ALL ABOUT ME

Place this sheet in an accessible location.

Member Information

Name: _____ *Receives OPWDD supports & services

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

Mobility support: Wheelchair Walker Gait belt Other

Communication support: _____

Other important information to know about me: _____

_____

_____

Personal Contacts

In an emergency, contact the support team below:

Emergency contact: _____ Relationship: _____ Phone: _____

Additional important personal contacts (family members, friends, neighbors)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Care Management Information

ACANY Customer Service Center: Call 1-833-692-2269 for 24/7 Care Management assistance.

Support team contacts (support broker, CDPAP, community habilitation, respite staff, NYSTART/CSIDD, 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: Life Plan Behavior Support Plan Plan for Protective Oversight