Health Home	CNY
Care Management Agency	_____
Patient Name	_____
Gender	_____
Date of Birth	_____
Medicaid ID	_____
NYS ID	_____
Home Phone	_____
Cell Phone	_____
Other phone	_____
Primary address	_____
Other address	_____

SAFETY PLAN

1. **Warning signs (thought, images, mood, situation, behavior) that a crisis may be developing** *

2. **Things I can do to take my mind off my problems without contacting another person** *

3. **People whom I can ask for help (Name, relationship, contact information)** *

4. **Professional agencies I can contact during a crisis (Name, relationship, contact information)** *

5. **Clinician or Physician Name (Name, relationship, contact information)** *

6. **Local Urgent Care Services (name, address, phone number)** *

7. **Other (MCO Nurse HELPLINE, Suicide prevention hotline, MCAT, etc.)** *