

CRISIS PLAN FOR CARE OF CHILDREN

By the INVISIBLE CHILDRENS' PROJECT – Mental Health America of Hawai'i

Name of Case Manager: _____ Date: _____

Case Manager's e-mail: _____ cell _____

Agency: _____

CLIENT NAME: _____

ADDRESS: _____

PHONE NUMBER(S) _____

EMAIL: _____ CLIENT GENDER: MALE _____ FEMALE _____ OTHER _____

Client's marital status: MARRIED/LIVING WITH PARTNER _____ SINGLE _____

Does someone have a POWER OF ATTORNEY? _____ NO _____ YES,

If yes, who and for what purposes?: _____

1) How many children under the age of 18 do you care for or are responsible for? _____

2) Do your children live at home with you?

_____ Yes, all the time. _____ Yes, some of the time.

_____ No, they live with: _____ Relationship: _____

3) Who else lives in the household with the children?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

4) Child(ren)'s pediatrician or clinic: _____ Phone _____

If your child does not have a pediatrician, where are his/her medical records located?

Name: _____ Phone: _____

5) Does your child have health insurance? If yes: Name _____

Policy #: _____

6. Who do you want to care for your child(ren) in case you are unable to do so or if you require hospitalization?

First: Name _____ Relationship _____
(spouse, friend, family, neighbor, partner, other)

Phone Number(s) _____

Has this person agreed to take care of your children? Yes _____ No _____

Back-up: Name _____ Relationship _____
(spouse, friend, family, neighbor, partner, other)

Phone Number(s) _____

Has this person agreed to take care of your children? Yes _____ No _____

7. Is Child Welfare Services or Child Protective Services involved with your family? YES ____ NO ____

Are you in VOLUNTARY CASE MANAGEMENT? YES ____ NO ____

Who is the Case Manager to be notified? _____ Phone: _____

8. Please list any special needs and regular bedtime the child may have:

Child's Name: _____ Bedtime: _____

Medical needs (medication, allergies, disabilities): _____

Emotional/Behavioral Concerns: _____

Child's Name: _____ Bedtime: _____

Medical needs (medication, allergies, disabilities): _____

Emotional/Behavioral Concerns: _____

Child's Name: _____ Bedtime: _____

Medical needs (medication, allergies, disabilities): _____

Emotional/Behavioral Concerns: _____

(use back of sheet for additional children)

Below is information regarding my children, who will be responsible for them in the event that I am unable, and any special needs that each child may have.

Child's name	Date of Birth	School or Day Care or After School Program	Time child is in program	Teacher or Program Caregiver Name/Phone number	Who picks up Child? Name and Phone #
	DOB M - F		From: _____ To: _____	Name _____ Phone # _____	Name _____ Phone # _____
	DOB M - F		From: _____ To: _____	Name _____ Phone # _____	Name _____ Phone # _____
	DOB M - F		From: _____ To: _____	Name _____ Phone # _____	Name _____ Phone # _____
	DOB M - F		From: _____ To: _____	Name _____ Phone # _____	Name _____ Phone # _____
	DOB M - F		From: _____ To: _____	Name _____ Phone # _____	Name _____ Phone # _____
	DOB M - F		From: _____ To: _____	Name _____ Phone # _____	Name _____ Phone # _____

Any other concerns about or needs of your children? _____

Questions? Please call Marya Grambs at 521-1846 or email at marya@mentalhealth-hi.org