When you have completed this workbook, please return it to:

Name of Family Support Specialist: _____
Office address: _____
_____
_____
_____
Phone number: _____

*** If you received this form electronically (by email), you should print and return it by mail to the office address listed above. Personal information sent via email may not be secure. In order to protect your personal information, please DO NOT return this form by email.**

Essential Lifestyle Plan (ELP)
Workbook
For

_____

THINGS OTHER PEOPLE LIKE ABOUT ME:

MUST HAVE:

(These are things you have to have in order to have a good day. You can't do without them.)

MUST NOT HAVE:

(These are things you cannot have or don't want in your life. These would make you have a bad day).

Important People:

Name	Relationship	Address & Phone

LIKES:
(Things to consider are people, activities, hobbies, religion, foods, things, places, music, TV shows, etc…)

DISLIKES:
(Things to consider are people, activities, hobbies, religion, foods, things, places, music, TV shows, etc…)

HOPES & DREAMS:
(Things you have always wanted to do)
(Someday I want to…..)

THINGS TO TRY & LEARN:
(New things I'd like to learn)

SUPPORTS :

General

Note: At the age of 18, you become your own guardian, unless the Court has appointed a guardian for you.

Who is your Guardian? ☐ Self ☐ Other

If you have a Guardian, does your Guardian have guardianship of:
☐ Person ☐ Property ☐ Both

Date of Court Order: _____

Name of Guardian: _____

Relationship: _____

Address: _____
_____

Phone: _____

Do you have a:

Power of Attorney	☐ Yes	☐ No
Custodian	☐ Yes	☐ No
Surrogate Decision Maker	☐ Yes	☐ No

Emergency Contact Person:
Name: _____

Relationship: _____

Address: _____
_____

Phone: _____

Financial

Can you handle your own money?	☐ Yes	☐ No
Coins:	☐ Yes	☐ No
Dollars	☐ Yes	☐ No

If yes, up to what amount? _____

Who is your Representative Payee?
☐ Self
☐ Other Name & Relationship: _____
_____

Financial Information:	Amount
SSI	$ _____
SSDI/OASDI	$ _____
VA Benefits	$ _____
Pension (company name: _____)	$ _____
Wages	$ _____
Child Support	$ _____
Total	$ _____

Checking Account: Account Number: _____
Name of Bank: _____

Savings Account Account Number: _____
Name of Bank: _____

Certificates of Deposit (CD's) Amount: _____
Name of Bank: _____

Trust Fund Trustee Name: _____
Trustee Phone Number: _____
Name of financial institution: _____

Life Insurance:
Person Insured: _____
Policy Owner: _____
Insurance Company: _____
Company Address: _____
Policy Number: _____

Pre-paid Funeral Arrangements ☐ Yes ☐ No
If yes, name of the Funeral Home? _____
Address of Funeral Home: _____
_____
Phone number of Funeral Home: _____
Burial Plan: _____
Burial Plot ☐ Yes ☐ No Location: _____

At Home

I live with
Name: _____

Relationship: _____

Address: _____
_____

Phone: _____

Do you have anyone coming into the home to help you? ☐ Yes ☐ No
If yes, name of support person or agency: _____
Address: _____
Phone: _____

Chores/responsibilities/activities that I enjoy doing around the house
_____
_____
_____

At school/work/day program

Name of school/work/day program: _____

Contact Person: _____

Address: _____
_____

Phone: _____

Hours_____

Things that I enjoy at school/work/day program _____
_____

Do you need to pack lunch? ☐ Yes ☐ No
Is your lunch provided? ☐ Yes ☐ No
Do you have a clothing restriction? ☐ Yes ☐ No What? _____
Do you take money daily? ☐ Yes ☐ No How much? _____
Do you have transportation? ☐ Yes ☐ No
What are the arrangements/times? _____
_____

Communication

I communicate in the following ways:

☐ I talk
☐ I gesture
☐ I sign
☐ I write
☐ I use a picture book
☐ I use a communication device
What type?_____
Who fixes it when it breaks? _____
☐ Other

Do you understand simple directions? ☐ Yes ☐ No

If people want to communicate with me they should

_____

_____

_____

How people can tell I like something

_____

_____

How people can tell I don't like something

_____

_____

Other important information about how I communicate

_____

_____

_____

If you don't use words to speak, please complete the following:

In this situation:	When I do this:	It means:	You should do this:
Example: Anytime you ask me to do something	Bite my hand	I don't want to do it	Stop asking for now, and ask me later

Eating

I eat without any help ☐ Yes ☐ No
I use ☐ fingers ☐ spoon ☐ fork ☐ knife
Do you use special utensils? ☐ Yes ☐ No
If yes what: _____
_____

I need all food finely cut ☐ Yes ☐ No
I need meat cut ☐ Yes ☐ No
I need my food mashed or pureed ☐ Yes ☐ No
I drink by myself from a cup ☐ Yes ☐ No

Special eating or feeding instructions: _____
_____

My favorite foods: _____
_____

Foods I don't like: _____
_____

Getting Around

Do you walk by yourself without help? ☐ Yes ☐ No
If no, how do you get around? _____
_____

Do you:

Sit up alone	☐ Yes	☐ No	☐ Need assistance
Stand alone	☐ Yes	☐ No	☐ Need assistance
Climb stairs alone	☐ Yes	☐ No	☐ Need assistance

Safety

Do you need someone to be with you all the time?	☐ Yes	☐ No
Can you use 911?	☐ Yes	☐ No
Can you use the telephone in emergencies?	☐ Yes	☐ No
Do you need protection from being taken advantage of?	☐ Yes	☐ No

Please explain: _____
_____
_____

Do you put non-food items in your mouth?	☐ Yes	☐ No
Are you aware of hot/cold?	☐ Yes	☐ No
Do you watch for cars when crossing the street?	☐ Yes	☐ No
Would you walk off/leave with strangers?	☐ Yes	☐ No
Do you need to hold hands?	☐ Yes	☐ No

Moods & Behaviors

Describe your general behavior: _____
_____

Describe how you act in the community (on shopping trips, in restaurants, etc…)
_____
_____
_____

Do you have any habits? _____
_____

Do you ever:
☐ Hurt yourself ☐ Hit others ☐ Hit objects ☐ Throw objects ☐ Scream
☐ Have temper tantrums ☐ Lie ☐ Shoplift

What causes this to occur? _____
_____
_____

Describe what happens_____
_____
_____

What should we do when this happens? (How do you want us to help you?)
_____
_____
_____

Describe how you react to:
Changes in your environment_____
_____
_____

Changes in your routine _____
_____
_____

Disappointment _____
_____
_____

Do you presently have, or have a history of any of the following:

	Currently	**In the Past**	**How is this treated?**
Aggressive behavior (physical)			
Aggressive behavior (verbal)			
Substance Abuse			
Setting Fires			
Running Away			
Self-Injuring			
Sexual Misconduct			
Stealing/Theft			
Psychiatric Issues			
Other			

Health

Medicaid #: _____

Managed Care Provider: _____

Medicare #: _____ ☐ Part A ☐ Part B

Medicare Prescription Plan (Part D): _____

Blood Bank ☐ Yes ☐ No

Other Insurance: _____

Do you have any allergies to:
Drugs ☐ Yes ☐ No
What: _____
_____
Describe Reaction: _____
_____

Foods ☐ Yes ☐ No
What: _____
_____
Describe Reaction: _____
_____

Other ☐ Yes ☐ No
What: _____
_____
Describe Reaction: _____
_____

Medical Diagnosis/Health Problems: _____

_____

_____

_____

Psychiatric Diagnosis: _____

_____

Name	Address	Phone	How often seen?
Family Doctor:			
Psychiatrist:			
Dentist:			
Other Doctors: 1._____ 2._____ 3._____ 4._____			

Medication:
☐ I take medicine myself ☐ I need help taking my medicine

Please tell us about ALL the medicines you are taking including prescription and non-prescription. For example, aspirin or suppositories, as well as dietary supplements such as vitamins.

Medication: _____
☐ Prescription ☐ Non-prescription

Reason Given: _____

How do you take it: _____

Medication: _____
☐ Prescription ☐ Non-prescription

Reason Given: _____

How do you take it: _____

Medication: _____
☐ Prescription ☐ Non-prescription

Reason Given: _____

How do you take it: _____

Medication: _____
☐ Prescription ☐ Non-prescription

Reason Given: _____

How do you take it: _____

Medication: _____
☐ Prescription ☐ Non-prescription

Reason Given: _____

How do you take it: _____
Do you have seizures? ☐ Yes ☐ No
Describe them: _____
_____
How often do you have seizures? _____
How long do they last? _____
What happens after a seizure? _____
What should we do when you have a seizure? _____
_____

Do you use or need any physical health aids?
☐ None ☐ Dentures ☐ Glasses ☐ Hearing Aid ☐ Power Wheelchair

☐ Manual Wheelchair ☐ Walker ☐ Cane ☐ Crutches ☐ Support Crutches

☐ Hospital Bed ☐ Vail Bed

Personal Care

Are you:
Independent (can do it by yourself)
Dependent (need someone to physically help you will all the steps)

Or do you need:
Verbal prompts (someone to talk you through the steps)
Physical assistance (someone to physically help you with some of the steps)

In the following areas:
Dressing: undergarments_____ shirt_____ pants _____
socks_____ shoes _____ coat _____

Special dressing instructions: _____
_____

Bathing: bath tub _____ shower _____ washing hair _____ sponge bath _____
hair grooming _____
I can regulate my own bath water temperature ☐ Yes ☐ No

Special bathing instructions: _____
_____

How often do you like to bathe? _____
Do you bathe in the morning? ☐ Yes ☐ No
Do you bathe in the evening? ☐ Yes ☐ No
Do you undress in the bathroom? ☐ Yes ☐ No
Where do you dress for bed? _____

Things I need to get a good night's sleep: _____
_____

Do you use deodorant? ☐ Yes ☐ No
Do you need help to apply it? ☐ Yes ☐ No

Do you need help brushing your teeth? ☐ Yes ☐ No

For Women:
How often do you have a period? _____
I use: ☐ a pad with belt ☐ tampons ☐ stick-on pad
Do you need help with your period? ☐ Yes ☐ No
Describe help needed: _____
_____

For Men and Women:

I like to shave ☐ Yes ☐ No
I prefer not to shave ☐ Yes ☐ No
Electric razor ☐ Yes ☐ No
Disposable razor ☐ Yes ☐ No
Do you need help? ☐ Yes ☐ No
If yes, how_____
_____

Do you:
Use the bathroom without any help? ☐ Yes ☐ No
If no, what help is needed: _____
_____
_____
Sign to use the bathroom? ☐ Yes ☐ No
Wear disposable undergarments?
1. During the day ☐ Yes ☐ No
2. At night ☐ Yes ☐ No
3. Both ☐ Yes ☐ No

Need reminders to use the bathroom? ☐ Yes ☐ No
Do you have a schedule? ☐ Yes ☐ No
Please list: _____
Any special bowel care? ☐ Yes ☐ No
If yes, please list: _____
_____