DSHS WASHINGTON STATE Department of Social and Health Services

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Cross System Crisis Plan

TODAY'S DATE	CLIENT'S NAME	DATE OF BIRTH
MENTAL HEALTH AGENCY		TELEPHONE NUMBER
MENTAL HEALTH AGENCY CASE MANAGER OR THERAPIST		TELEPHONE NUMBER
LEGAL REPRESENTATIVE / NSA NAME (Specify relationship)		TELEPHONE NUMBER
RESIDENTIAL SUPPORT AGENCY NAME	TELEPHONE NUMBER	ON-CALL NUMBER
DDA CASE MANAGER/SOCIAL WORKER		TELEPHONE NUMBER

MH and Medical Diagnosis (DSM-5TR)		
	CONTRACT THERAPIST FOR CPP PARTICIPANTS ONLY	TELEPHONE NUMBER
	DOC OR JUVENILE REHABILITATION CONTACT	TELEPHONE NUMBER
	FAMILY CONTACT	TELEPHONE NUMBER
	GENERAL PHYSICIAN / PRESCRIBER	TELEPHONE NUMBER
	MH CRISIS OR WISe TELEPHONE NUMBER	

COMMUNICATION	PREFERRED LANGUAGE
☐ Nonverbal ☐ Picture System ☐ Sound or Gestures ☐ Other Device: ☐ Verbal ☐ Processing delays:	☐ English ☐ Sign Language ☐ Spanish ☐ Other:

LEAST RESTRICTIVE ALTERNATIVE	LRA MONITORING AGENCY	TELEPHONE NUMBER
☐ Yes; expires: ☐ No		

Challenges

VISION / HEARING	SENSORY
MOBILITY	EATING / SWALLOWING CONCERNS

Contact for Updated Medication List (Agency name or staff title if residential provider)

NAME	TELEPHONE NUMBER

Risk Issues (For each box checked, include a brief description of the risk in the box below)

☐ Allergies (Food, Medication, Other)
☐ Medical Conditions
☐ Suicidal Ideation / Gestures
☐ Aggression
☐ Legal Issues
☐ Other:
☐ Eludes Supervision
☐ Sexual
☐ Fire Setting
☐ Substance Abuse
☐ Self-Injurious Behavior

RISK ISSUE NOTES

Symptom / Behavior Description	Action: (Briefly list triggers to avoid; when and who should be called; scripts; for what purpose)

Signatures (Client, legal representative if applicable, DDA plan author) **Plan Expiration Date:**

SIGNATURE	ROLE	PRINTED NAME	TELEPHONE NUMBER

Other Contributors to the Plan (Signature not required)

PRINTED NAME	ROLE	PRINTED NAME	ROLE

Review and Update (if plan requires significant revision, new plan must be developed)

COMMENTS / CHANGES	DATE	SIGNATURE