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: _______________________________________

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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

ACA/NY 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

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