MY DISABILITY MANAGEMENT PLAN

CLIENT INFORMATION:

CLIENT FIRST NAME:		CLIENT LAST NAME:	
EPBC CASE #:		PHONE:	
ADDRESS:			
PRIMARY DISABILITY:			
Details:			
SECONDARY DISABILITY:			
Details:			

TRIGGERS & SUPPORTS IDENTIFICATION:

Signs that suggest I am doing well:	1.	
	2.	
	3.	
	4.	
Events or situations that triggered relapses in the past:	1.	
	2.	
	3.	
	4.	
Early warning signs that I experienced in the past:	1.	
	2.	
	3.	
	4.	
Effective ways I can cope if I experience early warning signs: *(i.e. ways you can manage stress, regain balance, or calm yourself)*	1.	
	2.	
	3.	
	4.	
What early warning signs indicate I need help from others:	1.	
	2.	
	3.	
	4.	

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Who can I call or reach out to, to help me:		Name	Phone	Email
	1.			
	2.			
	3.			
	4.			

Why have I chosen these people or resources:		Name	Assistance they can provide?
	1.		
	2.		
	3.		
	4.		

DISABILITY MANAGEMENT & RELAPSE PREVENTION STEPS:

It is my goal to find and maintain employment. As soon as I experience early warning signs of a relapse, I will commit to the following steps in order to improve my chances of avoiding relapse and maintain employment:

1.
2.
3.
4.
5.
6.
7.
8.

____
Client Signature

____
Vocational Counsellor Name

____
Date

____
Vocational Counsellor Signature

____
Date