Leave completed form in an easy to find place like on fridge. Give copies to family and friends.

Planning Pages©

This planning tool can help you identify the information you need, track your planning and help with a transition of future care by putting all your important information in one place. (Double sided - please check back)

Date: _____ Family Member:_____ Age: _____

DOB:_____ Diagnosis:_____

Medications: _____

Communication Issues: _____

Modifications needed: _____

Likes: _____

Dislikes: _____

Works: _____

Doesn't work:_____

Daily Routine: _____

_____

_____

Independent: _____

Needs help: _____

Community Activities: _____

You can find copies of paperwork such as Individual Service Plan(ISP), Behavior Plan, Medication Reviews, Evaluations etc: _____

_____

Name and relationship of person(s) helping to complete this form:

Name and relationship to person:_____

Email: _____ Phone:_____

Name and relationship to person:_____

Email: _____ Phone:_____

Name and relationship to person:_____

Email: _____ Phone:_____

Form created & provided for you by: Marianne Marts of dba Advocate Arena
joeysupswithdowns@gmail.com **520-591-2007**
www.joeysupswithdowns.com

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Current Services in use:

☐ **AHCCCS** (AZ Health Care Cost Containment System)
Annual Review Month_____

☐ **ALTCS** (AZ Long Term Care) Member ID:_____
Health Care Agency:_____
Doctor:_____Phone_____
Specialist:_____Phone_____
Specialist:_____Phone_____

☐ **Assistive Technology** (Hearing aides, walker, ipad, wheelchair etc.)
Name:_____Phone_____Type:_____
Name:_____Phone_____Type:_____

☐ **Behavioral Health Agency** (Codac, La Fronterra, etc)
Name:_____Phone_____

☐ **Caregiver Support:** (Respite, Hab Providers) Agency: _____
Name:_____Phone_____
Name:_____Phone_____
Name:_____Phone_____

☐ **DDD Support Coordinator**
Name:_____Phone_____

☐ **Guardianship, Conservatorship, Power of Attorney**
Name:_____Phone_____Type:_____
Name:_____Phone_____Type:_____
Attorney:_____Phone_____

☐ **Housing Situation**
Home, Group Home, ADH, IDLA, Apt, Independent -
Agency:_____Phone_____

☐ **Social Security**
SSI, SSA, SSDI
Bank Name:_____ Acct#:_____
Representative Payee:_____Phone:_____

☐ **Therapies/Interventions:** (OT, PT, Speech, Music, Massage)
Therapist:_____Phone_____Type:_____
Therapist:_____Phone_____Type:_____
Therapist:_____Phone_____Type:_____

☐ **Transportation:** (Bus, Bike, Sun Van, Car Service, Private etc)
Agency:_____Phone_____
Regular route: _____

☐ **Others: Funeral Arrangements, Insurance, Trusts & Wills, etc.**
Name:_____Phone_____Type:_____
Name:_____Phone_____Type:_____
Name:_____Phone_____Type:_____

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