HOW TO USE THE
ADVANCE DIRECTIVE/MY PLAN FOR DIFFICULT TIMES

Part of recovery is learning what keeps you strong and what is helpful as you encounter difficulties in your daily life. My Plan for Difficult Times is a tool to support your recovery during crisis. You may guide your treatment during a crisis by planning ahead with your supporters and health providers.

It may also be used as an Advance Directive to direct your mental health treatment if you are not able to guide your own care. If this tool is used as an Advance Directive, you will need to designate a Patient Advocate and have the document signed by two witnesses.

Your decision to create either a Plan for Difficult Times or an Advance Directive for your mental health treatment is strictly voluntary. The law does not require you to do this in order to receive services. This Advance Directive does not qualify for any physical illnesses, accidents or terminal illness.

The intent of this Advance Directive is to assign a Patient Advocate who will direct your mental health treatment. Your Patient Advocate may exercise the power to make mental health treatment decisions only if a physician and a mental health practitioner both certify, in writing and after an examination, that you are unable to give informed consent for mental health treatment.

For your Advance Directive to be in effect it needs to be included in your medical record with your mental health provider. The attached release will allow the Community Mental Health agency to forward your Advance Directive if you are hospitalized.
MY PLAN FOR DIFFICULT TIMES/ADVANCE DIRECTIVE  
(This Form is to become part of my Person Centered Plan)

Name: _____________________________________ Case #: ___________ Date: ______________

Address: ______________________________________________________________________

Personal Doctor: ________________________________________________________________

I choose not to follow this form and will write my own plan: _______________ Go to page 7.  
(Initial)

What I am like when I am feeling well:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Stressors that affect me:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I know that these symptoms/feelings indicate I am moving toward a crisis:

☐ Decrease in sleep ☐ Not eating for several days ☐ Hearing voices
☐ Increase in sleep ☐ Wanting to hurt others ☐ Using drug/alcohol to cope
☐ Fighting with other people ☐ Becoming physically ill ☐ Feeling unsafe
☐ Possible loss of housing ☐ Not paying my bills ☐ Not keeping appointments
☐ Wanting to hurt myself ☐ Not taking my medications ☐ Over spending
☐ Over eating ☐ Seeing & feeling things that aren’t there ☐ Compulsive behavior

More details:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

NorthCare version2 5-12-05
In order to prevent a crisis I will take these actions:

I will call one or more of the following people:

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone Number</th>
</tr>
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<tbody>
<tr>
<td>Crisis Line</td>
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<tr>
<td>Doctor/Physician</td>
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</tbody>
</table>

If I need support, I will go to: _____________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

When I feel unsafe I will: _________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Other things I can do (in-home respite, Crisis Stabilization, talk to my doctor, etc.): __________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

My plan for my children, dependents, or pets: ________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
If my actions do not improve my symptoms, I want my supporters (named below) to take over responsibility for my care and to make decisions based on the information in this plan.

My Primary Supporter/Patient Advocate has the authority to make mental health care decisions for me. He/She may contact any individuals necessary to obtain the best care for me other than those specifically listed below:

My Primary Supporter/ Patient Advocate is:
Name:__________________________________________
Phone: _________________________________________

SUPPORTERS

<table>
<thead>
<tr>
<th>Supporter</th>
<th>Connection/Role</th>
<th>Phone</th>
<th>email-optional</th>
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</table>
Specific tasks for this person: ___________________________________________________

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<th>Connection/Role</th>
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</table>
Specific tasks for this person: ___________________________________________________

I DO NOT want the following people involved in any way in my care or treatment:

<table>
<thead>
<tr>
<th>Name</th>
<th>I don’t want him/her involved because (optional):</th>
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</table>
PLAN IF HOSPITALIZATION IS NECESSARY

Name: ____________________________ Case#: __________ Date: __________

Personal physician who I want notified: ____________________________

Address and Phone: ____________________________________________

My choice of hospital is: _________________________________________

I would like my Primary Supporter/Patient Advocate to be contacted immediately and they will notify my other supporters, OR contact the individuals below to activate my plan:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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</table>

I want the hospital to be aware of the following physical/medical conditions as of this date:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treating Physician</th>
<th>Medications</th>
<th>Phone Number</th>
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I have the following allergies:__________________________________________

I smoke □ I do not smoke □

My history of surgical procedures and dates:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Treatments:

If I have a choice of medications upon admission, I would like to receive ___________________
Medications and treatments that have worked best for me in the past are ____________________
______________________________________________________________________________

Medications that have not worked for me in the past: ________________________________
______________________________________________________________________________

**Children:** Please contact the following individual(s) to help care for my children:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I have listed this person as one of my supporters: Yes ______ No ________
The information I would like you to share with this person about my condition is: ____________
______________________________________________________________________________
______________________________________________________________________________

The individual listed above will need the following paperwork while caring for my children (for instance, authorization for medical treatment):
______________________________________________________________________________
______________________________________________________________________________

**Pets:** Please contact the following individual(s) to help care for my pets:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I have listed this person as one of my supporters: Yes ______ No ________
The information I would like you to share with this person about my condition is: ____________
______________________________________________________________________________
______________________________________________________________________________

**Other Concerns:**

If I am hospitalized more than a couple of weeks, the following items should be considered (e.g., monthly bills):

<table>
<thead>
<tr>
<th>What needs to be done</th>
<th>Who will make the arrangements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
<td></td>
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<tr>
<td>3.</td>
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<tr>
<td>4.</td>
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</tr>
</tbody>
</table>

The time I have used this plan: ________________________________
See the attached page six (6) for further instructions:  Yes _______  No _______

Further instructions for difficult times: ____________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

CHOOSE ONE OF THE FOLLOWING:

- This plan will be in effect until I choose to update it
- The plan will be updated before _________________________

    (date)

Case #: ___________________________________________________

Consumer: ________________________________________________ Date: _______________
Guardian: ________________________________________________ Date: _______________
Case Manager: _____________________________________________ Date: _______________

If this form is to be used as an Advance Directive for mental health treatment, I designate ______________________________ as my Patient Advocate.

Consumer: _______________________________________________ Date: _______________
Witness: _________________________________________________ Date: _______________
Witness: _________________________________________________ Date: _______________

Witnesses may not be a family member nor affiliated with a mental health agency

Acceptance by the Patient Advocate:
I agree to be the Patient Advocate for _______________________. I understand and agree to take reasonable steps to follow the desires and instructions in this plan.

Patient Advocate:
Sign Name_______________________________________________
Name___________________________________________________
Address__________________________________________________

_________________________________________________________

Home Phone________________ Work Phone_____________________
CMHSP AUTHORIZATION FOR RELEASE OF THE ADVANCE DIRECTIVE FOR MENTAL HEALTH TREATMENT

I ______________________________ Date of Birth _________________________

name of consumer

hereby authorize_________________________________________________________

Name of Community Mental Health Agency

To release my Advance Directive/Plan for Difficult Times to:

☐ My Primary Care Physician: __________________________________________

☐ If I am hospitalized, to the hospital where I am receiving treatment

☐ My treating psychiatrist if other than Community Mental Health staff

☐ My Patient Advocate __________________________________________

☐ Other ______________________________________________________

Specific Purpose of Disclosure is coordination of care with my Patient Advocate.

Method of Disclosure: _____Written   _____Fax

I understand that I may inspect or copy the individually identifiable health information or protected health information (PHI) to be used or disclosed. I further understand that I may refuse to sign the authorization.

I understand that I can, at any time, change my decision and revoke my authorization (in writing) for releasing and/or requesting information as noted on this form. This authorization will automatically expire once the purpose for which it was signed is accomplished or by ___________________________; or one year from date of signature.

*Any portions of my clinical record containing information about substance abuse information and/or information about serious communicable diseases or infections (HIV/AIDS, Tuberculosis and Venereal Disease) requires authorizing initials. __________________________ (Consumer Initials)

_________________________  __________________________
Consumer/Parent/Guardian   Date   Signature of Witness   Date

*Information disclosed pursuant this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State law.