An easy-to-use, customizable plan for people who want to create a Psychiatric Advance Directive or Mental Health Crisis Plan

ASAP* Guidebook & Plan Developed and Written by
Lauren Rieser Shawl, M.S.
Mental Health Association of Southeastern Pennsylvania

ASAP* Project Concept Development by
Jeffrey Draine, Ph.D.
University of Pennsylvania School of Policy and Practice

**EMERGENCY CONTACT INFORMATION**

for

Name ____________________________
Date of Birth ______________________

In the event of an emergency situation in which I cannot communicate clearly on my own behalf, please contact the person(s) named on the reverse side of this card.

**MENTAL HEALTH ADVANCE DIRECTIVE**

I, ____________________________, have created an Advance Self-Advocacy Plan which is be used as an advance directive concerning my mental health care. If I am hospitalized, please contact the person(s) named on the reverse side of this card.

My date of birth: ____________________

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Developed by the Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities
Funded by the National Institute on Disability and Rehabilitation Research
ADVANCE SELF-ADVOCACY PLAN*

The ASAP* is an easy-to-use, customizable plan for people who want to create a Psychiatric Advance Directive or Mental Health Crisis Plan in order to maintain a voice in their mental health care and personal choices during times of illness or hospitalization.

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Please note that the Advance Self-Advocacy Plan (ASAP)* forms do not constitute legal advice. State laws vary and it is possible that part or all of this document will not be effective in your state. It is recommended that you consult a lawyer or legal resource before you assume that you’re Advance Self-Advocacy Plan will be legally valid in your state as an advance directive.

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# ADVANCE SELF-ADVOCACY PLAN

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## MAKING YOUR ASAP A LEGAL DOCUMENT

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## PERSONAL INSTRUCTIONS SECTION

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ABOUT THE ADVANCE SELF-ADVOCACY PLAN (ASAP)

The Advance Self-Advocacy Plan is a simple tool to tell others how you want to be treated in case your mental health takes a turn for the worse sometime in the future. It helps you discover what you need to handle and recover from a psychiatric crisis and provides a way to address those needs, both in and out of the hospital.

Your ASAP is designed to keep you in the center of your care, even during times that you have difficulty communicating your needs to others. And because this planning process helps you to identify and better understand your needs, you can sometimes avoid a crisis altogether.

To ensure that the ASAP is relevant and useful, it was created with extensive input from people who have used mental health services and who have been hospitalized in psychiatric facilities. Behavioral health service providers also contributed important information to better help them to assess and implement the plan developer’s needs. As a result of the input, contributions and feedback from many sources, important topics that are not addressed in other mental health advance planning documents were included in the ASAP.

**Your ASAP can be used as a legally-binding psychiatric advance directive.**+ The form on page 15 of your Advance Self-Advocacy Plan can be used to inform crisis response and in-patient facilities that they need to provide mental health treatment and care as you have directed in your ASAP.

+Please note: Some states still do not recognize Psychiatric Advance Directives while others might require some modification of this form in order for it to be used as a legal document. See Resource #1 on page 25 for state-specific information about psychiatric advance directives.

The **ASAP GUIDEBOOK** was developed as a companion for this ASAP planning tool. We recommend that anyone interested in creating an Advance Self-Advocacy Plan use the Guidebook to get a better sense of what to consider as they make their own plan.

**AN IMPORTANT NOTE ABOUT THE NUMBERS ON YOUR ASAP PLANNING SHEETS:**

The ASAP is designed so that you can customize the page numbers of your personal plan. Most people will not need to use every ASAP planning sheet that is offered; you only need to include those pages that are relevant to your particular situation. (For example, if you do not have dependent children, you would not include ASAP pages 21, 22, or 23 in your plan.)

The number in parentheses at the bottom center of each page corresponds to the Table of Contents.

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There is also a blank space after the words “**Personal Plan p. #_____**” on the bottom right of each planning sheet where you can fill in your own numbers. After completing your personal ASAP, you can customize the page numbers for your plan by filling in the new, correct page number in that blank space for each of your planning sheets.
ADVANCE SELF-ADVOCACY PLAN (ASAP) FOR:

_________________________________________________
(print name clearly)

Address: ___________________________________________________________

Day Phone: _______________________________     Evening Phone: _______________________________

Effective Date: ____________________________     Signed: ______________________________

Updated: ________________________________       Signed: __________________________________

I have appointed a Mental Health Care Representative (Proxy):   Yes _________ / No __________

See Finances section for details (page 19).

[It is recommended that copies of your Advance Self-Advocacy Plan be given to trusted family members, friends and any people or agencies involved with your general health and mental health care, such as your primary care doctor, psychiatrist, therapist, case manager or mental health service provider.]

The following people have been given a copy of my Advance Self-Advocacy Plan or have access to my personal copy.

Name: _____________________________________     Relationship: ____________________________
Address and/or Phone Number(s): _______________________________________________________

Name: _____________________________________     Relationship: ____________________________
Address and/or Phone Number(s): _______________________________________________________

Name: _____________________________________     Relationship: ____________________________
Address and/or Phone Number(s): _______________________________________________________

Name: _____________________________________     Relationship: ____________________________
Address and/or Phone Number(s): _______________________________________________________

Name: _____________________________________     Relationship: ____________________________
Address and/or Phone Number(s): _______________________________________________________

Name: _____________________________________     Relationship: ____________________________
Address and/or Phone Number(s): _______________________________________________________
SELF-ASSESSMENT

MENTAL WELLNESS - This is what I’m like when I’m feeling well:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

SYMPTOMS, TRIGGERS and HELPFUL ACTIONS: If I experience a trigger (see Guidebook) and/or start to have uncomfortable symptoms or behaviors, the following actions can help me to feel more comfortable and possibly avoid a mental health crisis:

If I experience this (see below): This action will help me to feel better:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

WELLNESS AND RECOVERY TECHNIQUES - While in the hospital, I want to be permitted to use the following wellness techniques to help with my recovery:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Plan Creator: ____________________  Initials ____________  Date: ___________

**PREVIOUS HOSPITALIZATIONS** – My history and preferences regarding hospitalization include the following:

I have been admitted to a psychiatric or crisis response facility before _______ Yes _______ No

This is how I have felt and reacted when I was hospitalized in the past:

___________________________________________________________

___________________________________________________________

___________________________________________________________

The following aspects about being in the hospital make me feel uncomfortable:

___________________________________________________________

___________________________________________________________

___________________________________________________________

The hospital staff can take the following steps to reduce my anxiety and help me feel more comfortable about being in the hospital:

___________________________________________________________

___________________________________________________________

___________________________________________________________

If I am feeling suicidal, the best thing staff can do to reduce the intensity of this feeling is this:

___________________________________________________________

___________________________________________________________

___________________________________________________________
Plan Creator: ____________________________________________ Initials ___________ Date: ___________

MY REQUESTS REGARDING FUTURE IN-PATIENT HOSPITALIZATION ARE AS FOLLOWS:
(IT’S BETTER TO INITIAL YOUR RESPONSE RATHER THAN JUST PLACING A CHECK IN THE APPROPRIATE SPACE.)

TREATMENT FACILITIES — My choices of treatment facilities are as follows:
If my psychiatric condition is serious enough to require hospitalization, I would prefer to receive this care in this/these facilities:

Facility #1: ________________________________ City/State: ________________________________
Facility #2: ________________________________ City/State: ________________________________

I DO NOT wish to be admitted to the following facilities for psychiatric care (give reason if possible).
Facility: ___________________________________________________________________________________
Facility: ___________________________________________________________________________________

TREATING PHYSICIAN/DOCTOR — My choice of a treating physician is:

1st Choice of Physician: ________________________________ Phone: ________________________________
2nd Choice of Physician: ________________________________ Phone: ________________________________

I DO NOT wish to be treated by the following physicians: (optional)
Name of Physician: ________________________________ Name of Physician: ________________________________

EXPERIMENTAL STUDIES — Hospital staff might approach you about participating in experimental studies.

Initial your preference below:

________ I DO NOT want to be approached about participating in experimental studies.

________ I am willing to participate in experimental studies if my treating physician believes that the potential benefits to me outweigh the possible risks.

DRUG TRIALS — Hospital staff might approach you about participating in drug trials. Initial your preference below:

________ I DO NOT want to be approached about participating in drug trials.

________ I am willing to participate in drug trials if my treating physician believes that the potential benefits to me outweigh the possible risks.
Plan Creator: ____________________________  Initials _______  Date: __________

ECT — These are my preferences regarding electroconvulsive therapy (ECT):

_______ I agree to the administration of electroconvulsive therapy if my treating physician believes that the potential benefits to me outweigh the possible risks.

_______ I DO NOT agree to the administration of electroconvulsive therapy.

SECLUSION AND RESTRAINT — These are my preferences regarding the use of sedation and/or restraints:
I have one or more of the following risk factors; therefore seclusion or restraint should not be used as it could prove dangerous to my emotional and/or physical health:

- [ ] Pregnancy
- [ ] Seizure disorder
- [ ] Asthma
- [ ] Abuse history: physical/emotional, sexual, rape
- [ ] Head or spinal injury
- [ ] Other ____________________

_______ I DO NOT want restraint used during my hospitalization except as a last resort when all other possible safety interventions have been attempted.

_______ I DO NOT want seclusion used during my hospitalization except as a last resort when all other possible safety interventions have been attempted.

If it is determined that seclusion or restraint is absolutely necessary, (1) such treatment needs to be ordered by my treating physician and (2) I must be monitored, and the need for this measure assessed, at intervals of 15 minutes or less as per the “Rules and Regulations” Section of the Federal Register.

Staff can minimize use of restraint and sedation by doing — or letting me do — the following:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

RELIGIOUS REQUIREMENTS/PREFERENCES:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

DIETARY REQUIREMENTS/PREFERENCES:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

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Plan Creator: ____________________  Initials ____________  Date: ___________  

STREET DRUGS — Without admitting to or denying current use of street drugs, I offer the following information:

A. This is the drug (or drugs) I am or was most likely to use: __________________________________________________________________________________________________

B. I feel and behave this way after taking this drug (or drugs): ______________________________________________________________________________________________________________________________________________________________

C. When I arrive at the hospital or crisis unit, I would be comfortable letting medical staff know — in confidence — whether I have taken a street drug (initial response). _____Yes _____No

DISCHARGE CONCERNS — I will have to face the following difficult issue(s) when I am discharged; I would like to work on resolving these concerns during my hospital stay.

If I have not already done so, I would like to fill out this section of my Advance Self-Advocacy Plan as soon as I am able so that I can inform hospital staff about my discharge concerns.

Discharge Concern: ______________________________________________________________________________________________________________________________________________________________

Resolution to Problem: ______________________________________________________________________________________________________________________________________________________________

Discharge Concern: ______________________________________________________________________________________________________________________________________________________________

Resolution to Problem: ______________________________________________________________________________________________________________________________________________________________

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MEDICATIONS — These are my preferences regarding medications:

A. I agree to administration of the following medication(s):

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Medication is current as of date below</th>
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<tbody>
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</table>

(Optional) Physician Verification: ___________________________ Date: __________

(Optional) These above medications have been prescribed by:

Dr. ___________________________________________ Doctor Phone # ___________________________

Pharmacy ___________________________ Pharmacy Phone # ___________________________

B. The following medication(s) must be avoided:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reason (optional)</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

- MEDICATIONS Section Continued on Next Page –
Plan Creator: ____________________________ Initials __________ Date: ___________

MEDICATIONS continued (2) — ADDITIONAL INFORMATION

C. OTHER IMPORTANT INFORMATION about my medications (allergies, side effects, etc.):
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

D. MEDICATION HISTORY – This is a list of all medications that I can remember taking:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Approximate Date of Use</th>
<th>Discontinued?</th>
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<tbody>
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</table>
Plan Creator: ____________________  Initials ____________  Date: ___________

NOTIFICATION — In the event my psychiatric condition is serious enough to require hospitalization, I wish for the following people to be notified:

A. Primary Support Person: I request that the person named below is the first person notified about my hospitalization.

Name: _______________________________________________________________
Address: ___________________________________________________________________
Day Phone: ___________________________   Evening Phone: __________

If I lack the capacity to give consent to mental health treatment, I give my Primary Support Person full power and authority to make mental health care decisions for me as my mental health care representative (proxy). This includes the right to consent, refuse consent or withdraw consent to any mental health care, treatment, service or procedure consistent with any instructions and/or limitations I have stated in this Advance Self-Advocacy Plan, which may also be used as an advance directive. If I have not expressed a choice in this advance directive, I authorize my representative to make the decision that (s)he determines is the decision I would make if I were competent to do so.

I give permission for my Primary Support Person to serve as my legal mental health care representative (proxy) as detailed in the statement above. __________________________________________

I DO NOT give permission for my Primary Support Person to serve as my legal mental health care representative (proxy). __________________________________________

__________________________  __________________________
(signature)                           (signature)

B. Alternate Primary Support Person: If the person named above is unable or unavailable to serve as my Primary Support Person, I hereby appoint and request immediate notification of my alternate Primary Support Person, who is named below:

Name: _________________________________________________________________________
Address: _______________________________________________________________________
Day Phone: ___________________________   Evening Phone: __________

I give permission for my Alternate Support Person to serve as my legal mental health care representative (proxy) as detailed in the statement above. __________________________________________

I DO NOT give permission for my Alternate Support Person to serve as my legal mental health care representative (proxy). __________________________________________

__________________________  __________________________
(signature)                           (signature)

C. I request that my primary care physician and/or other health care/mental health care professional(s) be notified and consulted concerning my care as soon as possible:

Name: ___________________________________________  Phone Number: _______________________
Name: ___________________________________________  Phone Number: _______________________

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NOTIFICATION continued:

D. I request that staff of the Community Mental Health Program where I am a client be notified:

Program Name: __________________________________________________________

Phone #: ___________________________  City/State: ___________________________

Primary Counselor or Case Manager: ________________________________________

E. The following people may also be notified. I have indicated whether or not I give them permission to VISIT me in the hospital:

<table>
<thead>
<tr>
<th>Name: __________________________________________</th>
<th>Visiting Privileges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone # ___________________________  Relationship: __________________________</td>
<td>YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: __________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone # ___________________________  Relationship: __________________________</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Phone # ___________________________  Relationship: __________________________</td>
</tr>
</tbody>
</table>

I DO NOT want the following people notified of my hospitalization under any circumstances:

<table>
<thead>
<tr>
<th>Name: __________________________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name: __________________________________________</th>
</tr>
</thead>
</table>

ADDITIONAL NOTIFICATION NOTES:

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
STATEMENT OF INTENT

I, ______________________________________________________________ , being of sound mind, willingly and
voluntarily execute this health care advance directive to assure that, if I should be found to lack capacity to consent to
my own mental health treatment, my choices regarding treatment will be carried out despite my inability to make
informed decisions for myself.

In the event that a guardian or other decision maker is appointed by a court to make mental health care decisions for
me, I intend that this document take precedence over all other means of determining my intent while competent.

To the extent, if any, that this document is not valid under state law, it is my desire that it be considered a statement
of my wishes and that it be accorded the greatest possible legal weight and respect.

This document will become active and take effect upon the following two conditions:
(1) It has been determined that I do not have the capacity to make my own mental health treatment decisions and
it shall continue in effect only during that incapacity; and
(2) Determination of my capacity must be made by my designated physician or a psychiatrist and one other mental
health treatment provider, who have examined me.

Name (Please print): ____________________________________________________________
Signature: ____________________________ Date: ____________________________

SIGNATURE AND STATEMENT OF WITNESSES (Each witness must be 18 or older, not related to me by blood,
marriage or adoption and not a provider of my mental health care.)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and
acting of his or her own free will. He or she signed this document in my presence.

WITNESS 1: Name (Please print): ____________________________________________________________
Address: ______________________________________________________________________________
Day Phone: ____________________________ Evening Phone: ____________________________
Signature: ____________________________ Date: ____________________________

WITNESS 2: Name (Please print): ____________________________________________________________
Address: ______________________________________________________________________________
Day Phone: ____________________________ Evening Phone: ____________________________
Signature: ____________________________ Date: ____________________________

NOTARY ACKNOWLEDGEMENT: State of __________________________ County of __________________________
On __________________________ , 20____, before me the undersigned Notary Public personally appeared
____________________________________, known to me or satisfactorily proven to be the person(s) whose
name(s) is/are subscribed to the above Declaration for Mental Health Treatment as the Declarant and/or Witnesses
for the purposes expressed therein. I attest that he/she/they appear to be of sound mind and not under or subject to
duress, fraud, or undue influence.

Notary Public __________________________
My Commission Expires: __________________________
Personal Instructions Section

for the

Advance
Self-Advocacy
Plan

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ADVANCE SELF-ADVOCACY PLAN

FACILITY (HOSPITAL) INSTRUCTIONS

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☐ Wellness and Recovery Techniques ----------------------------------------------- 6
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ADVANCE SELF-ADVOCACY PLAN (ASAP) FOR:

______________________________________________________________
(print name clearly)

Address: ______________________________________________________________________________________

Day Phone: ___________________________      Evening Phone: ___________________________

Effective Date: ___________________________      Signed: _____________________________

Updated: ___________________________       Signed: __________________________________

- PERSONAL INSTRUCTIONS –

My Request Regarding Care for My Personal Responsibilities Are As Follows:

(IT’S BETTER TO INITIAL YOUR RESPONSES RATHER THAN JUST PLACING A CHECK IN THE APPROPRIATE SPACE.)

On the following pages I am providing information about how my personal responsibilities should be handled in the event that I am temporarily unable to take care of them. I have named the Support Person(s) I would like to take care of each responsibility in my absence.

NOTIFICATIONS:

_______  I give permission for ALL Support People named on the following pages to be notified of my condition.

_______  ONLY Support People who are named below may be notified of my condition.

Name and Phone Number(s) or Address:

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________
Plan Creator: ___________________________ Initials _________ Date: __________

HOME NEEDS: If I am temporarily unable to care for my home, I request that the following items be handled by the Support Person(s) named below:

Name of Support Person: ____________________________________________________________
Day Phone: ___________________ Evening Phone: ________________________________
Home Needs: ________________________________________________________________

MAIL: If possible, I would like my mail handled as follows:

Please ask __________________________________________________________ to:

☐ personally collect my mail in my absence
☐ have delivery stopped until I return home
☐ other __________________________________________________________

PETS: If I am temporarily unable to care for my pets, I request that they be cared for by the Support Person(s) named below as follows:

Name of Support Person: _______________________________________________________
Day Phone: ___________________ Evening Phone: ________________________________
Pets Support Person #2, Veterinarian or Boarding Facility contact information:

Pet #1 - Name: ____________________________ Type of Animal: ______________________
Care & Feeding Information _______________________________________________________

Pet #2 - Name: ____________________________ Type of Animal: ______________________
Care & Feeding Information ______________________________________________________

Pet #3 - Name: ____________________________ Type of Animal: ______________________
Care & Feeding Information ______________________________________________________
FINANCES: If you want or need to have someone else take care of your financial responsibilities, you will need to either (1) appoint someone to have power-of-attorney authority over your financial affairs or (2) give a trusted friend or family member your bank account (and possibly social security) information so that they can make these payments for you.

The person named below is my representative payee who already takes care of my finances. If I am hospitalized for more than ____ day(s), I agree to have him/her notified: _____ Yes _____ No

Name: ____________________________________________________________

Address: ______________________________________________________________________

Day Phone: __________________________ Evening Phone: __________________________

If I am temporarily unable to care for my finances, I have given the Support Person(s) named below the necessary information to care for the following payments until I am able to do so.

Name of Support Person ____________________________________________

Day Phone: __________________________ Evening Phone: __________________________

Alternate Support Person ____________________________________________

Day Phone: __________________________ Evening Phone: __________________________

RENT OR MORTGAGE PAYMENTS

Name of landlord, rental or mortgage company: ____________________________________________

Phone / Mailing address: ____________________________________________________________

On the _____ day of the month, I pay the following amount: $ ______________________

BILL PAYMENTS

<table>
<thead>
<tr>
<th>Type of Bill (water, electric, phone, etc.)</th>
<th>Account Number</th>
<th>Due on this day</th>
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Plan Creator: ____________________________ Initials ____________ Date: ____________

*Note: It can be difficult to find contact information about your job and/or school when you are not feeling well. Get it and fill it in NOW... before you need it!*

**EMPLOYMENT INFORMATION:**

Company: ____________________________________________________________

Name of Supervisor: ____________________________________________________

Work Phone: __________________________________________________________

Personnel Director: _____________________________________________________

Personnel or Human Resources Dept. Phone #: ________________________________

If I am unable to take care of this myself, I would like the following Support Person to contact my school about my employer on my behalf:

Name of Support Person: ________________________________________________

Day Phone: _____________________________ Evening Phone: __________________

**SCHOOL INFORMATION:**

School: _______________________________________________________________

Address (city & state): __________________________________________________

School’s Main Phone: __________________________________________________

Counseling Office and/or Office of Disability Phone: _________________________

Financial Assistance/Loan/Grant/Scholarship Office Phone: ____________________

Name and contact information (phone/email address) of counselor, teacher, or other people at school who should be notified if you are absent:

________________________________________________________________________

________________________________________________________________________

If I am unable to take care of this myself, I would like the following Support Person to contact my school about my absence on my behalf:

Name of Support Person: ________________________________________________

Day Phone: _____________________________ Evening Phone: __________________
CARING FOR MY CHILDREN:

If I am temporarily unable to care for my child/children, please immediately contact my child’s/children’s other parent or other close family member (named below) to take charge of their care.

Name: _________________________________________

Relationship to Child: _____________________________________________

Phone Number(s): __________________________________________________________

Address: __________________________

Under NO circumstances should my child/children be given to, or placed in the custody of, the following person (people):

_________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

It’s a good idea to identify more support people to act as back-up caregivers in case the first person you name is not available when you need this type of assistance. If you can think of other people who could be contacted to care for your child/children in your absence, list them in order of preference and/or indicate your first, second and third choices.

Please Note:

- It’s important to ASK each person on your list if he/she is willing to accept this responsibility if necessary and, if possible, sign your plan on page 23 under his or her name.

- It’s a good idea to share ASAP pages 21—23 with your chosen caregivers so that they are aware of your preferences and have important information about each of your children.
In the event that I am temporarily unable to take care of my children AND my children’s other parent is unavailable, unwilling or not allowed to have temporary custody, please contact these support people (in the order indicated) to care for my children:

Support Person’s Name: ___________________________________________________________
Relationship to Child: ___________________________________________________________
Phone Number(s): _______________________________________________________________
Signature: ___________________________________________________________________

Support Person’s Name: ___________________________________________________________
Relationship to Child: ___________________________________________________________
Phone Number(s): _______________________________________________________________
Signature: ___________________________________________________________________

Support Person’s Name: ___________________________________________________________
Relationship to Child: ___________________________________________________________
Phone Number(s): _______________________________________________________________
Signature: ___________________________________________________________________

**RESPITE CARE INFORMATION:** In the event that I am temporarily unable to take care of my children AND no other adult of my choosing is available, willing or allowed to have temporary custody, please contact one of these respite care facilities to care for my children:

Name of Organization: ___________________________________________________________
Phone Number(s): _______________________________________________________________
Address: ______________________________________________________________________
_____________________________________________________________________________

Name of Organization: ___________________________________________________________
Phone Number(s): _______________________________________________________________
Address: ______________________________________________________________________
_____________________________________________________________________________
Important information about my child or each of my children:

Name: ___________________________________________ Age: __________________
Birth Date: _______________ School and Grade: ________________________________
Medical condition(s) and medication(s):________________________________________

* Personality and/or other information: __________________________________________

Name: ___________________________________________ Age: __________________
Birth Date: _______________ School and Grade: ________________________________
Medical condition(s) and medication(s):________________________________________

* Personality and/or other information: __________________________________________

Name: ___________________________________________ Age: __________________
Birth Date: _______________ School and Grade: ________________________________
Medical condition(s) and medication(s):________________________________________

* Personality and/or other information: __________________________________________

Name: ___________________________________________ Age: __________________
Birth Date: _______________ School and Grade: ________________________________
Medical condition(s) and medication(s):________________________________________

* Personality and/or other information: __________________________________________

*such as favorite color, foods, TV programs, games or video games, best friend(s), etc.
PLANNING SUPPORT MATERIALS

Here are some things to keep in mind as you create your plan:

- Work on your plan (or parts of your plan) when you are feeling fairly well.

- You do not need to complete every section of the plan in order for it to be useful. However, you want to make sure that you fill out information for those areas that are most important to you.

- Think carefully about the information you include and perhaps discuss your choices and decisions with people who can contribute to the plan that you create. Be as specific as you can when writing down your preferences so that others will know exactly what you want.

- If it’s helpful, make use of Plan Contributors: If you need help thinking about or getting information for your plan, you can ask your Plan Assistant(s), Plan Supporter(s) and Mental Health Professionals to assist you.

- Don’t be discouraged if you don’t have all the information at your fingertips... write down whatever you DO know and make a note of what you need to find out. You can use the ASAP “Find It” Sheet located at the end of the guidebook to keep track of the information you need find and add to your ASAP.

- ADDITIONAL RESOURCES –

  National Resource Center on Psychiatric Advance Directives:  
  http://www.nrc-pad.org/index.php

  Bazelon Center for Mental Health Law (Template/Forms for completion, FAQs):  
  http://www.bazelon.org/issues/advancedirectives/index.htm

  Mental Health America (formerly National Mental Health Association) Psychiatric Advance Directive Toolkit:  
  http://www1.nmha.org/position/advancedirectives/index.cfm

  The Advocacy Center for Persons with Disabilities (PAD Toolkit):  
  http://www.advocacycenter.org/AdvanceDirectives/advancedirectives.htm

  National Disabilities Rights Network:  
  http://www.napas.org/issues/advdir/default.htm
The ASAP “Find It” Worksheet

<table>
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<tr>
<th>Plan or Guidebook Page #</th>
<th>Topic</th>
<th>Where to look for this information?</th>
<th>Who can help me find what I need?</th>
<th>Target Date to get info.</th>
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