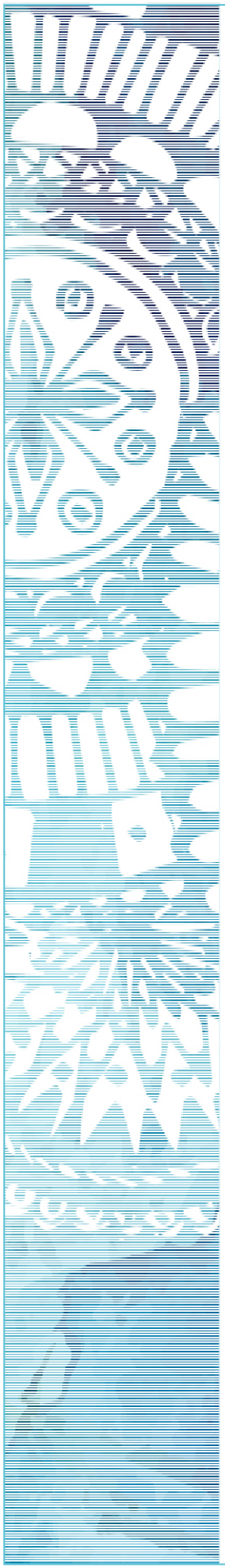

Rhode Island
Person-Centered Thinking Guide

Paul V. Sherlock Center on Disabilities, Rhode Island College
Rhode Island Division of Developmental Disabilities

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Purpose of this Guide

The purpose of the *Person-Centered Thinking Guide* is to help people, their families and friends, the people who support them, and all community members to implement a meaningful person-centered process and to provide person-centered services and supports.

The *Guide* is divided into five sections.

It begins with an **introduction** that explains the values and practices that are the foundation for Person-Centered Thinking. There is a diagram that illustrates the **steps in the process** and a description of the **core structural components of a Person-Centered Process** and the **quality indicators** supporting each component.

The process of developing a person-centered life plan is broken into **three phases**. There is an **implementation checklist** that is intended to help the person and facilitator determine that the components and quality indicators have been met. There is a **description of each component** with a few **examples** and a few core **resources**. Additional resources are listed at the end of the *Guide*.

Phase 1 focuses on **preparing for the plan.** This phase includes selecting a facilitator/advisor; preparing the person to fully and actively participate in the process; identifying and mapping community opportunities and resources; having a pre-meeting to determine topics to be discussed and topics not to be discussed and selecting a place and time for the meeting; and assembling the person's unique team.

Phase 2 focuses on **the planning meeting.** This phase includes developing a personal profile; selecting life directions or goals; action planning for each goal; selecting a format for the plan that matches the person's preferences and strengths; and identifying other resources that can support implementation of the plan.

Phase 3 focuses on **developing the plan.** This phase includes developing life directions or goals that are measurable; developing a strategy that allows the person to see his/her own progress; describing safety considerations; developing a schedule for reviewing the plan; obtaining signatures; and developing the CMS/BHDDH Plan of Care.

Introduction – What is Person-Centered Thinking?

Person-Centered Thinking is a set of values, skills, and tools that puts the person at the center of every aspect of life. It is not a plan or a form……but is a process through which each person:

- thinks about the experiences he/she wants to have in life or the goals he/she wants to accomplish;
- takes time to discover and learn about those goals and those experiences – where they happen, what really happens there, what skills are needed, what supports might be needed, how to get there, and other factors;
- develops a plan to reach his/her goals or to have those experiences;
- acts on that plan (maybe with the help of others); and
- reflects on what he/she has learned or achieved.

Any service or support is, after all, about the person.

Person-Centered Thinking is the basis for person-centered planning. If we don't really understand the person, plans will be more about the service or support provider than about the person. If the person is not at the center of every activity, then most likely the plan will not be really meaningful to that person. Goals or experiences that are set by the person are more likely to be achieved than plans that are developed for the person.

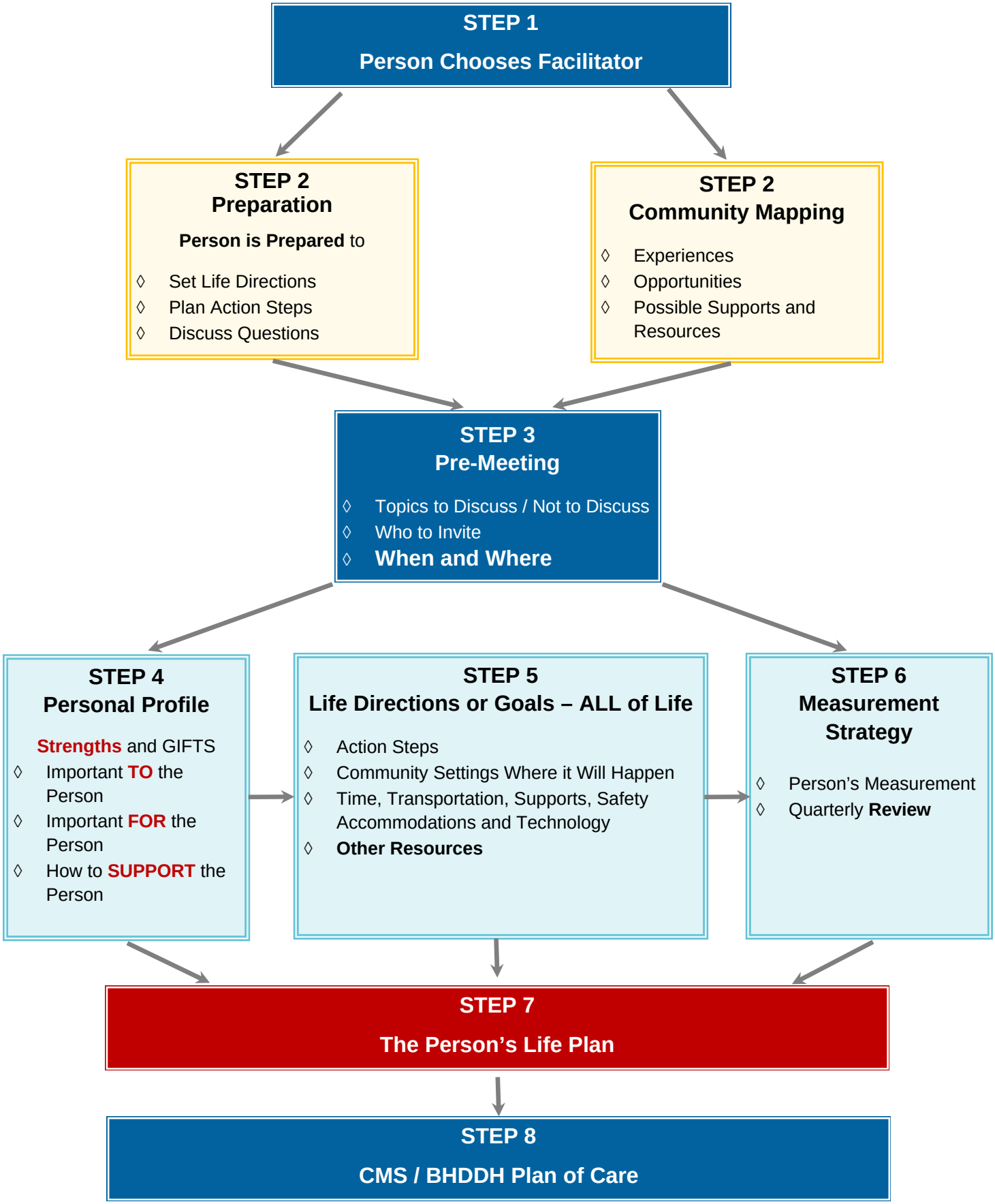
Through Person-Centered Thinking each person takes greater **control of his/her life**. To be more in control each person needs to learn how to participate more fully in the planning process. Each person:

- needs to have an increasing amount and variety of life experiences so that he/she knows what he/she wants to do;
- needs to be fully prepared for any meeting or planning and be able to talk about the questions or topics that come up;
- needs to learn how to think about how to achieve that goal or have that experience and needs to be able to communicate the goal or life experience in a way that makes sense for him/her.

Through Person-Centered Thinking each person thinks about **all of life**……not just the services or supports that are paid for with public funds. Each person needs a plan for where to live, developing and maintaining relationships with a variety of people, what jobs or careers he/she wants to try, how to have fun, how to stay healthy, how to get around the community, and anything else that is important to each person.

Person-Centered Thinking is about **being in the world**. To be in the world, each person needs to know about the communities in which they live.

Through Person-Centered Thinking each person (and their trusted family, friends, and supporters) learns about the opportunities and supports that are available in their communities. Belonging to community organizations is a very effective way of increasing the person's presence in the community and increasing the kinds of opportunities and experiences available to the person. The most successful plans use a combination of both publicly funded supports and community supports.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Although **there is no one way** to do this, we know that there are components of a person-centered process that need to occur for Person-Centered Thinking to change the person's life.

The *Guide*:

- lists those components,
- provides a brief explanation of each component,
- gives examples of a few ways to implement each component,
- provides some resources, and
- provides a checklist that helps the person and his/her team implement a true Person-Centered Process.

The next few pages list all the components of the Person-Centered Process and the descriptors that indicate that the process is being implemented with quality. Following that list, each component is discussed in detail. Some of the components have examples and resources.

There are also three checklists to help the person (and his/her facilitator/advisor and other team members) review if they have completed all the steps. The three checklists are:

- Preparation (Components 1-5)
- The Planning Meeting (Components 6-9)
- Plan Writing (Components 8, 10-14)

Several of the resources in this Guide contain links. There is a "Person-Centered Thinking" page on the Paul V. Sherlock Center website (www.sherlockcenter.org) where those links are live. This guide and the other resources listed in the guide can also be found on that website page.

A complete person-centered plan would include:

- Indicators that the person is prepared to actively participate in planning;
- Knowledge of community opportunities and experiences that would expand the person's life experiences and match strengths, interests, preferences, and needs;
- A personal profile;
- Plan details for each area included in the plan (current experiences, statement of goal or life domain expectations, action steps, and implementation details);
- Measurement strategies;
- Description of strategies and supports to keep the person safe (if needed);
- Schedule for review.

Person-Centered Process Structural Components

	Quality Indicators
1. Person has a qualified **facilitator/advisor** of his/her choosing	Person has a choice (more than one) of a qualified facilitator/advisor.
	Facilitator/advisor has participated in a training series. Facilitator/advisor understands role and responsibility. Facilitator/advisor has direct experience providing formal or informal support to people. Facilitator/advisor is not connected to an agency that provides direct service to the person. Facilitator/advisor is accountable to the person.
2. **Person is prepared to actively participate** in the planning process	Person is increasing in his/her ability to **self-determine** – i.e., knows how to set a direction or goal in life domains of his/her choice and how to problem solve about steps towards that and goal.
	Person is learning **strategies for participating** in the planning.
	Pre-planning – **personal preferences and interests**. Individual has met with facilitator/advisor (and other trusted ally of individual's choosing) to discuss (a) areas to be included in the discussion/ planning and (b) areas NOT to be included.
	Person and facilitator/advisor (and trusted allies) should **review life domains**. (Several tools exist for doing this.)
	Person and facilitator/advisor (and trusted allies) **summarize individual's experience** in each of the life domains chosen for discussion. (Note – this can serve both as baseline and as documentation of what additional discovery is needed…and is led by the individual with supports and prompting as needed).
3. Preparation – **Community Mapping**	Based on the life domains identified during pre-planning, the facilitator/advisor has (a) **identified resources and opportunities in the community** where the person lives (and broader communities), (b) identified individuals or organizations that match the individual's preferences and interests.

	Quality Indicators
4. Preparation – **Preliminary Meeting** Decide on topics to be discussed and topics not to be discussed. Select date, time, and place.	The person, the facilitator/advisor, and other trusted allies and friends have a preliminary meeting. • Outline the major topics to be discussed • Identify the topics the person does **NOT** want to be discussed • Selects community location, date, and time for the planning meeting.
5. Assemble the **Team**	Person, facilitator/advisor, and trusted allies select who will be invited. Possible attendees include: • Family members • Friends • Support Staff • Community Members connected to individual's interests and preferences • DDD staff • ORS staff • Others Person and Facilitator/advisor invite attendees.
6. Develop **Personal Profile**	Person and team answer these questions: • Things that others like and admire **ABOUT** me • Things that are important **TO** me • Things that are important **FOR** me • How to **SUPPORT** me *(There are several tools for developing and describing individual's strengths and interests).* Incorporate family context and cultural considerations.

	Quality Indicators
7. Develop **the plan**	Each life domain identified during preparation is discussed. A direction or goal is established for each domain. Actions to be taken to move towards that goal are listed. For each step identify: • The specific location - **WHERE** • The time – **WHEN** • **Accommodations and technology** needed • **Supports** Needed • How the person will get there - **transportation** • Who is **responsible** for ensuring the step happens?
	If the person and the team decide **more exploration or discovery** is needed, for each experience identify: • The specific location - **WHERE** • The time – **WHEN** • **Accommodations and technology** needed • **Supports** Needed • How the person will get there - **transportation** • Who is **responsible** for ensuring the experience actually happens? *Note* – there are multiple tools available for conducting and facilitating the planning. The facilitator/advisor uses one of these or a combination.
	The Rhode Island Consent Decree requires domains – (a) career development and (b) participation in meaningful activities in integrated community settings.
8. **Format of the Plan** is individualized to the person's mode of communication	Person and facilitator/advisor select a plan format that is **comfortable for the individual.** *Note* – there are countless formats for expressing the plan. The Person-Centered Thinking page on the Sherlock Center website provides examples, including formats developed by individuals, formats developed by service providers, formats developed by special education teachers, and formats from national projects.

	Quality Indicators
9. **Resources** are identified and described. How resources will be accessed is defined. Who will facilitate access to each resource will be identified.	A comprehensive life plan requires the **blending of many resources**. These include: • Waiver Funding • Other Medicaid Funding • ORS Funding • Assistive Technology • Housing Supports • Other Means Tested Supports • Community Resources • Other As the plan for each life domain or goal is being developed, individual and team members **discuss all possible resource options** as they relate to each domain. How resources will be **accessed** is defined. **Who** will facilitate access to each resource will be identified.
10. Life directions and/or goals are **measurable**.	Outcomes can be described in either **quality** or **quantity** terms. (Note – there are multiple strategies for measuring individual change – the "Guide" discusses these.)
11. Each person has a strategy for measuring their own progress and growth.	Person and facilitator/advisor select a measurement format for each life direction or goal that is comfortable for the individual. *(Note – although there are multiple strategies for doing this, a simple **"Goal Attainment Scale"** in the individual's preferred communication mode is preferred.)* Person and facilitator/advisor select a strategy for expressing **satisfaction** that is comfortable for the individual.
12. Description of Safety Considerations as applicable	If there is risk or safety concern involved in the life domain or goal, it is described in language that is comfortable for the individual.
13. Schedule for Review	Quarterly reviews are expected. Dates are specified.
14. Signature Page	Person has signed. Others with defined responsibility have signed.
15. CMS/BHDDH Plan of Care and other Attachments as required	

Phase 1
Preparing for the Plan
Components 1 – 5

Phase 1 Implementation Checklist
Preparing for the Plan

Have I selected a facilitator/advisor?	
Has anyone met with me to help me prepare for my plan?	
Has my facilitator/advisor or someone else helped me prepare to talk about things I want to do (goals or life directions) and what steps I need to take to do those things?	
Has anyone met with me to help me know how to answer all the questions that I will be asked?	
Has anyone helped me develop a list of all the activities and opportunities that are available in the communities where I spend time? Has anyone travelled around those communities with me to learn about new opportunities and experiences?	
Has anyone helped me think about the people I know? Has anyone helped me make a relationship map?	
Has anyone helped me think about my interests and how the experiences and opportunities and people match my interests?	
Has anyone helped me make a list of what things I can do by myself? What my family and friends can help me do? What other community people (from my relationship map) can help me do? What other community resources might help me? For what activities I need paid staff?	
Have I met with my facilitator/advisor to make a list of what I want to talk about and what I don't want to talk about in my plan?	
Have we picked a place and set a time for my planning meeting/s?	
Have I decided who I want to come to my planning meeting/s?	
Has my facilitator/advisor or someone else suggested other community people who know about things I am interested in?	
Have I invited all the people who I want to come to my planning meeting/s?	

Component 1
Person has a Qualified Facilitator/Advisor of his/her Choosing

It is essential that the facilitator/advisor of the process does not work for and is not affiliated with any agency providing support to the person. An independent facilitator's only commitment should be toward helping the person build a life that makes sense for them. As the facilitator helps identify supports to help make that happen, he/she needs to be free of any biases and be guided only by the person and their identified goals and support needs.

The requirements, skills, knowledge, and experience for an advisor / facilitator are listed below, along with expected roles and responsibilities. Some people who might have these qualities and make good facilitators could be family members (although not facilitators for their own family member); teachers or other professionals not working for an agency where the person receives support; retired professionals; and other community members with direct experience with disability. People may identify others who have these qualities to become trained as advisors/facilitators as well.

General Requirements:

- Facilitator/advisor has experience working with people with intellectual or developmental disabilities.
- Facilitator/advisor has participated in a training series.
- Facilitator/advisor is **NOT** connected to an agency that provides direct service to the person.
- Facilitator/advisor understands his/her role and responsibilities.

Skills/Qualities/Experience:

- Has a positive, upbeat, open attitude
- Has knowledge and real life experience with people who have intellectual and developmental disabilities
- Skilled at communicating with people who have intellectual and developmental disabilities
- Has a strong sense of social justice
- Supports self-determination, freedom, civil rights, and human rights
- Is a strong advocate for people with disabilities
- Demonstrates empathy
- Uses creative, non-traditional approaches to solve problems
- Is connected within her/his community and is familiar with available resources
- Is a clear, concise communicator and facilitator
- Cooperates effectively with people, families, providers, and state agencies
- Builds relationships with people, their families, and their communities
- Makes a personal commitment to those supported
- Knows how to lead
- Knows how to listen to the different ways people communicate
- Has respect for the cultural values of others
- Has a sense of humor
- Shows joy in her/his work
- Is comfortable working a flexible schedule

Role/Responsibilities:

- Spend time getting to know the person and their trusted allies well.
- Help the person identify other people who they want to help them plan.
- Use strategies to help the person prepare for and participate more fully in planning.
- Bring the planning team together.
- Help create a plan that builds on the person's strengths and capacities focused on what is important to and for them.
- Ensure that the person's voice is heard in the planning process.
- Use strategies that help the person to develop a plan and express his/her goals and life directions.
- Ensure that the selected family and friends have a say in the planning process.
- Ask questions that help explore a lot of different possibilities.
- Research and share information about resources in the community.
- Develop strategies for involving the person in his/her community.
- Ensure that the plan includes goals with clear action steps – who will do what, by when.
- Create a record of the plan that the person can understand.
- Use strategies that help the person and others measure progress and/or changes.
- Help make sure that people are following through with responsibilities.

Examples of who might be a facilitator/advisor - Some people who might have these qualities and make good facilitators could be:

◊ family members (although not facilitators for their own family member);

◊ teachers or other professionals not working for an agency where the person receives support;

◊ retired professionals;

◊ friends or other community members with direct experience with disability.

Component 2
Person is Prepared to Actively Participate in the Planning Process

Being ready to fully participate in the planning process is very important. Too many people did not have a meaningful role in developing their plans and do not know what is in their plans. The lives of many people are directed by others. Goals or experiences that are set **by the person** are more likely to be achieved than plans that are developed for the person. There are four important strategies that increase each person's ability to participate in the planning process.

First, each person and his/her facilitator/advisor needs to understand how the person communicates, how the person receives information, and how the person gives information. The person and his/her facilitator/advisor need to explain that to all others who will participate in the planning process and have the responsibility to ensure that all others are respectful of that.

Second, each person needs to become more self-determined. That means each person knows how to set their own goals and/or life directions, knows how to plan and take action, and knows how to review if they achieved their goal. There are three phases to this process.

- **Phase 1 – Setting a Goal or Life Direction**

  Question 1 – What do I want to do?
  Question 2 – What do I know about now about my goal or life direction?
  Question 3 – What do I need to do to find out what I need to know?
  Question 4 – What can I do to make my goal or life direction happen?

- **Phase 2 – Take Action**

  Question 5 – What can I do to learn what I don't know now?
  Question 6 – What could keep me from doing this?
  Question 7 – What can I do to remove those barriers?
  Question 8 – When will I do this?

- **Phase 3 – Adjusting my Plan**

  Question 9 – What have I done?
  Question 10 – What barriers have been removed?
  Question 11 – What has changed for me to reach my goal or life direction?
  Question 12 – Have I done what I wanted to do?

Third, each person needs to think about how he/she will answer the questions that will come up in the planning process. Some common questions are:

- Who do you want to be your facilitator/advisor?
- Who do you want to help you plan your goals or life directions? Who do you not want to help you plan?
- Profile – (a) things that people like and admire about me; (b) things that are important to me; (c) things that are important for me; (d) how to support me.
- What do I want to do?
- List all the goals or life directions I want to try.

- Are there organizations or people in the community that can help me with my goals or life directions?
- For each goal or life direction – (a) where will it happen, (b) when, (c) how will I get there, (d) who will support me, (e) what else do I need?
- How do I want my goals or life directions to be recorded – format of the plan.
- How will this be paid for?
- How will I know if I'm making progress?

Fourth, support and advice from a peer as each person prepares for the planning process is a very effective strategy.

Preparing a person for the planning process will require using a variety of tools that support the discovery process. Our goal is to engage the individual in goal setting through:

- Self-awareness
- Information/Education
- Individualized Support
- Empowerment

Supporting the person's network (families, friends, providers) is equally as important as preparing the person. Each person's network of support will be instrumental in the continuation and sustainability of a person-centered/person-driven life plan.

In Rhode Island, Advocates-in-Action (in collaboration with others) will develop a tool kit of resources and activities to help each person prepare for their plan. This Peer-to-Peer Support Model will recognize the Medicaid-acknowledged domains of life: home living, community living, citizenship, relationships, finance, and …. all other life domains each person wants to include in his/her plan.

A Few Important Resources:

National Gateway to Self-Determination – extensive resources on self-determination
Self-Determination Learning Model of Instruction (SDLMI)
Self-Determination Career Development Model (SDCDM)
www.ngsd.org

The Learning Community for Person-Centered Practices – Reading Room – materials on Person-Centered Thinking
https://tlcpcp.com/groups/reading-room/ (Click on Reading Room)

It's My Choice - A self-guided workbook on person-centered planning by William T. Allen, published by the MN Governor's Council on Developmental Disabilities.
http://mn.gov/mnddc//extra/publications/choice/Its_My_Choice.pdf

Advocates in Action
http://www.advocatesinaction.org/

Component 3
Preparation – Community Mapping

To actively **be in the world,** each person needs to understand the opportunities and resources that exist in his/her world and how to use those opportunities and resources to broaden and deepen his/her life.

There are five important ideas to understand about community mapping:

- Experience is how people develop interests and preferences;
- Everyone needs the opportunity to learn about new experiences;
- There is a need for matching community opportunities and experiences to each person's interests and personality;
- Most relationships grow out of experiences that are shared by people with common interests;
- The community has many individuals, organizations, and other resources that can support both new and familiar activities in which each person wishes to participate.

One purpose of community mapping is to identify experiences that will **increase the person's understanding and participation in his/her community**. This includes:

(a) cultural events in which many citizens of a community participate – like community holiday celebrations, festivals, music or art events;

(b) sports and recreational activities – like community sports leagues, recreation centers, YMCA/YWCA, fitness centers;

(c) organizations and clubs that are built around common interests, social clubs, or charitable organizations;

(d) learning activities – like community centers, colleges or technical schools; and

(e) religious organizations, many of which sponsor other social and community events.

As the saying goes, variety is the spice of life. The more experiences a person has, the more likely it is that person has a wide variety of interests. However, there are many people who have very limited experiences with many life domains. For people with limited experiences, it is important to identify and provide experiences and opportunities that will increase each person's variety of interests.

Another purpose of community mapping is to identify experiences or organizations that **match the person's interests.** The final purpose of community mapping is to identify individuals or organizations or resources that **can support the person** in his/her life activities.

In preparation for developing the person's plan, four activities need to occur.

First, using a variety of sources, the person and his facilitator/advisor and other friends need to develop a **list of community activities and opportunities** that are available to the person.

Second, help the person make a **relationship map**. For each domain in the person's life (family, neighbors, friends, jobs, leisure and fun, church, community groups, school, service providers), make a list of (a) people you are closest to; (b) people who are friends but who you know less well than the first group; and (c) acquaintances.

Third, using questions from "Friends Connecting People with Disabilities and Community Members" (Amado, 2013), help the person **match the community activities and relationships on the lists with the person's interests and personality**.

- Who does the person already know with whom the relationship can be deepened and strengthened?
- Who would appreciate the person's gifts and personality?
- Where might the person find other people interested in similar things?
- What are the associations or clubs that the person might join?
- Where are the community places where people engage in one or more of the person's interests?
- What community places would be hospitable and welcoming?
- What are the community places where the person can fit in just as they are?

Fourth, for each of the activities or events or organizations that the person is interested in, help the person think about these **questions about who can help**:

- Can I do it myself?
- Can my family or my friends help me?
- Are there other community members (from my social map) who can help me?
- Are there other community resources that I can use?
- Will I need a paid staff to help me?

These four activities will help the person and his/her facilitator/advisor to be ready to make a plan.

Community mapping is simply looking around and seeing who and what is out there. It is an ongoing process of exploration and searching the community to discover people, places, and experiences that would be valuable to the person. It can be formal or informal. It goes beyond a "schedule of activities" selected by an agency. It is individually focused.

It is how the person **learns about the world** and **becomes part of the world**.

John is 22 years old. During his school years John spent all of his time in self-contained special education classrooms, and he rarely participated in any after school or community activities. John has significant support needs. When asked about his interests, John smiles and repeats the last thing someone on his team said. John's team recognizes that he needs to discover possible activities and opportunities across a range of activities. John's team...

- Made a list of every **recreational opportunity** in the town where he lived – they found several gyms, movie theaters, karate centers, two libraries that offered several afternoon and evening adult clubs and activities, two recreational center that offered more than 50 mini-classes for adults in a variety of areas, a bowling alley, a bocce club, two public swimming pools, parks that had walking trails, and several other fun things. Their final list included more than 100 possibilities. John likes to move and likes to watch people. John's team picked seven activities that involved movement in places where other people did the same thing – the walking trails, a ballroom dancing class offered through the town recreation program, an introductory karate class, bowling, jazzercise at the local library, and attending two sports leagues where he could watch other people. They worked out a schedule so that John could try out each of the seven activities at least once every two weeks for three months. As they thought about each activity, they planned for when it would happen, how John would get there, who would go with him, and how John would pay for the things that had a cost.
- Went to the local Chamber of Commerce and got a list of all the **town-wide cultural events** throughout the year. They found a Veteran's Day Parade, Fourth of July Fireworks, a band concert every Wednesday night during the summer in a town park, a cook-off to celebrate the beginning of summer, two music festivals, and four other festivals sponsored by local faith communities. They worked out a schedule so that John could attend most of these events. Again, as they thought about each activity, they planned for when it would happen, how John would get there, who would go with him, and how John would pay for the things that had a cost.
- Made a list from the local newspaper of organizations that were looking for **volunteers**. They identified a charitable organization that needed someone to stuff envelopes, a civic club that maintained green spaces in town, a food pantry that needed helped unloading boxes and stocking shelves, and a community preschool that needed volunteers to play with the children. Recognizing John's need to move, the team picked the club that maintained green spaces and the food pantry. They planned for an afternoon volunteering in one of those two opportunities every other week. Again, as they thought about each activity, they planned for when it would happen, how John would get there, who would go with him, and how John would pay for the things that had a cost.
- Completed a **relationship map**. The only names on John's relationship map were family members and three paid staff.
- Embedded **self-determination instruction** into every activity to help John communicate what he liked most and which he would like to do in the future.

Six months later two guys who walked the same trails invited John to walk with them. They picked him up twice a week. He decided he didn't like bowling, jazzercise or karate, but he goes to ballroom dancing class every other week with a neighbor. He attends several town-wide events and wears his sports gear to local sporting events accompanied by staff or other fans. His relationship map has nine new names who have become John's companions for several activities.

Martha **is 47 years old and wants a job.** Martha has many interests and many things she wants to do, but has no money to pay for them. Martha uses a wheelchair and has no experience with work. Martha's team...

- Analyzed **labor market data** for the town in which Martha lived and identified career categories and growth occupations that matched Martha's accessibility needs. They identified two local businesses for each identified job type……and identified someone on Martha's team (paid staff or natural support) who knew each business and was willing to accompany Martha on a visit. After the visits, Martha and her team selected three businesses for trial internships. The team made arrangements for the internships. They planned when each would happen, how Martha would get there, what accommodations were needed, what instruction and support Martha needed and who would provide that, and what funding would be available for support services. After Martha completes the three internships, Martha will choose a career path. Her team will assist her in that process.

- Timely **transportation** to/from the internships and from a job will be challenging for Martha. Martha's team listed all transportation options – the public transit system, accessible taxis, individuals from her relationship map – and developed a transportation plan.

- Having established relationships with local businesses, Martha's team (and teams supporting others in the area) organized a **community conversation** to connect individuals and businesses and to build a neighborhood network to promote employment.

Six months later Martha was employed part time in an accessible small office on the first floor. Her team had secured funding to support the use of accessible taxis.

Craig **is a very lonely man.** Craig lives in a group home in a community different from the community in which he grew up. He wants to have friends who will visit him and who will do things with him. Craig's team...

- Used the **seven questions** from **"Friends Connecting People with Disabilities and Community Members"** (Amado, 2013) to identify individuals and organizations who could be connected to Craig. ……and identified someone on Craig's team (paid staff or natural support) who knows the individuals or organizations and was willing to make an introduction.

- Craig's **Team members belonged** to two **civic organizations and a sports league** that matched Craig's interests. The team members introduced Craig to these organizations and accompanied him to several meetings.

- Made a list from the local newspaper of organizations that were looking for **volunteers**. Craig's team identified two organizations – one collected and recycled household goods, one maintained playing fields for a community sports league. For each activity Craig's team planned when each would happen, how Craig would get there, what accommodations were needed, and who would provide any needed support.
- Completed a **relationship map** to identify who in Craig's life could accompany him to various

activities. The only names on Craig's relationship map were family members and three paid staff. The team used the relationship map to track changes in Craig's social networks.

Six months later Craig was an active member of one of the civic organizations. Through that organization he had met several other people who introduced him to a number of new activities and events. Once a week he volunteered to help maintain playing fields – other members of that organization picked him up and also went with him to sporting events that occurred on those fields.

A Few Important Resources:

Community Mapping Resource Toolkit – Florida Department of Education
http://project10.info/files/CommunityResourceMapToolkit5.08.14.pdf

Friends Connecting People with Disabilities and Community Members (Amado, 2013); Research and Training Center on Community Living, Institute for Community Inclusion, University of Minnesota.
https://rtc.umn.edu/docs/Friends_Connecting_people_with_disabilities_and_community_members.pdf

National Gateway to Self-Determination – extensive resources on self-determination
Self-Determination Learning Model of Instruction (SDLMI)
Self-Determination Career Development Model (SDCDM)
www.ngsd.org

The Learning Community for Person-Centered Practices– Reading Room – materials on Person-Centered Thinking
https://tlcpcp.com/groups/reading-room/ (Click on Reading Room)

Community Mapping Practice
Matching a Person and a Community

The preceding pages provided stories about how community mapping strategies were used to identify opportunities and resources for a person with significant support needs and limited community connections, a person who wanted a job, and a person who wanted friends. To further your understanding of the process of community mapping, we are asking the readers to engage in a practice exercise. Thinking about your community, how would you identify community opportunities and supports for each of the following people.

Joe, age 25, enjoys unified basketball. He wants someone to hang out with outside of practice.

Amanda, age 36, is very involved in her church. She needs someone to help with baking and serving at "coffee hour", as well as someone to attend other church and community activities with her. She has no means of transportation.

Maya, age 45, likes to sing and wants to be on stage, but sings off key.

Kie, age 31, is looking to find a significant other and hopes to start a family. Kie is looking to become a regular in restaurants and recreation settings near his home. He wants to be greeted and wants more friends.

Andrew, age 27, is content to not have a lot of people in his life. He has had many negative experiences with people. What experiences would increase his level of comfort and his level of community engagement?

Tony, age 70, has retired from the workshop and needs something(s) to do. He lives in a rural area and does not have a computer.

Mary, age 31, is new to the area and has always wanted to be a police officer.

Component 4 - Preparation
Preliminary Meeting

The person, the facilitator/advisor, and other trusted allies and friends have a preliminary meeting to accomplish the following tasks:

- Outline the major topics to be discussed
- Identify the topics the person does **NOT** want to be discussed
- Selects community location, date, and time for the planning meeting

The person, the facilitator/advisor, and other trusted allies and friends need to decide when and where any team planning meetings will occur.

Some guidelines to think about when selecting time and place include:

- The setting should be a place where the person is comfortable.
- The setting should be easily accessible for anyone who is attending.
- The setting should be in the community.
- The time should be a time when the person and key participants are available.
- The setting should provide sufficient accessible parking.
- There should be accessible transportation to the meeting location.
- If an interpreter (ASL, linguistic, or other) is needed, arrangements should be made for the interpreter to attend the meeting.

> Most people interviewed in the process of developing this guide felt strongly that there were topics and items that they did not want to be discussed at the team meeting. The person's request for **privacy** in any matter should always be respected. The facilitator/ advisor should be very aware of these topics and should steer the team discussion away from these topics.

Component 5
Assemble the Team

Each person, his/her facilitator/advisor, and other trusted allies and friends meet to decide who should be invited to participate in the planning process. Team members can include anyone and everyone who can contribute to helping the person (a) think about all of life and (b) think about how to accomplish his/her goals or life directions.

Common team members include:

- the person
- the facilitator/advisor
- trusted allies
- family members
- friends
- support staff
- community members connected to the individual's interests and preferences
- DDD staff
- ORS staff
- others

Some guidelines to think about:

- Anyone the person thinks is important should be invited to attend.
- Team members could include community members who know about the person's interests.
- Team members could include people who could identify resources or provide support.

Before joining the team, each team member should commit to respect the privacy of the person and should acknowledge that they are accountable to the person.

Every team member should consider themselves AGENTS OF CHANGE. The purpose of the team is not to simply attend a meeting or write a plan…but to increase the opportunities and resources to which the person has access and to add to the depth and breadth of the person's life.

Phase 2
The Planning Meeting
Components 6 - 9

Phase 2 Checklist
The Planning Meeting

Have I (and my planning team) developed a personal profile? Have we listed what is important **about** me? Have we listed what is important **to** me? Have we listed what is important **for** me? Have we listed the best ways to **support** me?	
Is the personal profile in a format that I am comfortable with?	
Have my facilitator/advisor and I agreed on how the planning meeting(s) will be organized? What parts of the meeting will I direct? What parts of the meeting will the facilitator/advisor direct?	
If we are going to use forms or components from an existing planning format (MAPS, PATH, Life Course or something else), have we agreed on what we will use and how?	
Have my facilitator/advisor and I agreed on a format for my plan?	
Before the meeting starts, have I reviewed with my facilitator/advisor all the life domains I want to talk about and all the topics I do not want to talk about?	
During the meeting, for each life domain, did we talk about if I have enough experiences to decide what I want to do? Or do I need more experiences before I decide?	
For every area in which I need more experiences, did my team list specific experiences and places?	
For each goal area or life domain, did my team list specific action steps?	
For each action step, did my team list (a) where it will happen, (b) when it will happen, (c) how I will get there, (d) what accommodations I might need, and (e) what it costs?	
For each action step, did my team talk about (a) what things I can do by myself; (b) what my family and friends can help me do; (c) what other community people (from my relationship map) can help me do; (d) what other community resources might help me; (e) for what I need paid staff?	
For each action step, did we review the other community resources that might help me? Did we select any? Did we decide who will contact them?	

Component 6
Develop the Personal Profile

The team planning process begins with the development of a **Personal Profile.** The purpose of developing a personal profile is to gather information from the person and their trusted team that will form the basis of the person-centered plan. The facilitator guides the person and their team to identify strengths, capacities, things that are important to and for the person, as well as best ways to support the person. The profile is a way to introduce the person to others in a positive way that describes their uniqueness, as well as describing how best to support them. Goals, directions for change, types of supports, and an action plan are all then based on this profile.

To develop the profile, the person and their team answer the following questions:

1. What are the things that others like and admire ABOUT the person? This can include:

- What positive adjectives describe the person?
- What do they bring to other people? Their contributions?
- Gifts, capacities, and strengths – what are they good at? Proud of?
- Gifts of the heart – compassion, empathy, caring, a good friend, bright smile?
- Gifts of the head – things they know, know how to do, remember?
- Gifts of the hands – things they can do with hands?
- Gifts of history – their personal identity, faith, family culture?
- Anything else that others like or admire about the person?

Be sure to keep the language here in words you might wish others to introduce you. Avoid terms you would only use about disability or about a child.

2. What is important TO the person?

Here responses from the person are primary. This is the place to record what the person believes is important **TO** them, NOT what others think SHOULD be important to the person. If the person does not communicate in traditional ways, the facilitator and team should work with the person and their knowledge of him/her to identify what is important **TO** the person.

- Which people and relationships are important to the person?
- What things to do are important? Places to spend time?
- What routines or rituals are important? Pace of day? Early riser or night owl?
- Are there cultural factors important to the person?
- What works for the person? Environments or conditions that create aliveness, interest, motivation
- What doesn't work for the person – things to avoid? Environments or conditions that create boredom, frustration, depression.

3. What is important FOR the person?

There may be many things that are not important **TO** a person, but are important **FOR** them. For example, it may not be so important **TO** a person that they exercise, but it might be important **FOR** them. This is a chance to describe these things. Often these might be things that will keep the person safe and healthy. Some things to consider that might be important **FOR** a person could be:

- Special diets or ways to prepare food (e.g., pureed, cut in to small pieces, etc.)
- Allergies, other sensitivities – what to avoid
- Medications or other protocols for medical conditions
- Certain equipment available, its maintenance, proper use
- Safety and supervision needs

If the person is living with others – family or other non-paid caregivers, it may be important to consider what is important for them.

- How does necessary support of the person impact family or household life?
- Are there routines important to the family or caregiver that impact goals / supports for the person?
- How can any tensions between the two best be resolved?

4. How to support the person?

Here the team discusses the important things anyone supporting the person will need to know. These will be unique for every person, but some things to consider could be:

- How does the person communicate? What do you need to know to understand their communication? How should you communicate to him/her? (What works / doesn't work?)
- What do people need to **KNOW** to help person have what is important **TO** and **FOR** them in their life?
- What do people need to **DO** to help them with what is important **TO** and **FOR** them?
- Any unique strategies for specific circumstances (e.g., Mary is sensitive to babies crying. If baby starts to cry, guide her from setting – she may hold hands over her ears, guide her by the elbow and walk slowly)
- Also consider any special characteristics of people who support the person best (e.g., energetic, upbeat OR calm, gentle, laid back).

Profile *This profile is from Dr. Beth Mount, Person-Centered Planning: Finding Directions for Change Using Personal Futures Planning, New York, NY; Graphic Futures, 2000.*

Who is _____? *(List capacities, gifts, strengths, interests, identities. What are you good at? What do you like to do? What do other people like about you? What makes you, you?)*

What Works – creates aliveness, energy, motivation, interest, enthusiasm, well-being	**What Doesn't Work** – creates boredom, frustration, depression, upset

Communication Issues (Optional)

What Works	What Doesn't Work

Health Issues (Optional)

What Works	What Doesn't Work

Respect - Behavioral Issues (Optional)

What Works – Positive Qualities	What Doesn't Work – Leads to Rejection

Hopes, Dreams, Goals

Work	
Continued Learning	
Home	
Friends and Community	

Fears and Obstacles *(List fears, worst nightmare, worries, concerns, barriers, and obstacles to achieving dream)*

Youth	Family

Current and potential home, school, and community environments and opportunities related to goals.

Person's Interest or Talent	Community Opportunity	Potential Valued Role/Contribution

John Doe — 29, non-verbal, own legal guardian, family involvement

Who Am I?

A younger sibling to 2 sisters and 2 brothers, from an Italian/Portuguese heritage, happy, jokester, sensory oriented, a housemate, a friend, a helper, energetic, affectionate, and animal lover.

What is important to Me:

Spending time with family (Holidays & weekends)
Looking nice (I don't like strings or tags)
Being with others (helps me feel safe)
Utilizing my communication book so I can express myself
Sticking to the Routine
Updating my calendar so I know what is next in my day
Going to Church weekly
Attending my Community day program Monday - Friday

My Idea of FUN!

Car rides
Throwing balls
Listening to Music
Swimming
Coloring/Painting
Bowling
Sitting on my swing
Splashing in a bath
Going to the beach
Dancing
Walking in a park
Rollercoasters

My Family, Friends & Community Connections

Carol – Mom
Fred – Dad
Susie – Sister
Patricia – Sister
Frank – Brother
Peter – Brother
Keri – best friend
Sue – friend (have lunch together)
McDermott Pool (weekly swim)
Citizens Bank (banking)
Warwick Animal Shelter (Volunteer on Saturdays w/Support)
St. Mary's Church (Sunday worship)

Please help me:

Budget money, guide me through daily routines with verbal cues, identify risk and stay safe in the community, plan rides and schedule time with friends and family, continue to build my independence and encourage participation, explore new activities, keep my communication book updated, stay relaxed and follow sensory programming, going to doctors' appointments and maintaining my health

Health Goal:	Community Goal:	Life Enrichment Goal
Note goal here	Note goal here	Note goal here

2018

Values/Traditions

List Here

Employment/Career Goal:

My Life Goals:

Vacation with my family

Obtaining a community job working with animals

Continue list here...

Supporting Agency Name Here

Component 7
Develop the Plan

The development of the **Person-Centered Plan** creates the opportunity, one person at a time, to participate in life activities that are meaningful to that person. The intent of the plan is to increase participation in opportunities that (a) lead to new ambitions, (b) redefine interests and life goals, (c) add life experiences, and (d) develop connections that add value and increase life satisfaction for the person.

The **Person-Centered Plan** is not a form, but is a new way of thinking. The plan is based on people having control over their own lives and making choices about goals and activities that match interests and desires and address what is important **TO** them, what is important **FOR** them, and the best way to **SUPPORT** them.

We know that goals or experiences that are selected **by the person** are more likely to be achieved than goals that are developed for the person. Thus, it is very important that the person is **prepared to fully participate** in the planning process. **Component 2** of this process provides strategies and resources for preparing each person.

We know that plans must be **connected to real world, community activities.** Thus, it is very important for the person and the facilitator/advisor to take time to understand the opportunities and resources and supports that are available in all the communities in which the person spends time. **Component 3** of this process provides suggestions and resources for:

- developing a list of community activities and opportunities available to the person;
- developing a relationship map;
- matching the opportunities and relationships to the person's interests, desires, and personality; and
- identifying individuals or organizations or other community resources that can help the person achieve his/her goals.

We know that plans are about the person. Thus, it is important that the team take time to fully understand the person. **Component 6** provides suggestions and resources for **developing personal profiles** that describe the whole person – gifts, desires, needs, supports.

The **Person-Centered Plan** needs to address all the life domains that are important **to** and **for** that person. Thus, the team needs to help the person think about and answer questions such as:

- Where do I want to live?
- Who do I want to live with?
- Where will I get health care?
- How will I stay healthy?
- What jobs do I want to try?
- What job do I want to have for a long time?
- What else do I want to learn?
- What new things do I want to try?
- What will I do for fun?

- How will I get around the community?
- What places do I want to visit?
- What organizations do I want to join?
- Do I want to belong to a faith community?
- How can I make new friends?
- Who do I want to support me?
- What technology will help me?

Some of these questions and life domains may or may not be important to each person…but each question should be discussed to ensure that the person (and the team) think about **ALL of LIFE**, not just those domains considered important by a state or private agency.

Goals and life directions selected as part of the plan need to be specific enough to actually be achievable. The action steps for each goal need to be clearly stated and have sufficient detail. Actions to be taken to move towards that goal are listed.

For each step identify:

- The specific location – **WHERE**
- The time – **WHEN**
- **Accommodations and technology** needed
- **Supports** Needed
- How the person will get there – **transportation**
- Who is **responsible** for ensuring the step happens.

If the person and the team decide **more exploration or discovery** is needed, the team needs to list specific experiences.

For each experience identify:

- The specific location – **WHERE**
- The time – **WHEN**
- **Accommodations and technology** needed
- **Supports** Needed
- How the person will get there – **transportation**
- Who is **responsible** for ensuring the experience actually happens.

Although plans are intended to be very individual, because of the Rhode Island Consent Decree, there are two required areas - Career Development and Participation in Meaningful Community Activities.

The **self-determination** process of (a) setting a goal or life direction, (b) problem-solving how to achieve that goal, (c) taking action, and (d) adjusting my plan described in **Component 2** can be used in developing each goal in the plan. We know that the more often people use this basic process, the better they become at setting and achieving goals.

There are several tools for Person-Centered Planning that are referenced in the **Additional Resources** section at the end of the Guide.

Component 8
Format of the Plan is Individualized to the Person's Mode of Communication

In this Person-Centered Planning Process the plan will be **two parts**:

- The person's plan belongs to the person; thus, it can be in whatever format is most comfortable for that person. This plan should address **all domains in a person's life** (that is, everything this is important TO and FOR that person), not just those services and supports that are covered by the Medicaid Waiver.

- A "**Plan of Care**" as required by Medicaid which describes the services that will be funded by the Medicaid Waiver. The format for the Plan of Care will be developed by the RI Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH).

There is no required form for the Person-Centered Plan. The format of the plan should be specifically designed to match to the communication needs and learning characteristics of the person who is the focus of the plan. Things to consider when selecting a plan format include language level, sensory needs, the manner in which the person communicates, a format that allows the person to understand the goals and the action steps. Every plan will look different.

The plan puts people in control of their own lives; however, each plan should contain the following **core components**:

1. **Demographic Information** (as required by BHDDH).
2. A list of **team members**, their role in the person's life, and their contact information (***Component 5***);
3. Information about the Person—a **Personal Profile**—what others like about me, what's important to me, what's important for me, supports needed, strengths, skills, and capacities (***Component 6***).
4. **What the Person wants to do**, to learn, to achieve or to experience in every domain that is important to that person – including employment and meaningful community activities. **Goals** should be clearly and simply stated (***Component 2***).
5. Each goal should include a set of **action statements** that describe how the goal will be achieved. Each action will specifically describe **what** will be done, **where** it will happen, **when** it will happen, **who** will provide supports, how will the person get there – **transportation**, what **accommodations** are needed, and any cost (***Component 7***).
6. What individuals, organizations, or resources other than waiver funds will be used to **support** the person as they implement the goal (***Components 3 and 9***).
7. A method for **documenting progress and outcomes** (***Components 10 and 11***).
8. If there is any risk to the person, a description of **how the person will be safe** (***Component 12***).
9. A plan for **reviewing activity and progress** on a quarterly basis (***Component 13***) and revising/problem-solving as needed.
10. Any other attachments required by BHDDH.

A format for the Plan of Care will be developed by BHDDH.

Sample Person-Centered Planning Formats

There are literally hundreds of formats for writing person-centered plans – below are just a few. The forms in every example can be used both for the required employment goal and other goals.

Whatever format is used, there are two important criteria:

- The person who is the focus must be comfortable with the format.
- The plan needs to address the components described throughout this process.

Example 1 – No Paper
After team discussion, the focus person records his/her version of each goal or life domain. He/she also tapes (video or audio) what the actions are that will happen to achieve each goal. Other team members add their comments and needed detail on the tape. Quarterly reviews are done in the same way.

Example 2 – Draft format aligned to components in the process
This format prompts the person and the team to address the core components in the Person-Thinking Process. The same process is used for every goal or life domain.

Example 3 – Saying it All Person-Centered Planning Format
The Saying it All website (www.sayingitall.com) is a web resource for persons with disabilities in North East Lincolnshire, England. The website has several person-centered planning tools including a pre-meeting booklet, a template for a person-centered plan, a personal profile workbook, several sample plans, and other resources. The plan format can be found at http://www.sayingitall.com/v2/help-support/person-centred-planning/

Example 4 – Pre-Planning and Plan Summary Formats
This format was designed by two special education teachers (Kerry Walker and Alicia Matthews). Its original purpose was to be used with adolescents in transition, but it can easily be adapted for use by adults. This format uses daily schedule as the basis for planning.

Example 5 – ISP format from Missouri
Missouri has done extensive work in person-centered planning. A one-page goal planning work sheet is included at the end of this Guide. The Missouri Individual Service Plan template can be found at https://dmh.mo.gov/media/pdf/individual-support-plan-isp-state-template.

Example 6 – Career Development Plan Implementation
This example was developed by the director of an adult agency (Mike Wilson). Using a color-coded process and format, it demonstrates the detail needed to implement an employment goal.

These and other example plan formats are available on the "Person-Centered Thinking" page on the Sherlock Center website at www.sherlockcenter.org.

Example 7 – Employment Related Forms from "Putting Faith to Work"
Putting Faith to Work was a project funded by the Kessler Foundation. It provides a simple form for planning for employment and for planning the supports needed.
www.faithanddisability.org

Component 9
Resources are Identified and Described
How Resources will be Accessed is Defined
Who will Facilitate Access to Each Resource will be Identified

If you want to have a great person-centered plan, it is important to find out what else is available beyond DDD funding to support your plan and the life you want.

By looking at resources beyond the world of services, you open up the possibility of new friends/ new jobs/new opportunities for a richer, fuller life.

DDD funding can pay for some services and personal support, but it can't pay for many other important things, such as housing-related expenses. It's a good idea to not rely only on DDD funding because that can and does change. The more resources you can identify to support your desired lifestyle, the better!

Resources are a supply of tools/supports/assistance that help a person live the way s/he would like. Resources could be money, services, devices, materials, or staff assistance that includes government funding like Medicaid and SSI but goes beyond that.

As you are working on your plan, it may be helpful to consider each important area of your life. Some of those might be:

- Personal support – What staff assistance do I need?
- Home living – Where and how do I live?
- Career/education/life-long learning – What assistance do I need to become employed in my area of interest? How do I keep growing and learning over the course of my life?
- Finance – How will I pay for the things that are important to me?
- Health – What supports do I need to be healthy and safe?
- Transportation – How can I get to where I want to go?
- Assistive Technology – What devices and modifications can help me be most independent?

Think about the roles that you want – like citizen, worker, volunteer, neighbor, friend, etc.

It is important to build a Directory of Resources that can help with your plan and your life.

- Let your team members know that you want a plan and a life that goes beyond DD services and may require other resources.
- Make sure that you have people on your team that are good at accessing community resources – know how to do research, network, and make an "ASK" (not shy about going for it!).
- Start with exploring resources in the domain that is most important to you – for example, if you are interested in buying your own home, figure out who on your team knows about this area or add someone from the housing community to your team.
- For each resource area you want to explore in your plan, there should be a responsible person assigned, a specific task that they will do, and a timeframe for reporting back to you and the team.

The following pages list several resources that can be used to provide needed support.

Resources for Personal Support

- Home Health Services – assistance with daily living and personal care
  RI Department of Health has a list of agencies providing these services.
  http://www.health.ri.gov/healthcare/providers/homehealthagencies
- Homemaker and Companion Services – not personal care, not licensed providers
  For a list of agencies providing these services:
  http://www.care.com
- Homemaker and companion services for special needs populations
  For a list of local providers (individuals and agencies)
  http://www.care.com/home-care-agencies
- Personal Care Assistance – through Medicaid's Personal Choice Program
  Ocean State Center for Independent Living (OSCIL)
  http://www.oscil.org
- Natural Supports – Family, Friends, Neighbors, Co-workers

Resources for Home Living

- Homeownership Programs –for first-time homebuyers who have low income. Can provide counseling, down-payment assistance, and low interest financing:
  Rhode Island Housing - http://www.RIHousing.com
  RI Down Payment Assistance Program - http://www.firstdownri.org
- HUD/Section 8 – rental assistance program; housing choice voucher program
  http://www.section-8-housing.org/Rhode-Island
- Heating and Fuel Assistance Programs (LIHEAP) – federally funded program to assist low-income individuals to pay their heating bills. You apply for this program through your local Community Action agencies – to find your particular CAP agency, use link below.:
  http://www.ricommunityaction.org/member-agencies
- Food Stamps/SNAP – income-based food assistance program falls under RI Department of Human Services. To apply:
  http://www.dhs.ri.gov/Programs/SNAPApplyNow.php
- Volunteer Home Improvement Assistance – Habitat for Humanity, Offices:
  South County: http://www.southcountyhabitat.org
  Greater Providence: http://www.habitatprov.org
  West Bay: http://www.HabitatRIWestBay.org
- Eviction Resources – RI Legal Assistance program: http://www.rils.org
- Clothing and Furniture Banks – through Community Action Programs
  http://www.ricommunityaction.org/member-agencies. Also worth checking local furniture stores for donations.
- Cell phone assistance – SafeLink Wireless – a Lifeline supported service and a government program for free cell phone services (limited minutes/texts) for Medicaid/SNAP recipients. May use your own phone or apply for a phone through the program
  http://www.safelink.com

Resources for Career/Education/Life-long Learning

- **Disability Services for Students at Community College of Rhode Island** recognizes disability as a form of cultural diversity and works to foster an inclusive environment for all students in the higher education community through education, awareness, and accessibility.
  http://www.ccri.edu/dss

- **EmployRI** is RI Department of Labor and Training's online job-matching service.
  http://www.employri.org

- **Governor's Workforce Board** is Rhode Island's policy-making body on workforce development matters; the Governor's Workforce Board (GWB) invests in a range of programs and services that serve hundreds of companies and thousands of workers annually through Real Jobs RI, internships, and incumbent worker training. The GWB uses part of the assessment of employers' taxable payroll to fund initiatives to help employers meet their demand for talent.
  http://www.gwb.ri.gov

- **Institute for Community Inclusion at UMASS Boston** supports the rights of children and adults with disabilities to participate in all aspects of the community.
  http://www.communityinclusion.org

- **netWORKri** is Rhode Island's one-stop career center system and is a proud partner of American Job Center network.
  http://www.networkri.org

- **Office of Rehabilitation Services**
  http://www.ors.ri.gov

- The **Vocational Rehabilitation Program** is the public state and federally funded program that assists individuals with disabilities to choose, prepare for, obtain, and maintain employment.
  http://www.ors.ri.gov/VR.html

- **Paul V. Sherlock Center on Disabilities at Rhode Island College** is a University Center for Excellence in Developmental Disabilities (UCEDD) – a national network of 67 interdisciplinary centers. UCEDDs are evidence driven and designed to advance policies, practices, and research that improve the health, education, social, and economic well-being of people with disabilities, their families, and their communities. The mission of the Sherlock Center is to promote membership for all in school, work and the community.
  http://www.sherlockcenter.org

- **RI Association of People Supporting Employment** is a local organization with an exclusive focus on integrated employment and career advancement opportunities for individuals with disabilities.
  https://apse.org/chapter/rhode-island/

- **RI Department of Labor and Training**
  http://www.dlt.ri.gov

- **Real Jobs RI** is a demand-driven, workforce and economic development initiative that is collaborative, flexible, and business-led.
  http://www.dlt.ri.gov/realjobs

- It is designed to ensure that Rhode Island employers have the talent they need to compete and grow while providing targeted education and skills training for Rhode Island workers.
- The goal of Real Jobs RI is to develop Real Jobs Partnerships that convene industry employers, key stakeholders, and groups in partnerships that build alliances to address business workforce demands.

- **Job Seeker Resources**
  http://www.dlt.ri.gov/jobseeker.htm

- **RI Job Exchange** aims to provide the best tools, resources, and information to connect employers to diverse job seekers.
  http://www.americasjobexchange.com/RI/state-jobs

- **RI Regional Adult Learning** is a private nonprofit adult education agency whose mission is to assist adults in the process of reaching their academic, occupational, or personal goals through education, counseling, and training.
  http://www.riral.org

- **RI Small Business Development Center at the University of Rhode Island** provides local small business owners with the services and expertise they need to succeed – no-cost expert counseling, relevant training, and access to important resources. Our experienced business counselors are available to support you and your business at every stage, from start-up through maturity.
  http://www.uri.edu/risbdc

- **Skills for Rhode Island's Future** is a nonprofit public-private partnership working to match businesses that have current, unmet hiring needs with qualified unemployed and underemployed job seekers.
  https://www.skillsforri.com

- **Social Enterprise Greenhouse** provides social entrepreneurs and ventures with the services they need to move from idea to execution to scale including: incubation, acceleration, later stage strategy and financial services, and below market rate loan funding.
  http://www.segreenhouse.org

- **PrepareRI** is an initiative to prepare all Rhode Island youth with the skills they need for jobs that pay. It represents a strategic partnership between the Rhode Island government, private industry leaders, the public education system, universities, and non-profits across the state. https://www.prepare-ri.org/

Resources for Health and Safety

- Healthcare Plan Services – Neighborhood Health - https://www.nhpri.org
- Community Health Centers – for link to CHC in your area and information on services, contact RI Health Center Association
  http://www.rihca.org
- Home Health Services – assistance with daily living and personal care, may include nursing. RI Department of Health has a list of agencies providing these services.
  http://www.health.ri.gov/healthcare/providers/homehealthagencies
- Telemedicine Options – RI now requires healthcare plans to cover services provided via telemedicine. This can be a good option for people who have difficulty traveling to medical appointments or to improve access to medical attention. This may be a part of your health plan's offerings
- LIFE-line – emergency back-up system. Mobile and other personal alert systems
  For low-income individuals, federal program: https://www.fcc.gov/general/lifeline-program-low-income-consumers

  For anyone: http://www.lifeline.philips.com
- Wellness Programs for chronic conditions – diabetes, heart disease, Parkinson's, etc. Contact national organizations for information, education, assistance with managing condition, resources for medications, etc.
- Free or Reduced Cost Medication programs –
  RI Rx Card: http://www.rirx.com
  RI Pharmaceutical Assistance to the Elderly (RIPAE): https://medicineassistancetool.org/
  Eyeglass and Exams Assistance Program – RI Lions Sight Foundation:
  http://www.lions4sight.org
- Free dental care and clinics –
  http://www.freedentalcare.us/st/rhode_island or check your local Community Health Center.
- Visiting Nurse Services –see Home Healthcare Services
- Community Wellness Events/Classes/Activities
- Alzheimer's Education and Support - RI Chapter/Alzheimer's Association
  http://www.alz.org/ri/
- Behavioral Health Services – https://bhddh.ri.gov/
- Community Mental Health Services – to find services near you, contact RI Council of Community Mental Health Providers – http://www.riccmho.org

Transportation Resources

- RIDE and other RI paratransit
  https://www.ripta.com/ada
- RIPTA – Reduced Fare Pass
  https://www.ripta.com/reducedfareprogram
- Travel Training
- Specialized vehicle ownership programs – financing options and resources
  http://www.themobilityresource.com
- Specialized vehicles –new and used
  https://www.mobilityworks.com/financing/grant-assistance/
- UBER, Lyft, and other ride-sharing services
  https://accessibility.uber.com/
  https://www.lyft.com
- Taxi – specialized contracting
  http://www.ripuc.ri.gov/utilityinfo/motorcarriers.html
- Informal request for transportation assistance in appt. setting or neighborhood
- Shared ownership of vehicle
- Ride sharing around employment
  https://www.ripta.com/stuff/contentmgr/files/0/d621337022b235a3ea4e0ceccdde9dd9/files/crri_carpool_palm_4.pdf
  https://www.enterprisirideshare.com/vanpool/en.html
- Micro-Transit
- Volunteer Driver Programs
- Driver Training/Education
- Disability Parking Placard
  http://www.dmv.ri.gov/forms/disability/index.php
- Adaptive Equipment for a vehicle
- Other Resources
  http://www.nadtc.org/resources-publications/
  https://www.colemaninstitute.org/cognitive-technology-database/

Communication

- Proloquo2Go – AssistiveWare
- iCommunicate for IPAD – Grembe, Inc.
- iComm – Bappz (free)
- My Talk Tools Mobile – Spectrum Visions
- Look2Learn-AAC – MDR
- Voice4u – Spectrum Visions
- iConverse – Xcellent Creations
- Speak It!
- Read2Go for use w/ Bookshare digital library
- Dragon Diction
- Notability
- Talking calculator

Home Modifications

- Office of Rehabilitation Services
  http://www.ors.ri.gov
- The Mobility Resource – disability grants and assistance in RI
  http://www.themobilityresource.com
- RI Housing – for home modifications
  http://www.rihousing.com
- Home modification including stair lift, ramps, lifts, and overall safety in the home
  http://www.Homehealthsmith.com
- Environmental Controls
  Access to environmental control – Tobii Dynavox
  https://www.tobiidynavox.com/en-US/archive/products2/software/windows-control/benefits/access-to-environmental-control/
- Apps for iPad
- Evoassist
- EnvirOn

Service Dogs

- Autism Service Dogs of America (http://autismservicedogsofamerica.com/)
- Canine Behavior Services Inc. (https://www.k9behavioralservices.com/)
- Pro-train Innovative Dog Training (http://protraindog.com/)
- Wildwood Service Dogs (http://wilderwood.org/)

Job Site Modifications

- Office of Rehab Services
  http://www.ors.ri.gov

Electronic Health Management Systems/Tools

- The Marketplace Application and Disabilities | HealthCare.gov
  https://www.healthcare.gov/people-with-disabilities/marketplace-application/
- Automatic pill dispenser
  https://www.epill.com/esthedifotat.html

Phase 3
Developing the Plan
Components 10 – 15

Phase 3 Implementation Checklist
Developing the Plan

Have my facilitator/advisor and I agreed on a format for my plan?	
Did we include all the life domains or experiences that I wanted?	
Does my plan talk about employment and career development?	
For each life domain or experience, did we describe the experiences and skills I already have?	
For each goal area or life domain, did my team list specific action steps?	
For each action step, did my team list (a) where it will happen, (b) when it will happen, (c) how I will get there, (d) what accommodations I might need, and (e) what it costs?	
For each action step, did my team talk about (a) what things I can do by myself; (b) what my family and friends can help me do; (c) what other community people (from my relationship map) can help me do; (d) what other community resources might help me; (e) what I need paid staff?	
For each action step, did we review the other community resources that might help me? Did we select any? Did we decide who will contact them?	
Did we select a measurement strategy for documenting progress? How will this be done? Who will do this?	
Did we decide on a strategy I can use to review my own progress? How will this be done?	
If there are any risks associated with this goal, did we describe what strategies and supports will keep me safe?	
Did we select a date for the quarterly review of my plan?	

Component 10
Life Directions and/or Goals are Measurable

It is important to know if the person is achieving his/her goals or having the experiences he/she wants. Thus, each goal in the person's plan should have a strategy for measuring and documenting change.

Too often we make these measurement strategies too complex or not meaningful. We should remember that this is about real people leading real lives. Measurement strategies should be:

- Appropriate to what is actually being measured
- Based on real activities in real settings (not simulations or make-believe activities)
- Simple to use
- Simple to report

There is a table at the end of this section that suggests some basic strategies and examples for measuring and documenting changes in the person's life. These are not the only ways to measure change but are intended to stimulate how we think about measurement.

It is also important to understand the difference between measuring systems change and measuring person change. Statewide employment surveys are about measuring whether the system is getting better at increasing opportunities and supports for employment for all individuals. National surveys, like the National Core Indicators, collect responses from a sample of people in many states to make general statements about how the country and individual states are doing across several areas of systems performance. What is measured in a person-centered plan is whether the person's life is changing.

In any person-centered plan, there are three important factors to consider:

- Did the action steps listed for each goal actually occur?
- **Did the person**'s abilities **change**? Is the person's daily life different because of what he/she has learned? This is the focus of this section.
- **Is the person satisfied** with what is happening?

The first two can be measured and described easily. Satisfaction is much more difficult. At the quarterly review there should be a real discussion with each person about whether or not he/she is satisfied with the activities in his/her daily life and whether or not he/she would like to make changes. If the person wants change, it is the responsibility of the team (as change agents) to revise the plan and to help the person have the life he/she wants to have.

Examples of Strategies for Measuring Progress

Measurement Strategy	Simple Goal Examples	Measurement
Description of Performance of Core Indicators	Fred will be a regular at a local restaurant. Indicators (selected by Fred): • Goes to restaurant weekly • Knows how to get there • Has favorite foods • Is greeted by name • Knows name of staff	Describe change in indicators on a predictable schedule. Record progress.
Description of Quality Indicators - **Sampling**	Fred will become a better conversationalist. Indicators: • Has three ways to initiate • Has three ways to respond when others initiate • Has three ways to keep conversation going • Has three ways to end • Selects topics appropriate to setting • Has enough vocabulary	Once every six weeks follow Fred around for an hour or two. Write down (a) the number of ways he starts conversations; (b) the number of ways he responds to others; (c) the number of ways he keeps it going; (d) the number of ways he ends; (e) yes or no if topics were appropriate; (f) yes or no if he had enough vocabulary.
Number of steps performed in a task analysis	Fred will plant a garden in his back yard. 1. Simple Task Analysis: • Select what to grow. • Buy plants. • Select area. • Prepare soil. • Add fertilizer. • Dig holes. • Plant. • Water • Water every other day. • Plants grow. And so on.	Two levels: Initial planting Ongoing maintenance. This is an effective strategy for many types of activities that have steps that can be listed; especially, household or other daily living skills.
Number of steps performed in a task analysis	Fred will **learn** how to……. Fred will **do**…… Any **job** can be broken down into steps.	Simply record how many steps are performed on a given day. Record increase in number of steps over time.
Actual **number**	Fred will exercise more indicated by # of steps he takes or How many houses he passes or Some other number	Use a fit bit or Count houses

Time	Fred will work at his job for an hour before taking a break. Fred will take less than 15 minutes to perform a work task.	Twice a week use a timer to record time – can be used to measure increase or decrease in time.
Actual **Number and Time**	At his restaurant job Fred will set 10 tables in 30 minutes.	

More Complex Examples

	Fred will be an active member of the ___ club.	On a quarterly or semi-annual basis, observe and record what Fred does.
Performance Performance	Attends meetings Pays dues.	
Performance	Knows members by name. Members know him by name. Has ways to initiate with members. Has ways to respond.	
Task Analysis	Participates in bi-monthly club service projects. Knows what to do.	
Number	Has only two beers at holiday party.	
	Fred's social network will increase.	
Actual **Number**	Number of places visited each month where there is the opportunity to meet new people.	Keep a tally.
Performance	Has ways to initiate/respond.	Do an occasional sample in a new place.
Social Mapping	Has broader social network.	Do a quarterly social map.
	Fred will develop the skills needed to become (job of his choice).	
Performance	Completion of Training Program	Communication with training site
Task Analysis	Performance of Skills at Internship or Job Site	Observe and record
Ask him	Satisfaction	

Component 11
Each Person has a Strategy for Measuring his/her own Progress and Growth

Person-Centered Thinking is about each person assuming greater control and responsibility for his/her own life. One of the steps in the self-determination process (described in Component 2) is reviewing the goal and the plan to determine if it actually achieved the outcomes the person wanted. Thus, it is important to give **each person** a simple strategy for **measuring and thinking about whether his/her plan accomplished what they wanted.**

The **"Goal Attainment Scale"** is a widely used strategy that provides people a simple way of thinking about their plan and their goals. For each goal, the person:

- Describes expectations in simple, clear terms.
- Describes a little more, a lot more … a little less, a lot less.
- Describes what he/she actually does at the beginning.
- Describes what he/she has changed every quarter.

This can be done with words, with pictures, with symbols, with someone else writing or recording what the person says, or any other way that makes sense to the person.

	Beginning	Quarter 1	Quarter 2	Quarter 3	Quarter 4
A lot More					
A Little More					
Expectation					
A Little Less					
A Lot Less					

The Goal Attainment Scale format is also a good strategy for team members to document and report progress and change.

Component 12
Description of Safety Considerations (as applicable)

Keeping every person safe is the bottom line need that must be met in order to function in all areas of life. When safety is compromised, a person will often feel anxiety, internal conflict, and even can experience trauma. Safety holds different meanings for different people. Each person has a different tolerance for risk.

Common **Areas of Risk** include:

- Financial – Overspending, not having enough money, poor management, credit card misuse, theft, giving money to others
- Community – Personal safety, poor boundaries
- Health – Difficulty with daily personal care, challenging health conditions, lack of needed care
- Relationships – nonconsensual sex, risk for assault, pregnancy, disease, harassment, boundary issues
- Transportation – being safe on public transportation, getting lost
- Natural Supports – boundaries, safe relationships, understanding roles and responsibilities
- Jobs – keeping job, transportation to and from job, personal safety in workplace
- Housing – home care, kitchen safety, safe food practices, fire safety, neighbor issues
- Technology – how to manage if technology fails

If any of these circumstances exist in the person's life, the plan should describe what strategies and supports will be used for keeping people safe.

See the "Additional Resources" section at the back of this Guide for a sample tool for evaluating risk and safety.

Component 13
Schedule for Review

Since every person's life changes, it is important to review the plan at least every quarter. Scheduling the dates for review should be part of the planning process.

The review should include:

1. Reviewing the personal profile, has anything changed about what is important **ABOUT** the person, **TO** the person, **FOR** the person, or **HOW TO SUPPORT** the person?

2. Reviewing each goal or life domain in the plan, (a) **have the action steps happened**, and (b) **has progress been made**? Using the **measurement strategies** as part of this review is very important. Using the Goal Attainment Scale (or something similar) to document progress is important.

3. Do any of the goals or life domains need to be **revised**?

    - Any new or different action steps?
    - Changes in where it occurs?
    - Changes in when it occurs?
    - Changes in who provides support?
    - Changes in transportation?
    - Changes in accommodations or technology needed?

4. Are there **new goals or activities** the person wants to pursue?

5. Use the **same plan format** as the original plan to record revisions or new goals.

6. Have any **concerns about safety** occurred? Describe them and describe the strategies or supports that will be used to keep the person safe.

Component 14 – Signature Page

Component 15 – CMS/BHDDH Plan of Care and Other Documents Required by BHDDH

The members of the person's team should sign the plan documenting both their participation in the development of the plan and the support each team member will provide to the person as he/she implements the plan.

The RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) is developing a format for a Plan of Care. This Plan of Care will specify which components and activities of the Person's Life Plan will be supported by waiver or other state funds.

Additional Resources

Resources to Assist in Preparing the Person to Actively Participate

Advocates in Action
http://www.advocatesinaction.org/

Paul V. Sherlock Center on Disabilities – http://www.sherlockcenter.org

I'm Determined - https://www.imdetermined.org

Helen Sanderson Associates – Person-Centered Thinking tools
http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/

The Pacer Center
http://www.pacer.org/transition/learning-center/independent-community-living/person-centered.asp

National Gateway to Self-Determination – extensive resources on self-determination
Self-Determination Learning Model of Instruction (SDLMI)
Self-Determination Career Development Model (SDCDM)
www.ngsd.org

The Learning Community for Person-Centered Practices– Reading Room – materials on Person-Centered Thinking
https://tlcpcp.com/groups/reading-room/ (Click on Reading Room)

Inclusion Press
https://inclusion.com/path-maps-and-person-centered-planning/

Oregon ISP
https://oregonisp.org/isp-checklist/

Beaulieu, Lionel, Southern Rural Development Center. *Mapping The Assets of Your Community: A Key Component for Building Local Capacity*.
http://srdc.msstate.edu/trainings/educurricula/asset_mapping/asset_mapping.pdf

Carol, Katherine. *Helping Our Loved Ones Prosper: Supporting Social Networking to Build Careers*. Institute on Community Integration, University of Minnesota
http://ici.umn.edu/products/impact/251

Crane, Kelli, and Marianne Mooney. *Community Resource Mapping: A Strategy for Promoting Successful Transition for Youth with Disabilities*. Institute of Community Integration, University of Minnesota
Email: publications@icimail.umn.edu

Delgado, Melvin, and Denise Humm Delgado. *Asset Assessment and Community Social Work Practice*. Oxford Press
http://www.oxfordscholarship.com

Goodall, Jane. Community Mapping 101, Assessing Community Needs and Potential Resources. Jane Goodall Institute
http://www.janegoodall.org

Gould, Joy, Rooshey Hasnain, Jennifer Bose and John Butterworth. Making *Networking Easier for Job Seekers: A Guide*. Institute for Community Inclusion/UCEDD U Mass Boston
https://www.communityinclusion.org/article.php?article_id=138

Griffin, Cary, Bob Niemiec and Megan Zeilinger. *Customizing Job Development: Un-Occupying the Workshop, One Person at a Time*. Institute on Community Integration, University of Minnesota
http://ici.umn.edu/products/impact/251

Hasnain, Rooshey, Jennifer Rose, Joy Gould, John Butterworth. *Job Networking in Diverse Communities: Research to Practice*. Institute for Community Inclusion/UCEDD U Mass Boston
http://communityinclusion.org/article.php?article_id=139

McKnight, J. (1992). *Building community*. AHEC Community Partners Annual Conference, Keynote address. Northwestern University: Center for Urban Affairs and Policy Research.

McKnight, J. (1992). *Mapping community capacity*. Chicago, IL: Northwestern University: Center for Urban Affairs and Policy Research.

Moore, M. (1994). *Community capacity assessment: A guide for developing an inventory of community level assets and resources* -. Santa Fe, NM: New Mexico Children, Youth and Families Department.

PowerPoint presentation by S. Rengasamy: *Adopting Asset Mapping in an Urban Ward in Madurai City. (Tamil Nadu, India)*
https://www.slideshare.net/srengasamy/introduction-to-community-asset-mapping-presentation

Assets-Oriented Community Assessment. Patricia A. Sharpe, Mary R. Greaney, Peter L. Lee, Sherer W. Royce. *Public Health Reports*, March/April and May/June, 2000; vol. 115.
https://www.jstor.org/stable/4598513

The Asset-Based Community Development Institute. John McKnight and Jody Kretzmann's base at Northwestern University's School of Education and Social Policy. The wellspring of asset-based community development.
https://resources.depaul.edu/abcd-institute/Pages/default.aspx

Essential Tools: Improving Secondary Education and Transition for Youth with Disabilities, prepared by Kelli Crane and Marianne Mooney. Another excellent resource that makes use of community resource mapping, devoting much attention to the process of asset identification, as well as to technique.
www.ncset.org/publications/essentialtools/mapping/NCSET_EssentialTools_ResourceMapping.pdf

National Gateway to Self-Determination – extensive resources on self-determination
Self-Determination Learning Model of Instruction (SDLMI)
Self-Determination Career Development Model (SDCDM)
www.ngsd.org

The Learning Community for Person-Centered Practices– Reading Room – materials on Person-Centered Thinking
https://tlcpcp.com/groups/reading-room/ (Click on Reading Room)

Bunch, Gary, Kevin Finnegan and Jack Pearpoint. 2009. *Planning for Real Life After School: Ways for Families and Teachers to Plan for Students Experiencing Significant Challenges.* Toronto: Inclusion Press. http://5c2cabd466efc6790a0a-6728e7c952118b70f16620a9fc754159.r37.cf1.rackcdn.com/cms/Teacher_Resource_-_Planning_for_Life_After_School_2742.pdf

Dingwall, Charlotte, Kristi Kemp and Barbara Fowke. (2006). *Creating a Good Life in Community: A Guide on Person-Directed Planning.* Ontario, Canada: The Individualized Funding Coalition for Ontario. https://www.mcss.gov.on.ca/documents/en/mcss/publications/developmental/GuideonPersondirectedPlanningFinal.pdf
Plain language version - https://www.mcss.gov.on.ca/documents/en/mcss/publications/developmental/PlanningGuidePlainLanguageMCSS.pdf

Mount, Beth. 2000. *Life Building: Opening Windows for Change Using Personal Futures Planning.* New York, NY: Graphic Futures.

Mount, Beth. 2000. *Person-Centered Planning: Finding Directions for Change Using Personal Futures Planning.* New York, NY: Graphic Futures.

Mount, Beth and Kay Zwernik. 1988. *It's Never Too Early, It's Never Too Late.* St. Paul, MN: Metropolitan Council.

O'Brien, John and Connie Lyle O'Brien, Eds. 2002. *Implementing Person-Centered Planning: Voices of Experience.* Toronto: Inclusion Press.

O'Brien, John and Herbert Lovett. 1992. *Finding a Way towards Everyday Lives: The Contribution of Person-Centered Planning.* Harrisburg, PA: Pennsylvania Office of Mental Retardation. https://eric.ed.gov/?id=ED356596

O'Brien, Jack Pearpoint and Lynda Kahn. 2010. *The PATH and MAPS Handbook; person-centered ways to build community.* Toronto: Inclusion Press.

Pearpoint, Jack, John O'Brien and Marsha Forest. 1993. *PATH: Planning Alternative Tomorrows with Hope: A Workbook for Planning Possible Positive Futures.* Toronto; Inclusion Press.

Other Facilitator Tools:
How to Develop and Write an Effective Individual Instruction and Support Plan. Washington State Department of Social and Health Services. 2017. This is a PDF of a six-module training designed for writers of goals and IISPs.
https://www.dshs.wa.gov/sites/default/files/DDA/dda/documents/IISP%20training%20module%20participant%20book%20%282%29.pdf

A Person-Centered Arizona: an information and resource site for person-centered thinking, planning, and practices.
http://pcp.sonoranucedd.fcm.arizona.edu/resources/person-centered-planning-tools

Person-Centered Thinking Tools. Helen Sanderson Associates.
http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/

Allen, William T. 2006. *It's My Choice.* Minnesota Governor's Council on Developmental Disabilities Tools to prepare for planning meetings, promoting more full participation in discussions/ decisions about services and supports to meet your individual needs in a variety of life areas. Available as editable PDF workbooks. Each of the Guides and Checklists in this workbook can be completed electronically. Each is a separate PDF file that can be downloaded and printed out, and the responses can be saved for future reference or revised and updated when you want to make some changes. Also available in Spanish and in audiofile.
http://www.mnddc.org/extra/publications.htm

The Beach Center on Disability - Information and Resources on Self-Determination
https://beachcenter.lsi.ku.edu/beach-self-determination

Charting the Life Course
http://lifecoursetools.com

Imagine: Finding New Stories for People Who Experience Disability
Articles by David Pitonyak on such topics as "Importance of Belonging," "Positive Behavior Supports," "Person-Centered Planning," many also in Spanish. Annotated resources and links.
http://www.dimagine.com

Inclusion Press
MAPS, PATH materials, inclusion Newsletter, other print and video materials developed by John O'Brien, Judith Snow, Marsha Forest and Jack Pearpoint.
http://www.inclusion.com

The Learning Community for Person-Centered Practices
The "Reading Room" on this website includes articles on Essential Lifestyle Planning,
Articles by Michael Smull, "Families Planning Together Handbook", in English and Spanish.
https://tlcpcp.com/groups/reading-room/docs/

National Gateway to Self-Determination
Extensive resources on self-determination
Self-Determination Learning Model of Instruction (SDLMI)
Self-Determination Career Development Model (SDCDM)
www.ngsd.org

The Learning Community for Person-Centered Practices– Reading Room
Materials on Person-Centered Thinking
https://tlcpcp.com/groups/reading-room/ (Click on Reading Room)

Putting Faith to Work – Tools and Forms
http://faithanddisability.org

Risk Identification Tool

Person's legal name: _____ Date of last update: _____

HEALTH AND MEDICAL

☐ No risk identified in this section (skip to next section)

1. Aspiration (check all that apply)	Yes	Possible	No	History
☐ a. Diagnosis of dysphagia, or has been identified to be at risk for Aspiration by a qualified medical professional	☐	☐	☐	☐
☐ b. Ingests non-edible objects, places non-edible objects in mouth, or has a diagnosis of pica				
☐ c. Has a feeding tube				
☐ d. Diagnosed with gastroesophageal reflux (GER) and the physician has identified the person at risk of Aspiration				
☐ e. Complains of chest pain, heartburn, or have small, frequent vomiting (especially after meals) or unusual burping (happens frequently or sounds wet) and the physician has identified the person at risk of Aspiration				
☐ f. Someone else puts food, fluids, or medications into this person's mouth				

Comments:

If the person experiences any of the following symptoms, a current evaluation by a qualified professional is expected to determine if the person is at risk of Aspiration. (Check all that apply)

- ☐ g. Food or fluid regularly falls out of this person's mouth
- ☐ h. Coughs or chokes while eating or drinking (more than occasionally)
- ☐ i. Drools excessively
- ☐ j. Chronic chest congestion, pneumonia in the last year, rattling when breathing, and persistent cough or frequent use of cough/asthma medication
- ☐ k. Regularly refuses food or liquid (or refuse certain food/liquid textures)
- ☐ l. Needs his/her fluids thickened and/or food texture modified
- ☐ m. Eats or drinks too rapidly

Evaluation results: ☐ Risk present ☐ No risk ☐ Other (see comments)

2. **Dehydration** (check all that apply)	Yes	Possible	No	History
☐ a. Asks for or routinely requires assistance to get something to drink	☐	☐	☐	☐
☐ b. Receives fluids through a tube	**Comments:**			
☐ c. Required intravenous (IV) fluids due to dehydration in the past year				
If the person experiences any of the following symptoms, a current evaluation by a qualified professional is expected to determine if the person is at risk of Dehydration. (Check all that apply)				
☐ d. Takes medication known to cause dehydration and this person would not recognize or communicate if he/she were dehydrated				
☐ e. Coughs or chokes while eating or drinking (more than occasionally)				
☐ f. Drools excessively				
☐ g. Chronic chest congestion, pneumonia in the last year, rattling when breathing, and persistent cough or frequent use of cough/asthma medication				
☐ h. Regularly refuses food or liquid (or refuses certain food/liquid textures)				
☐ i. Needs his/her fluids thickened and/or food texture modified				
Evaluation results: ☐ Risk present ☐ No risk ☐ Other (see comments)				

3. **Choking** (check all that apply)	Yes	Possible	No	History
☐ a. Ingests non-edible objects, places non-edible objects in mouth, or has a diagnosis of pica	☐	☐	☐	☐
If the person experiences any of the following symptoms, a current evaluation by a qualified professional is expected to determine if the person is at risk of Choking. (Check all that apply)	**Comments:**			
☐ b. Eats or drinks too rapidly				
☐ c. Stuffs food into his/her mouth				
☐ d. Coughs or chokes while eating or drinking (more than occasionally)				
Evaluation results: ☐ Risk present ☐ No risk ☐ Other (see comments)				

Person receiving services: _____ **Date of last update:** _____

	Yes	Possible	No	History
4. Constipation (check all that apply) ☐ a. Takes routine bowel medications for constipation or has taken "as needed" (prn) medications for constipation more than two times a month within the past year (do not include fiber) ☐ b. Required a suppository or enema for constipation within the past year ***If the person experiences any of the following symptoms, a current evaluation by a qualified professional is expected to determine if the person is at risk of Constipation.(Check all that apply)*** ☐ c. Has had more than one episode in the past year of complaining of pain when moving his/her bowels ☐ d. Has had more than one known episode of hard stool in the past year ☐ e. Takes a medication that causes constipation and this person would not recognize or communicate if he/she were constipated ***Evaluation results:*** ☐ Risk present ☐ No risk ☐ Other (see comments)	☐	☐	☐	☐
Comments:				
5. Seizures (check all that apply) ☐ a. Has a diagnosis of seizures or epilepsy and/or had a seizure within the past five (5) years ☐ b. Takes medication to control seizures and/or has taken medication to control seizures within the past five (5) years ☐ c. Has had a seizure in the past year. *Address safety precautions e.g. driving, water safety, bicycle use, safety equipment, etc.*	Yes ☐	Possible ☐	No ☐	History ☐
Comments:				

	Yes	Possible	No	History
6. Unsafe medication management: At risk of serious harm as a result of misuse of medication, medication overdose, frequently missing a medication dose, or lifestyle choices that conflict with medications (diet, supplements, alcohol, other drugs or medications, etc.)	☐	☐	☐	☐
7. Complications of Diabetes: Has a diagnosis of Pre-Diabetes or Diabetes	☐	☐	☐	☐
8. Complications associated with *(list type of tube or ostomy)* **:** Has an ostomy or tube, such as a urinary catheter, colostomy, etc.	☐	☐	☐	☐
9. Unreported pain or illness: Does not report or is unable to describe pain, signs of illness, or where it is located	☐	☐	☐	☐
10. Lack of access to medical care: Transportation, geographical, financial, cultural, or other (non-behavioral) reasons exist that prevent medical care	☐	☐	☐	☐

Person receiving services: _____ **Date of last update:** _____

	Yes	Possible	No	History
11. Injury due to falling: Needs support to avoid an injury due to falling. Consider risk due to mobility or transfer support needs	☐	☐	☐	☐
12. Other serious health or medical issues: Consider any other important, serious health or medical issues. List specific additional risk(s):	☐	☐	☐	☐

Comments:

SAFETY

☐ **No risk identified in this section (skip to FINANCIAL section)**

	Yes	No	Possible
13. Water temperature safety: Needs any support to adjust water temperature to avoid scalding	☐	☐	☐
14. Fire evacuation safety: Needs any assistance to evacuate when a fire or smoke alarm sounds	☐	☐	☐
15. Household chemical safety: Needs any support to avoid serious injury from household chemicals	☐	☐	☐
16. Vehicle safety: Needs any assistance to remain safe around traffic, while getting in or out of a vehicle, or while riding in vehicles	☐	☐	☐
17. Court-mandated protection: Someone else has a court-mandated condition or restriction against them to address this person's safety (e.g. protective orders or restraining orders to keep this person safe). If yes, list court order and date:	☐	☐	☐
18. Significant risk of exploitation: Evidence, signs, or circumstances of significant increased risk of abuse or exploitation	☐	☐	☐
19. Enters into contracts that he/she may not be able to complete: Consider the person's capacity to make an informed decision about contracts or agreements he/she enters into.	☐	☐	☐
20. Safety and cleanliness of the residence: Conditions within the residence may lead to injury, illness, eviction, or significant loss of property.	☐	☐	☐
21. Other safety issues: Consider any other important, serious safety issues at home or in any other setting (e.g. workplace equipment, bullying, harassment). List specific additional safety risk(s):	☐	☐	☐

Comments:

Person receiving services: _____ **Date of last update:** _____

FINANCIAL

☐ No risk identified in this section (skip to MENTAL HEALTH section)

	Yes	Possible	No	History
22. Potential for financial abuse: Complaints or evidence of significant increased risk of financial exploitation (e.g. provider organization staff or Foster provider handle the person's money, frequently loans money or property to others, bills are unpaid, etc.)	☐	☐	☐	☐

Comments:

MENTAL HEALTH

☐ No serious risk identified in this section (skip to BEHAVIOR section)

	Yes	Possible	No	History
23. Mental Health: Needs support managing or coping with mental health	☐	☐	☐	☐
24. Suicide: Engages in suicidal ideation, attempts, gestures, or threats ***A current evaluation by a qualified professional is expected to determine if the person is at risk of Suicide.*** ***Evaluation results:*** ☐ Risk present ☐ No risk ☐ Other (see comments)	☐	☐	☐	☐
25. Other mental health issues: Consider any other important, serious mental health issues, such as past trauma, addiction, etc. List specific additional mental health risk(s):	☐	☐	☐	☐

Comments:

BEHAVIOR

☐ No risk identified in this section.

	Yes	Possible	No	History
26. Physical aggression: Engages in behavior that is aggressive toward others	☐	☐	☐	☐
27. Self-Injury: Engages in behavior that presents an immediate risk of tissue damage to the person, or any behavior that, if continued, presents a significant risk of tissue damage to the person in the near future. Self-injurious behavior may refer to any behavior that can cause tissue damage, such as bruises, redness, and open wounds.	☐	☐	☐	☐

Person receiving services: _____ **Date of last update:** _____

	Yes	Possible	No	History
28. Property destruction: Engages in property destruction	☐	☐	☐	☐
29. Leaving supervised setting: Leaves or attempts to leave supervised settings and is unsafe to do so	☐	☐	☐	☐
30. Unsafe use of flammable materials: Engages in the unsafe use of flammable materials	☐	☐	☐	☐
31. Substance abuse: Abuse of alcohol or illegal drugs	☐	☐	☐	☐
32. Illegal behavior: Engages in any behavior that violates federal, state, or local laws	☐	☐	☐	☐
33. Court-mandated restrictions: Has any court mandated conditions or restrictions resulting from this person's behavior. If yes, list court order and date:	☐	☐	☐	☐
34. Ingesting non-edible objects: Ingests non-edible objects or has a diagnosis of pica	☐	☐	☐	☐
35. Non-edible objects in mouth: Places non-edible objects in his/her mouth that may cause poisoning, aspiration or choking	☐	☐	☐	☐
36. Refusing medical care: Refused medical services, treatments, or medications or has required mechanical, physical, or chemical restraint to receive medical services or mental health care in the past year. Consider the person's capacity to make an informed decision.	☐	☐	☐	☐
37. Extreme food or liquid-seeking behavior: Seeks, grabs, or stuffs food or consumes liquid in a manner that could cause harm. For example, for a person without teeth, it may mean that they will grab food that they cannot safely chew. ***A current evaluation by a qualified professional is expected to determine if the person is at risk of extreme food or liquid-seeking behavior.*** ***Evaluation results:*** ☐ Risk present ☐ No risk ☐ Other (see comments)	☐	☐	☐	☐
38. Illegal or high risk sexual behavior: Engages in unsafe sexual behavior such as approaching others for sexual behavior that is unwanted/non-consensual; grabbing others' genitals; touching others' breasts; solicitation for sexual activity; unprotected sex with strangers; any of the following exhibited publicly: masturbation, fondling others, fondling self, talking about sexual activity or using sexual language, or walking into an area disrobed.	☐	☐	☐	☐
39. Undesirable sexual behavior: Engages in sexual behavior that is not illegal but socially undesirable. Including: Touching paid providers in a sexually suggestive manner, soliciting sexual activity from paid providers or other professionals in their life, socially undesirable use of sexual language/talking about sexual activity, masturbating/fondling self in common areas of shared housing.	☐	☐	☐	☐
40. Harm to animals: Engages in behavior that is harmful to animals	☐	☐	☐	☐
41. Use of objects as weapons: Uses weapons or objects in an attempt to injure self or others	☐	☐	☐	☐

Person receiving services: _____ **Date of last update:** _____

	Yes	Possible	No	History
42. Unsafe social behavior: Consider internet/texting/webcam/media safety risks, lack of awareness of boundaries with strangers, etc. Engages in behaviors that place the person at risk of being victimized or engages in behaviors that place others at risk of being exploited. Consider bodily safety and social interactions with strangers.	☐	☐	☐	☐
43. Other behavior issues: Consider any other important, serious behavior issues at home or in any other setting. List specific additional behavior risk(s):	☐	☐	☐	☐

Comments:

EVALUATIONS

List any evaluations that were used to determine presence or absence of a risk.

Risk(s)	Type of evaluation	Evaluation date	Has condition changed since evaluation?	Where evaluation is kept
			---	

CONTRIBUTORS

Name	Title/Relationship	Name	Title/Relationship

Person receiving services: _____ **Date of last update:** _____

Rhode Island Person-Centered Thinking Guide

May, 2018

Available electronically at www.sherlockcenter.org.