MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

SAFETY PLAN

ELIGIBLE ADULT NAME

LIST HOUSEHOLD MEMBERS (INDIVIDUALS PRESENT)

QUESTIONS TO ASSESS SAFETY

1. ARE YOUR ESSENTIAL NEEDS MET, SUCH AS FOR FOOD, WATER, ELECTRICITY, AND MEDICAL CARE?

☐ YES ☐ NO IF NO, DESCRIBE WHAT NEEDS ARE NOT MET.

2. DO YOU FEEL SAFE IN YOUR HOME?

☐ YES ☐ NO IF NO, DESCRIBE THE SITUATION.

3. IS THERE ANYONE WHO LIVES IN OR VISITS YOUR HOME THAT MAKES YOU FEEL UNCOMFORTABLE OR UNSAFE?

☐ YES ☐ NO IF YES, DOCUMENT WHO MAKES HIM/HER FEEL UNSAFE AND DESCRIBE THE SITUATION.

4. ARE YOU ABLE TO CARE FOR YOURSELF AND PERFORM ACTIVITIES OF DAILY LIVING WITHOUT ASSISTANCE?

☐ YES ☐ NO IF NO, DESCRIBE UNMET NEEDS.

5. DO YOU CURRENTLY RECEIVE ASSISTANCE IN YOUR HOME?

☐ YES ☐ NO IF YES, LIST NAME OF AGENCY/CAREGIVER.

WHAT TYPE OF ASSISTANCE ARE YOU RECEIVING AND ARE THEY MEETING YOUR NEEDS?

6. DESCRIBE THE SAFETY PLAN DEVELOPED WITH THE ELIGIBLE ADULT/AUTHORIZED PERSON. *(INCLUDE ACTION ON ANY UNMET NEEDS IDENTIFIED ABOVE.)*

☐ **NO SAFETY CONCERNS**

ELIGIBLE ADULT/AUTHORIZED PERSONS SIGNATURE	DATE

☐ **Refused/Unable to participate** ☐ **Agrees to the plan but chooses not to sign or unable to sign**

APS STAFF SIGNATURE	DATE