**+CLIENT CRISIS PREVENTION/SAFETY PLAN**

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| Agency Name: |
| Client Name/ID (or affix label): | Date: |
| [ ]  *I choose not to do a crisis plan at this time. I understand that I can change this decision at any point.* |

1. What are things like for you (or your child) when things are going okay? (Going to school/work, eating well, getting along with family, etc.) What helps you accomplish that?

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1. What has stressed you, overwhelmed you, or upset you (or your child) in the past?

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1. How would you and/or others know that you (or your child) are stressed/overwhelmed/upset? (What does being in a crisis mean to you?)

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1. When you (or your child) are feeling stressed/overwhelmed/upset, what helps you (or your child) feel better?

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1. Who are your supports and how do they support you? (What is helpful? What is not helpful?)

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1. If you need to involve mental health staff and crisis response professionals, what would be helpful? What would not be helpful? (Where do you start? What will you try next?)

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1. How will you (or your child) know when you are no longer stressed/overwhelmed/upset?

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1. If there is a concern for the safety of self or others, please complete the following two questions. [For children, this is completed with the parent(s)/caregiver(s)]

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* 1. What needs to happen to keep everyone safe? (i.e., Securing medications, sharps, weapons, etc., line of sight, involvement of family members, etc.)

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* 1. If you (or your child) still feel unsafe, what is the next step? (Call 911, go to ER, call crisis line, etc.)

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1. What are some of your clinician’s observations/recommendations to address your safety and health concerns?

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| Client Name/ID (or affix label): | Date: |

Volunteers of America Care Crisis Line:

1-800-584-3578

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| Client Name/ID (or affix label): | Date: |

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| Client or Parent/Guardian Signature:  | Date: |

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| Primary Clinician Signature:  | Date: |

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| Crisis plan reviewed on this date and NO CHANGES were necessary; information is still current and accurate. |  | Crisis Plan reviewed on this date and it was REVISED (if further revisions are needed, a new form should be used). |
| Date: | Clinician Initials: | Client Initials: |  | Date: | Clinician Initials: | Client Initials: |
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