

SEDGWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION

Person Centered Support Plan Review

Name of Individual Reviewed: _____

PCSP Date: _____

Names of Reviewers: _____

Date reviewed: _____

<i>Areas to Consider</i>	<i>Present</i>	<i>Not Present</i>	<i>Comments</i>
Plan approval signed by guardian or consumer			
Description of type of setting person wants to live in			
Description of with whom the person wants to live			
Description of what work or other valued activity the person wants to do			
Description of with whom the person wants to socialize			
Description of the social, leisure, religious or other activities in which the person want to participate			
The plan lists and describes necessary activities, training, materials, equipment, assistive technology & services			
Health and medical needs are addressed			

Name of individual reviewed: _____

Behavior support needs are addressed			
Evidence of consideration of self advocacy training or support needs			
Describes opportunities for choice			
Identifies a lead coordinator for the plan development and health care			
Plan is regularly reviewed and revised			
Behavior Support plan is in place if necessary			
Psychotropic Medication plan is in place if necessary			

Other Comments: _____

