or type of routine supervision required is: Camera supervision in the home

f) Staff assignments, including size, gender or other critical attributes: N/A

g) Risk sites to be avoided near home location: N/A

h) Bedroom assignments (roommates and location within the home): Line of sight

i) Community limitations (allowable activities, van routes, supervision):

j) Day program or work environment supervision: N/A

k) Alarms and monitoring devices needed: May require a door alarm

Additional Notes/Comments/Considerations