IMPORTANT CARE INFORMATION

Place this sheet in an accessible location.

ACA/NY ADVANCE CARE ALLIANCE

Member Information

Name: _____ *Receives OPWDD supports & services

Takes medication: ☐ Yes ☐ No Medication location: _____ Allergies: _____

Mobility Support: ☐ Wheelchair ☐ Walker ☐ Gait Belt ☐ Other

Communication Support: _____

Personal Contacts

In an emergency, contact the support team below:

Emergency Contact: _____ Relationship: _____ Phone: _____

Additional Important Personal Contacts (family members, friends, health care agent)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Care Management Information

ACA/NY Customer Service Center: Call 1-833-692-2269 for 24/7 Care Management support.

Support Team Contacts (Support Broker, CDPAP, Community Habilitation, Respite staff, NYSTART/CSIDD, Behavior Therapist)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Other Information

Medicaid #: _____ Medicare #: _____ Other Insurance: _____

Primary Care Physician's (name/phone/address): _____

Psychiatrist (name/phone/address): _____

Pharmacy (name/phone/address): _____

Preferred Hospital (name/address): _____

Plans in place attached to this sheet: ☐ Life Plan ☐ Behavior Plan ☐ Plan for Protective Oversight

Other Important Information to know about me: _____