**CLIENT PERSONALISED CARE AND SUPPORT PLAN**

|  |  |
| --- | --- |
| **My name:** |  |
| **My Address:** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Telephone No:** |  | **Date of Birth** |  | **Age:** |  | **Ref No** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of visit:** |  | **Initial visit plan** | **Yes** | **No** | **Review or**  **Update Plan** | **Yes** | **No** | **Plan start date:** |  |

|  |
| --- |
| **Name of Co-ordinator completing this plan:** |
| **What I want from My Support Plan**  **(Client’ own words)** |
|  |

|  |
| --- |
| **My Support Plan** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **No** | **Areas of expressed need** | **Support & care actions to be undertaken** | **Rationale**  **(Why is this important to me)** | **Outcome**  **(What will be achieved)** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Consent to support**

**Client Signature: ……………………………………………………………………. Date: ………………………………….**

**Unable to sign (Assessor to write UTS or consent by: ………………………………………………………………… Relationship to client: …………………………...**

**(if someone is signing on the client’s behalf, they must show proof of POA and a copy obtained for the office)**

|  |
| --- |
| **My Financial Plan** |

|  |  |
| --- | --- |
| **Type of payment plan** |  |
| **No of allocated hours** |  |
| **Hourly rate** |  |
| **Payroll company** |  |
| **Any other instructions:** | |

**Planned Review schedule: Monthly / Quarterly / Annually / Other (specify or circle one option)**

|  |
| --- |
| **Review of Plan and Outcomes** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Areas of need (quote no from previous page)** | **Comments** | **Update required:**  **YES / NO** | **Signature of Assessor** |
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|  |  |  |  |  |

**Additional Documentation Relating To This Care And Support Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tick if applicable**  **(separate Assessment forms must be completed)** | **Tick (as relevant)** | **Date completed** | **Comments**  **(Alternatively make reference to relevant assessment forms** |
| Personalised Needs Assessment |  |  |  |
| Generic Home Risk Assessment |  |  |  |
| Manual Handling |  |  |  |
| Financial Risk Assessment |  |  |  |
| Medication Assessment |  |  |  |
| Mental Capacity Assessment & Best Interest Decision |  |  |  |
| Other (specify) |  |  |  |
| Equipment (specify) |  |  |  |

**CLIENT PERSONALISED CARE AND SUPPORT PLAN**

Name of Assessor completing this support plan:

Signature of Assessor completing this support plan:

Date:………………………………………………………………………

Name of Client:

Signature of Client: ………………………………………………………………………..

Date of next Review: