Name____________________________

SEDWICK COUNTY
DEVELOPMENTAL DISABILITY ORGANIZATION

Supportive Home Care for Adults

If the person uses a communication method other than verbalization, please indicate how these questions were answered (i.e. family/staff answered questions, person indicated with non-verbal cues, etc.)

____

Individual and/or Family Review:

1. Is there anything you would change about where or with whom you are living? YES NO
   If yes, what?____

2. Is there anything you would change about what you do during the day? YES NO
   If yes, what? ____

3. I understand that you like to
   ____
   ____
   (List preferred activities from PCSP)

4. I understand you like to spend time with __________________________________
   (List from PCSP)
   Do you get to spend as much time with them as you like? YES NO
   If no, why? ____

5. Do you go shopping for things that you need? YES NO
   If no, who does?____________________Are you OK with that?__________

6 If you don't like what you're having for a meal, do you have other choices? YES NO
   If no, explain ____

7. What do you do:
   a. In case of a tornado?__________________________________
   b. In case of a fire?__________________________________
   c. In case the electricity goes out?__________________________________
   d. If someone hurts/mistreats/is mean to you?__________________________
   e. If you are hurt/sick?__________________________________
   f. If your staff does not show up for work?__________________________

8. Tell me what goals you are working on. ________________________________
   ____

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Name____________________________

Do you have any questions or is there anything else that you would like to tell me?____________________
____

Staff Review

Staff Name: ____
How long has staff been working with this individual? ____
How long has staff been working for this agency? ____

1. Does this person:
   a. Have special diet needs? (calorie, modifications, allergies) YES NO
      If yes, what?____
      Is this per doctor's order? YES NO
      If no, where did you learn about the diet needs? ____
      Is he or she OK with this diet? YES NO
      What do you do if the person refuses to follow the diet?___________________________________

   b. Have health needs? YES NO
      If yes, what?____
      How do you accommodate them?____

   c. Have a notable impairment which requires additional assistance? YES NO
      If yes, what? (allergy, loss of hearing or vision, etc.) ______________________________________
      How do you accommodate them? ____
      ____
      How did you learn about this? ____

   d. Have any restrictions? YES NO
      If yes, what? ____
      Is this addressed in the person's plan? YES NO
      Is it approved by the Behavior Management Committee YES NO

   e. Have behavior needs? YES NO
      If yes, what?____
      How do you handle them?____

   f. Have a Behavior Plan? YES NO
      If yes, have you received training on how to implement the plan? YES NO

   g. Take psychotropic medications? YES NO
      If so, what are the potential side effects or where do you go to find them?
      ____

2. Have you received a copy of the PCSP? YES NO

3. Tell me about the individual's goals. ____
   ____

Name______________________________

4. What do you do:
   a. In case of a tornado?____
   b. In case of a fire?____
   c. In case of a power outage?_______________________________________
   d. If the next shift does not show up for work?_____________________
   e. If you suspect abuse, neglect or exploitation?___________________

5. Do you know how to make an ANE report directly to APS?______________

Do you have any questions or is there anything else that you would like to tell me?

____
____
____

Reviewer's Observations

As a reviewer, do you feel:				IF NO, EXPLAIN.
a. Interactions were positive between the parent/family and the person?	YES	NO	N/A	______________
b. Interactions were positive between the staff and the person?	YES	NO	N/A	______________
c. The person expressed his/her own opinions?	YES	NO	N/A	______________
d. The property is reasonably clean and well maintained?	YES	NO		______________
e. The property is safe and secure?	YES	NO		______________
f. There is adequate lighting inside and out?	YES	NO		______________
g. There is adequate space?	YES	NO		______________
h. The home is accessible to meet the person's needs?	YES	NO		______________
i. The services are consistent with the PCSP?	YES	NO		______________

If no, what needs to change? ____

Kudos (positive observations that the reviewer has noted about the staff, the person receiving services, the home, etc): ____
____
____

Comments/Concerns:____
____
____