+CLIENT CRISIS PREVENTION/SAFETY PLAN

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?

   _____

   _____

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

   _____

   _____

3. 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?)

   _____

   _____

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

   _____

   _____

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

   _____

   _____

6. 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?)

   _____

   _____

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

   _____

   _____

8. 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)]

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

      _____

      _____

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

      _____

      _____

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

_____

_____

Client Name/ID *(or affix label)* _____	***Date:***

Volunteers of America Care Crisis Line: 1-800-584-3578

Client Name/ID *(or affix label)* _____	***Date:***

_____ _____

Client or Parent/Guardian Signature *Date*

_____ _____

Primary Clinician Signature *Date*

Crisis plan reviewed on this date and NO CHANGES were necessary; information is still current and accurate.
Date: _____ Initials: _____ clinician _____ client
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Crisis Plan reviewed on this date and it was REVISED (if further revisions are needed, a new form should be used).
Date: _____ Initials: _____ clinician _____ client
Submit to Data Entry after revised **Data Entry completed:** _____/_____/_____(Date) _____ (Initial)