Assisted Living Facility with Limited Mental Health License
Community Living Support Plan

Resident's Name: _____

Assisted Living Facility: _____ **Administrator** _____

Address: _____ **Phone#:** _____

Mental Health Provider: _____ **Case Manager:** _____

Address: _____ **Phone #** _____

Emergency Mental Health Numbers: _____

Medicaid Eligible Y/N **Waiver/Type: Y/N**

The specific needs of the resident to enable the resident to live in the assisted living facility:

1. The clinical mental health services to be provided by the mental health provider in order to meet the resident's needs and the frequency and duration of such service:

Service	**Frequency**	**Duration**

2. Other non-clinical services and activities to be provided by or arranged for by the mental health care provider or mental health case manager and the frequency and duration of such services and activities:

Service	**Frequency**	**Duration**

3. The responsibilities of the facility to assist the resident in attending appointments, (e.g. arranging transportation to appointments and activities) and additional supports:

Service	**Frequency**	**Duration**

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4. The special needs of the resident (i.e., substance abuse, head injury, medical, forensic issues) and any precipitating factor which may indicate the need for professional services. _____
_____
_____
_____
_____

5. Identify strategies to diffuse a potential crisis (as report by resident/family and case manager/service provider): Recommend using *Personal Safety Plan*, Form# 3124, at http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws available in English and Spanish and attach to this Plan. _____
_____
_____
_____
_____
_____

6. Identify barriers which may prevent resident from receiving services deemed necessary and plan to eliminate the barriers (i.e., transportation, insurance coverage, location): _____
_____
_____
_____
_____

7. Additional needs or services requested by the resident: _____
_____
_____
_____
_____

_____ _____
Resident's Signature Date Case Manager Date

_____
Administrator's Signature Date