

HOW TO USE THE ADVANCE DIRECTIVE/MY PLAN FOR DIFFICULT TIMES

Part of recovery is learning what keeps you strong and what is helpful as you encounter difficulties in your daily life. My Plan for Difficult Times is a tool to support your recovery during crisis. You may guide your treatment during a crisis by planning ahead with your supporters and health providers.

It may also be used as an Advance Directive to direct your mental health treatment if you are not able to guide your own care. If this tool is used as an Advance Directive, you will need to designate a Patient Advocate and have the document signed by two witnesses.

Your decision to create either a Plan for Difficult Times or an Advance Directive for your mental health treatment is strictly voluntary. The law does not require you to do this in order to receive services. This Advance Directive does not qualify for any physical illnesses, accidents or terminal illness.

The intent of this Advance Directive is to assign a Patient Advocate who will direct your mental health treatment. Your Patient Advocate may exercise the power to make mental health treatment decisions only if a physician and a mental health practitioner both certify, in writing and after an examination, that you are unable to give informed consent for mental health treatment.

For your Advance Directive to be in effect it needs to be included in your medical record with your mental health provider. The attached release will allow the Community Mental Health agency to forward your Advance Directive if you are hospitalized.

MY PLAN FOR DIFFICULT TIMES/ADVANCE DIRECTIVE
(This Form is to become part of my Person Centered Plan)

Name: _____ Case #: _____ Date: _____

Address: _____

Personal Doctor: _____

I choose not to follow this form and will write my own plan: _____ Go to page 7.
(Initial)

What I am like when I am feeling well:

Stressors that affect me:

I know that these symptoms/feelings indicate I am moving toward a crisis:

- | | | |
|---|--|---|
| <input type="checkbox"/> Decrease in sleep | <input type="checkbox"/> Not eating for several days | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Increase in sleep | <input type="checkbox"/> Wanting to hurt others | <input type="checkbox"/> Using drug/alcohol to cope |
| <input type="checkbox"/> Fighting with other people | <input type="checkbox"/> Becoming physically ill | <input type="checkbox"/> Feeling unsafe |
| <input type="checkbox"/> Possible loss of housing | <input type="checkbox"/> Not paying my bills | <input type="checkbox"/> Not keeping appointments |
| <input type="checkbox"/> Wanting to hurt myself | <input type="checkbox"/> Not taking my medications | <input type="checkbox"/> Over spending |
| <input type="checkbox"/> Over eating | <input type="checkbox"/> Seeing & feeling things that aren't there | <input type="checkbox"/> Compulsive behavior |

More details: _____

Consumer Name _____

Consumer ID _____

In order to prevent a crisis I will take these actions:

I will call one or more of the following people:

Name	Phone Number
Crisis Line	
Doctor/Physician	

If I need support, I will go to: _____

When I feel unsafe I will: _____

Other things I can do (in-home respite, Crisis Stabilization, talk to my doctor, etc.): _____

My plan for my children, dependents, or pets: _____

Consumer Name _____

Consumer ID _____

If my actions do not improve my symptoms, I want my supporters (named below) to take over responsibility for my care and to make decisions based on the information in this plan.

My Primary Supporter/Patient Advocate has the authority to make mental health care decisions for me. He/She may contact any individuals necessary to obtain the best care for me other than those specifically listed below:

My Primary Supporter/ Patient Advocate is:

Name: _____

Phone: _____

SUPPORTERS

Supporter	Connection/Role	Phone	email-optional

Specific tasks for this person: _____			

Specific tasks for this person: _____			

Specific tasks for this person: _____			

I DO NOT want the following people involved in any way in my care or treatment:

Name I don't want him/her involved because (optional):

Name I don't want him/her involved because (optional):

Consumer Name _____

Consumer ID _____

PLAN IF HOSPITALIZATION IS NECESSARY

Name: _____ Case#: _____ Date: _____

Personal physician who I want notified: _____

Address and Phone: _____

My choice of hospital is: _____

I would like my Primary Supporter/Patient Advocate to be contacted immediately and they will notify my other supporters, **OR** contact the individuals below to activate my plan:

Name	Relationship	Phone Number

I want the hospital to be aware of the following physical/medical conditions as of this date:

Condition	Treating Physician	Medications	Phone Number

I have the following allergies: _____

I smoke I do **not** smoke

My history of surgical procedures and dates:

Treatments:

If I have a choice of medications upon admission, I would like to receive _____

Consumer Name _____

Consumer ID _____

Medications and treatments that have worked best for me in the past are _____

Medications that have not worked for me in the past: _____

Children: Please contact the following individual(s) to help care for my children:

I have listed this person as one of my supporters: Yes _____ No _____

The information I would like you to share with this person about my condition is: _____

The individual listed above will need the following paperwork while caring for my children (for instance, authorization for medical treatment):

Pets: Please contact the following individual(s) to help care for my pets:

I have listed this person as one of my supporters: Yes _____ No _____

The information I would like you to share with this person about my condition is: _____

Other Concerns:

If I am hospitalized more than a couple of weeks, the following items should be considered (e.g., monthly bills):

What needs to be done

Who will make the arrangements

1. _____

2. _____

3. _____

4. _____

The time I have used this plan: _____

Consumer Name _____

Consumer ID _____

CHOOSE ONE OF THE FOLLOWING:

- This plan will be in effect until I choose to update it**
- The plan will be updated before _____**
(date)

Case #: _____

Consumer: _____ Date: _____

Guardian: _____ Date: _____

Case Manager: _____ Date: _____

If this form is to be used as an Advance Directive for mental health treatment, I designate _____ as my Patient Advocate.

Consumer: _____ **Date:** _____

Witness: _____ **Date:** _____

Witness: _____ **Date:** _____

Witnesses may not be a family member nor affiliated with a mental health agency

Acceptance by the Patient Advocate:

I agree to be the Patient Advocate for _____. I understand and agree to take reasonable steps to follow the desires and instructions in this plan.

Patient Advocate:

Sign Name _____

Name _____

Address _____

Home Phone _____ Work Phone _____

Consumer Name _____

Consumer ID _____

CMHSP AUTHORIZATION FOR RELEASE OF THE ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I _____ Date of Birth _____
name of consumer

hereby authorize _____
Name of Community Mental Health Agency

To release my Advance Directive/Plan for Difficult Times to:

- My Primary Care Physician: _____
- If I am hospitalized, to the hospital where I am receiving treatment
- My treating psychiatrist if other than Community Mental Health staff
- My Patient Advocate _____
- Other _____

Specific Purpose of Disclosure is coordination of care with my Patient Advocate.

Method of Disclosure: _____ **Written** _____ **Fax**

I understand that I may inspect or copy the individually identifiable health information or protected health information (PHI) to be used or disclosed. I further understand that I may refuse to sign the authorization.

I understand that I can, at any time, change my decision and revoke my authorization (in writing) for releasing and/or requesting information as noted on this form. This authorization will automatically expire once the purpose for which it was signed is accomplished or by _____; or one year from date of signature.

***Any portions of my clinical record containing information about substance abuse information and/or information about serious communicable diseases or infections (HIV/AIDS, Tuberculosis and Venereal Disease) requires authorizing initials.**

_____ (Consumer Initials)

Consumer/Parent/Guardian Date

Signature of Witness Date

*Information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State law.