Introduction to Person Centered Planning

A RESOURCE BOOK FOR PARENTS AND GUARDIANS




Utah Parent Center | Special needs, extraordinary potential

utahparentcenter.org

Introduction to Person-Centered Planning for Parents and Guardians – A Resource Manual

The development and update of information in this manual has been completed with cooperation from the Division of Services for People with Disabilities and Utah Parent Center staff.

Contact the Utah Parent Center for:

- Free individual consultations and advocacy support
- Free Utah Parent Center workshops
- Additional information on topics covered in this book

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HOW TO USE THIS MANUAL

Dear Reader,

The purpose of Person-Centered Planning is to develop the supports and services to assist an individual with an intellectual or developmental disabilities in achieving the life they want for themselves.. This manual gives suggestions about what you can do to facilitate a person-centered plan.

As you review the following information, you may find that you have questions or need further explanation. Please call the Utah Parent Center for further assistance. We would be happy to support you during this process.

The Utah Parent Center Staff

Utah Parent Center
Special needs, extraordinary potential

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What is DSPD?

The mission of the Division of Services for People with Disabilities (DSPD) is to promote opportunities and provide supports for individuals with disabilities to lead self-determined lives. DSPD oversees Home and Community-Based Services (HCBS) for more than 5,000 people who have disabilities. HCBS helps individuals with disabilities live in their own homes and communities instead of institutions. Types of support provided by DSPD include community living, day services, and supported employment services.

Funds are allocated by both the federal and state government through Medicaid and a Medicaid match program. DSPD uses those funds to oversee programs that allow people with disabilities access to the community, to be employed and to lead meaningful lives. There is an eligibility process which begins with intake and a waiting list where those with the highest needs are provided services first.

DSPD offers an array of waivers, depending on the type and severity of the disability. Services are provided with each waiver, designed to enable your child or adult with a disability to live as independently as possible. Person-Centered Planning is one way for your child or adult to lead a self-determined life.

Definitions

Provider: Any company that contracts with DSPD to deliver planned supports to individuals with disabilities.

Support Coordinator: A person contracted with DSPD to provide assistance in developing needed services and support to a person receiving DSPD funding. They help create the Person-Centered Support Plan (PCSP), monitor the progress the child or adult makes, coordinate services from providers, manage the budget, and ensure the health and safety of the individual.

Setting: Where individuals with disabilities live or receive services. Residential settings are where individuals receive services where they live, such as in an apartment or group home. Non-residential settings are where individuals receive services, such as a day program or employment services.

The Settings Rule: The Settings Rule is a set of rules that providers, support coordinators, and states must follow when it comes to home and community-based services (HCBS). The Settings Rule requires that individuals receiving services through Medicaid HCBS waiver programs have full access to community life and are able to receive services in the most integrated setting possible; promote individual choice; ensure individual rights, individual independence, and choices regarding services and providers. For more information, visit the following links:

https://dspd.utah.gov/settings-rule/

https://dspd.utah.gov/wp-content/uploads/2019/12/Setting-Rule-FAQ-Families-and-selfadvocates.pdf

https://dspd.utah.gov/wp-content/uploads/2018/01/Setting-Fact-sheet-2017.pdf

http://materials.ndrn.org/HCBS/HCBS-Settings-Rules_What-You-Should-Know-5-13-19-final.pdf

Person-Centered Planning

It's not about creating a great plan - it's about creating a great LIFE!

Person-Centered Planning (PCP) is a way of planning services and supports to help a child or adult with an Intellectual or Developmental Disability (IDD) achieve their goals and get the life they want for themselves. PCP considers the child or adult as the expert of their life, interests, and talents. It places them at the center of the planning process, with the focus being on what is important to and for the child or adult. PCP ensures that the child or adult has the options, information, and experience to make informed choices.

PCP typically occurs in a meeting or series of meetings with the support team. A support team can be made up of the child or adult's support coordinator, provider, family members, friends, professionals, and anyone that the child or adult would like to invite to the PCP meeting. The support team should help the child or adult in thinking through what kind of a life they would like, and how to make it a reality.

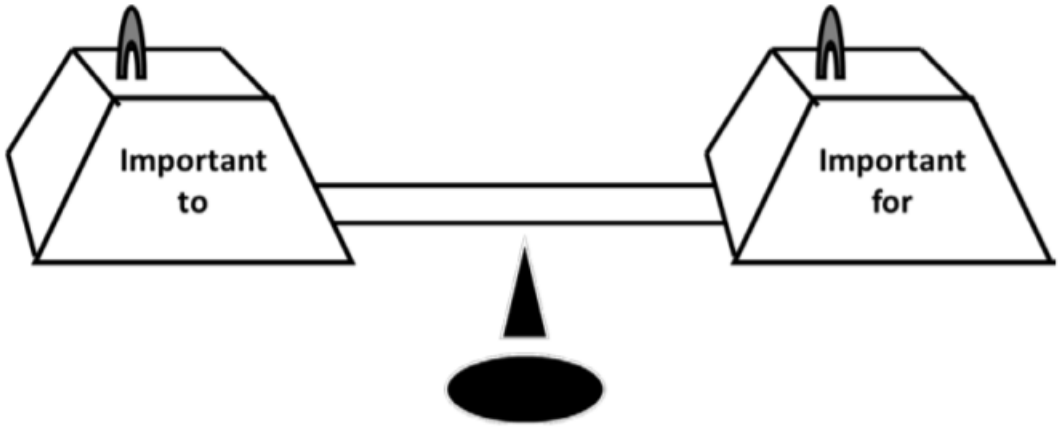
The person-centered planning process:

- Is led by the child or adult where possible
- Includes participants chosen by the child or adult; the child or adult may also choose to exclude participants from the meeting
- Provides the information that the child or adult needs in order to make sure that they are able to control the planning process as much as possible, and make informed choices and decisions
- Happens at times and places that are easily accessible for the child or adult
- Reflects cultural considerations of the child or adult and is conducted by providing information in plain language and in a manner that is accessible to them, and those who are limited English proficient
- Includes tactics to resolve any conflict or disagreement that may occur during the process, and addresses any potential conflicts of interest
- Offers informed choices to the child or adult regarding the services and supports they receive and from whom
- Includes a way for the child or adult to request updates to the plan as needed
- Documents if the child or adult considered any other settings (such as non-disability specific settings, which are settings where people with and without disabilities can go to participate or live).

Tip:

Place the person in the center and listen to what THEY want to do - not what is feasible for the parent or what the parent thinks the person can do or can not do.

What is important to and for the child or adult



It is key to person-centered planning to separate between what is important to and what is important for an individual and to find a balance between the two. Although services are often very good at describing and delivering what is important for someone, what can often be missed is what matters to the individual.

Important for: When we consider what is important for an individual, we think about issues of physical and emotional health and safety; including wellness, prevention, and the support needed to ensure an individual's well-being. We also consider what others see as important to help the individual be a valued member of their community.

Important to: When we consider what is important to the individual, we think about those things in life that will help the individual be satisfied, comforted, fulfilled, content, and happy from their perspective. This includes an individual's goals, passions, and interests. We take into account relationships, things to do, places to go, things to have, and routines that matter to them. What is important to an individual includes what matters most, by the individual's definition.

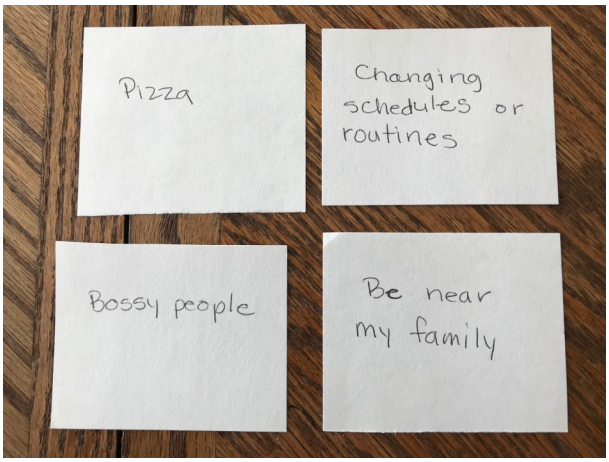
If we want individuals to address what is important **for** them, there has to be an element of it that is important **to** them.

Source: Roehl, Anne. An Introduction to Person Centered Thinking: Making a Difference Now. https://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_191036.pdf. PowerPoint Presentation)

Alternative Communication Methods

You may have heard or believe that if the family member is not able to communicate verbally, then it is less likely that they will be able to be involved in the Person-Centered Planning process. Every individual has a communication style and an existing communication system. Often, close family members and friends know what the child or adult is communicating even if verbal language is not being used; whether that is gestures, sign language, or a voice output communication system. When you presume competence and believe that the child or adult is able to tell you what they want and don't want, you can then create a way for others to understand them as well.

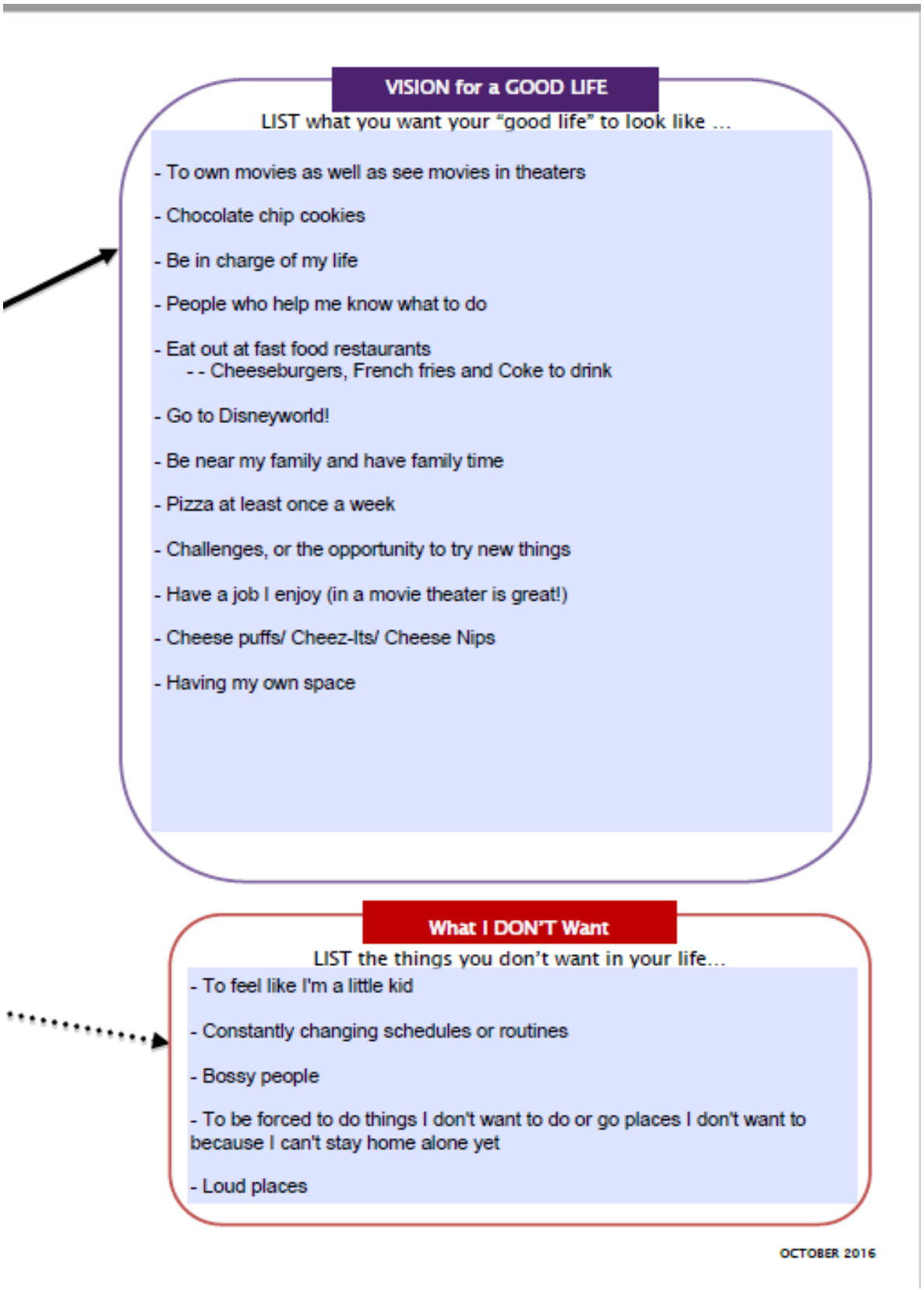
If additional assessments or expressive language support is needed, you can talk with the support coordinator to find a resource in your community to help assist you. One resource is the Utah Center for Assistive Technology (UCAT) which offers information and technical services to help individuals with disabilities acquire and use assistive technology devices. UCAT offers free evaluations to anyone within the state of Utah. To find out more, please visit their website at https://jobs.utah.gov/usor/vr/services/ucat.html



Example:

Brandon, age 24, is the youngest of four children. He has some verbal communication but is not conversational and does not like to answer questions. His mom wanted to find out what his vision was for a good life but didn't know how to get him to tell her. People that knew him well - his parents, his siblings and his siblings-in-law - wrote down what they thought Brandon would want in his good life. They also wrote things they thought he would NOT want in his life. Mom took all of the responses and put them on index cards. Then she had Brandon sort them into piles - what he wanted in his life, what he didn't want in his life and then a pile he wasn't sure about. The end result became the road map for his Person Centered Support Plan (PCSP).

Sample Vision for a Good life



VISION for a GOOD LIFE

LIST what you want your "good life" to look like …

- To own movies as well as see movies in theaters
- Chocolate chip cookies
- Be in charge of my life
- People who help me know what to do
- Eat out at fast food restaurants
  - - Cheeseburgers, French fries and Coke to drink
- Go to Disneyworld!
- Be near my family and have family time
- Pizza at least once a week
- Challenges, or the opportunity to try new things
- Have a job I enjoy (in a movie theater is great!)
- Cheese puffs/ Cheez-Its/ Cheese Nips
- Having my own space

What I DON'T Want

LIST the things you don't want in your life…

- To feel like I'm a little kid
- Constantly changing schedules or routines
- Bossy people
- To be forced to do things I don't want to do or go places I don't want to because I can't stay home alone yet
- Loud places

OCTOBER 2016

Person-Centered Support Plan (PCSP)

THE MORE TIME YOU SPEND DEFINING THE PROBLEM... THE BETTER THE SOLUTION.

Person-Centered Planning (PCP) results in a Person-Centered Support Plan (PCSP), a written plan that reflects the services and supports that are important for the child or adult (determined through assessments) and those that are important to them (determined through the PCP conversation about the individual's preferences). You do not have to be in DSPD services to have a PCSP meeting. Anyone can use the tools and principles discussed in this manual to develop a plan for themselves or someone else.

Individualized Education Program

Families that are familiar with the Individualized Education Program (IEP) could draw a likeness to the PCSP. The IEP is similar to the PCSP in that it outlines the child or adult's goals. The IEP only applies to education, while the PCSP applies to all life domains and stages. Both are intended to individualize services and supports.

All individuals who receive services through DSPD must have a PCSP. The PCSP must be reviewed and updated on a yearly basis at minimum, when the child or adult's circumstances or needs change significantly, or when they request a change to the PCSP. The child or adult does not have to wait a full year to make changes to their PCSP.

The PCSP must:

- Reflect that the setting where the child or adult lives or receives services was chosen by the individual
- Reflect the child or adult's strengths and preferences
- Reflect clinical and support needs as determined through a functional assessment. A functional assessment analyzes the child or adult's "need" for HCBS.
- Include goals and desired outcomes identified by the child or adult
- Identify services and supports - both paid and unpaid - that will help the child or adult achieve their goals. The provider of these supports and services must also be identified, along with any natural supports. Natural supports are voluntary, unpaid supports that an individual receives from their everyday relationships.
- Include risk factors and measures in place to reduce risk, including back-up plans and strategies as-needed
- Be written in plain language or in a manner that is understandable to the individual
- Identify who will be responsible for monitoring the plan
- Be agreed to by the child or adult. They must provide written, informed consent to the plan and sign off on it. The providers who are responsible for carrying the plan out must also agree and sign the plan.
- Be distributed to the child or adult, and others involved in the plan
- Include any services that the child or adult may choose to self-direct
- Prevent any unnecessary or inappropriate services and supports

Understanding Rights

All adults, including those with disabilities, have certain rights. These rights include, but are not limited to, the right to privacy, dignity and respect, and freedom from coercion and restraint.

- Privacy: The adult can be alone if they want to and can decide when and with whom to share spaces, conversations, and information.
- Dignity: The adult has the right to feel good about themselves and be treated like someone that has value and worth.
- Freedom from coercion: People cannot make the adult do something they do not want to do.
- Freedom from restraint: People cannot hold the adult against their will, including physical restraints and other types of restraints, such as withholding access to food or personal items.
- Respect: The adult should be treated with kindness and consideration by others.

Children also should be respected and treated with dignity and allowed privacy and freedom from coercion and restraint as is appropriate based on their age and abilities.

Rights Restrictions & the Person-Centered Support Plan (PCSP)

Any rights restriction(s) the child or adult has must also be documented and justified in the Person-Centered Support Plan (PCSP). A "rights restriction" is a limitation to the rights of your child or adult due to a specific assessed need in order to support the health or safety of them or their community. There are times when the child or adult; and their support team may decide it is necessary to restrict or modify their rights after all of the options for less restrictive interventions have been unsuccessful. When this is decided, a rights restriction plan is created by the provider and submitted to the provider's human rights committee.

Examples of Rights Restrictions

An example of a rights restriction may include restricting the ability of the child or adult to come and go freely because they have a tendency to wander into the street or other unsafe places; and therefore, a restriction or modification is necessary in order to ensure their well-being.

Another example of a rights restriction includes keeping food locked away or controlling what food the child or adult has access to because if an individual has Prader Willi syndrome, having access to food might make them sick.

Each provider has its own Human Rights Committee which reviews rights restriction plans.

Restrictions should not be put into place, modified, or removed without the approval of the provider Human Rights Committee. For more information about provider human rights committees, read DSPD general directive 1.1 Human Rights:

https://dspd.utah.gov/pdf/1.1%20Human%20Rights.pdf

A rights restriction that has to do with electronic surveillance must go through the Division Human Rights Council (DHRC) before it is implemented. "Electronic surveillance" is observing or listening to persons, places, or activities with the aid of electronic devices such as cameras, webcams, global positioning systems, motion detectors, weight detectors or microphones, in real-time (R539-1-3: https://rules.utah.gov/publicat/code/r539/r539-001.htm#T3).

If the child or adult does not agree with a decision made by a provider human rights committee, they may ask for a reconsideration or review, otherwise known as an "appeal," of the decision from the Division Human Rights Council.

Requests for appeals to the Division Human Rights Council should be sent to:

Division of Services for People with Disabilities
Attn: Human Rights
195 N. 1950 W.
Salt Lake City, Utah 84116

Once a rights restriction has been approved through either the provider Human Rights Committee or in certain cases, the Division Human Rights Council, the restriction must be justified in the PCSP.

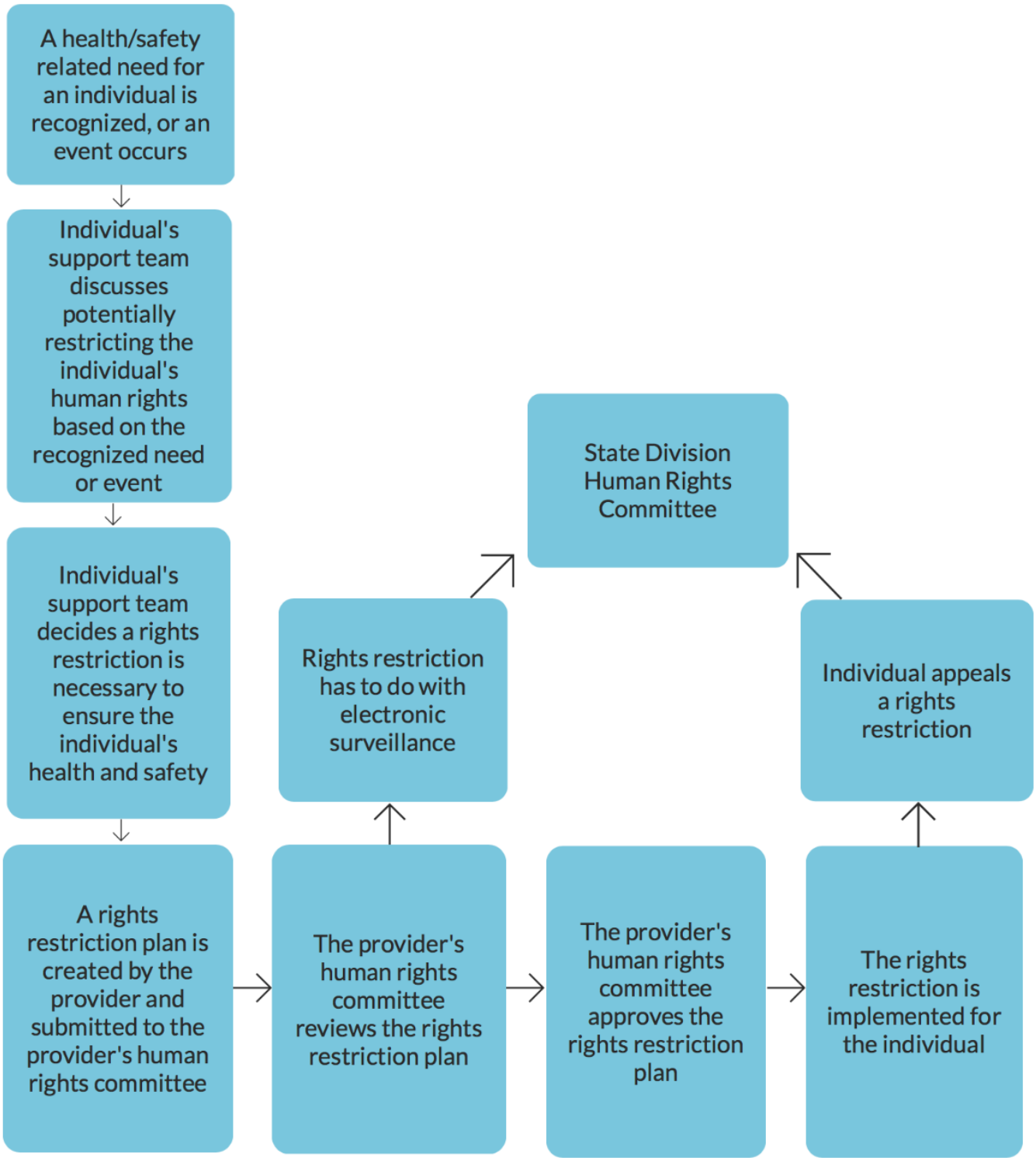
The process for implementing the rights restriction is person-centered and the following must be documented in the PCSP:

- A specific and individualized need based on an assessment
- Explanation of the services and supports that were tried before the modification
- Approaches/strategies to meeting the need that have already been tried but did not work
- Clear description of the condition that is directly proportionate to the specific assessed need
- Data collection/review to measure the ongoing effectiveness of the modification
- Specific time limits to review if the modification is still necessary (i.e. helping the individual meet their goals) or whether it can be brought to an end
- The individual/representative must agree to the modification. The explanation of the modification must be in a language the individual or their representative can understand.
- An assurance that the modification will not cause harm to the individual

Role of Support Coordinator in the Human Rights Process

The child or adult's support coordinator should be involved in any proposed rights restriction and should be present at the provider Human Rights Committee or Division Human Rights Council when someone they support is being discussed. They will receive a signed copy of any approved restriction for the child or adult and should monitor the implementation of the rights restriction, along with documenting it in the PCSP. The support coordinator should be an advocate for the individual in the human rights process.

Human Rights Process



Life Domains

Individuals lead whole lives made up of specific, connected, and integrated life domains that are important to a good quality of life. Life domains are the different aspects and experiences of life that we all consider as we age and grow.

What does it mean to have an integrated and connected life? It means that what happens in one area of our life (such as, in our health) affects another (such as employment). As the child or adult creates a person-centered support plan, it is important to recognize the interconnectedness of everyday life so our lives can be as complete and fulfilling as possible. You will want to plan for the following life domains:

Daily Life & Employment

This domain includes what a person does as part of everyday life– school, employment, volunteering, communication, routines, life skills, and individual as well as life with their family. When a child is young, the focus is on getting them ready for school. During the school years, the focus turns to getting the child ready for adult life. It's not too early to start working toward a vision of what the child will do after school ends. What kind of job might they like? What will they do every day? As adults, the focus will be on what the child/adult does all day and planning for their future as they age.

Community Living

This domain includes the housing and living options, community access, transportation, home adaptations, and modifications the child or adult with disabilities needs. A young child probably lives with family and will do so until they finish schooling. Then a young adult may want to change their living situation. They may want to attend college and live in a dormitory or get an apartment with a friend. Keeping the goal of independent living in mind with a child, giving them responsibilities and teaching them basic life skills, will help them to prepare for living life as an adult in the way they envision.

Safety & Security

This domain is the area that seems to get the most attention when planning for children and adults with disabilities but needs to be balanced with the other life domains. Staying safe and secure, however, is extremely important. Having plans for emergencies, taking care of the child or adult's well-being, considering guardianship options, and knowing the legal rights and issues that affect you and the child or adult are all part of this life domain.

There are skills that can be learned and practiced by the child or adult to assist them in being safe, secure and supported as well as helping them make their own choices and decisions. It is important to balance helping the child or adult to stay safe and even to allow them to learn from making occasional (non-life-threatening) mistakes! And balance this domain with the other five domains.

Healthy Living

The Healthy Living domain includes managing and accessing health care and staying well. In this domain, you will consider the child or adult's medical, mental health, behavior, and developmental needs. Beginning when a child is young, you encourage them to live a healthy lifestyle and learn healthy habits, which continue throughout their life. This domain can positively or negatively affect other parts of the child or adult's life, such as their ability to go to school or work, live independently, and participate with family, friends and the community.

As a child transitions to adulthood, they can take control of their own health care to the best of their ability. This can include choosing what to eat, what type of exercise they enjoy, and actively participating in medication management, doctor's visits, and other health care decisions.

Social & Spirituality

Activities in this life domain include building friendships and relationships, engaging in leisure activities, creating personal networks, and connecting to a faith community. Having friends and personal connections is key to having a happy and successful adult life. Friends and connections that children make during early and school years – at school, in community activities such as scouting or sports, or in their faith community – have an impact on their adult life. Those school, church or neighborhood friends may end up being future employers, neighbors, business owners, and most importantly, friends in adult life!

Advocacy & Engagement

This domain is also referred to as Citizenship and Advocacy.

Building valued roles, making choices, setting goals, assuming responsibility and being able to direct their own life is all part of the Advocacy and Engagement domain. Being known and valued in the community gives the child or adult a sense of worth and of being a contributor and a good citizen, not just someone who needs assistance. Learning to make choices, set goals, and knowing how to speak up for wants and needs leads to being more self-determined in life and is essential to becoming an advocate for yourself or others.

Source:
All of the definitions of the life domains are based on Charting the Life Course at https://www.lifecoursetools.com/principles/understanding-life-domains/

Role of Employment

Work has many positive benefits for individuals including greater access to the community, a sense of self-worth, and improved quality of life. Employment is a natural part of adulthood and the child or adult should be presumed as capable of working. "What do you want to be when you grow up?" should be a question asked of every child. Utah is an Employment First state and therefore, employment is the preferred service option before other day service options.

Employment First

Employment First is a belief that community-based, integrated employment should be the primary day activity for working age youth and adults with disabilities. It supports an overarching goal that eligible persons with disabilities should have access to integrated work settings most appropriate for them, including the supports necessary to help them succeed in the workplace. Employment First does not mean employment only and does not deny individual choice, but is intended to increase employment opportunities for individuals with disabilities. For more information, visit: https://dspd.utah.gov/employment-first/

A child may be too young right now to seek employment, but it is never too early to start planning for the future. All children benefit from having household chores and learning responsibility. As they get older, the chores and responsibilities can grow with them. Meaningful volunteer experiences can provide connection to the community as well as teach valuable skills to the child or adult. They can also learn "soft" skills which are the skills the child or adult needs to interact with others in school, the community, and in employment. It includes such things as independent grooming and care, social skills, making a good impression and behavior management. More on soft skills can be found at https://utahparentcenter.org/ioti/ioti-soft-skills/.

Tip:

What is your child or adult's dream? Don't limit them and don't let yourself limit them. If you had the brightest, most brilliant minds to help create a Person Centered Support Plan, what would you do?

The goal for all individuals is competitive, integrated employment. Competitive Integrated Employment (CIE) means that individuals with disabilities are able to work in the community with people of all abilities; and that they are paid at a rate comparable to those people without disabilities who work in the same place doing the same job. Your adult is not required to work, but they must be given the opportunity to work in competitive integrated settings. An "opportunity to work" includes having discussions about what possibilities and support options exist when it comes to employment, which may include exploring and experiencing possible work options. DSPD, other state agencies and community-based agencies offer supports to help the child or adult with disabilities find and maintain employment. This can include career exploration, skills training and job coaching.

Customized Employment is a flexible, personalized job search technique where the goal is to match the skills, interests and abilities of the individual with disabilities with the needs of an employer. Customized Employment begins with a person-centered determination of the strengths, needs and interests of the individual, otherwise known as a "Discovery process." After Discovery, an Employment Specialist will assist the individual in working with an employer to facilitate a job placement. Once an individual has been placed, an Employment Specialist will provide job coaching services to teach the individual the essential skills needed to maintain employment, and ensure continued success at work.

To learn more about Customized Employment, contact Vocational Rehabilitation (VR): https://jobs.utah.gov/usor/vr/contact.html

Customized Employment Resources

Webinar on Customized Employment: https://ceiutah.com/webinars/?tx_project-type=competitive-employment-employment

Customized Employment Flyer:

https://dspd.utah.gov/wp-content/uploads/2018/01/customized-employment.pdf

VR Customized Employment Memo:

https://jobs.utah.gov/usor/vr/about/memoseven.pdf

Tip:

It is always okay to say you want to take a break if things start to get overwhelming during the meeting. Sometimes a 15 minute break is all you need

Person-Centered Planning Tools

There are many different tools that can help the child or adult with the person-centered planning process. Some of these tools may be very useful as you prepare for the person-centered planning meeting, but all of the tools can be used throughout the different stages of the planning process and beyond. The following tools come from Charting the LifeCourse.

The tools with the exception of the Relationship Map are free to access at: https://www.lifecoursetools.com/planning/.

The purpose of these different tools is explained on the following pages.

The Relationship Map

The Relationship Map is an easy tool to use that can assist the child or adult in identifying people in his or her "circle" and can be used to identify who might be invited to the Person-Centered Planning meeting. It can show where the child or adult has solid support, or where they may be lacking in support.

There are five areas on the Relationship Map:

- Family - Parents/guardians, grandparents, foster parents, brothers, sisters, other relatives (aunts, uncles, cousins)
- Friends - Neighbors, friends of the family, friends from school
- People and organizations that support me at home - therapists, child care providers
- Family members who are involved in my life - see Family
- People and organizations that support me at work, school, and/or training. - Pastors, ministers, teachers, employers, social workers/case managers, community leaders

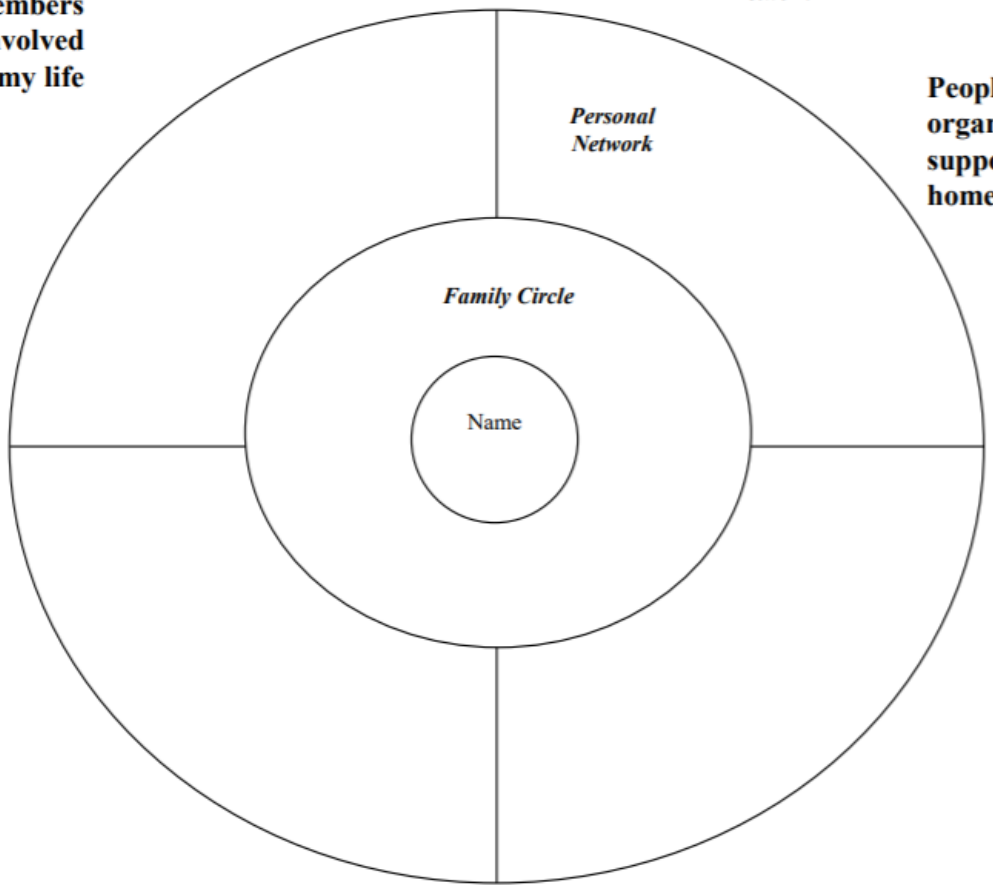
The Relationship Map can be found at the following link: https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Documents/Quad.RelationshipMap.pdf

To learn more about this tool, including how to fill it out, refer to the Appendix.

Tip:

Include a sibling, other family member, or friend that is close to the age of the child or adult that can help you focus on age appropriate activities, goals, etc.

Person-Centered Planning
Relationship Map



Developing a Vision

In order to determine what goals the child or adult wants, it is helpful to look to the future to see where they want to be. The Developing a Vision tool helps individuals with disabilities at any age along with their families to begin planning for an inclusive, full and meaningful life. It includes a section for each of the life domains for creating a life that is well-rounded which may become part of the Person-Centered Support Plan as goals to work towards now or in the future.

Families can use the tool with a very young child, an adult or someone in between to start to think about a vision for how their family member will live their life as an adult. The child or adult may use the tool to help them think about a specific vision for each life domain for how they want to live their adult life, and prioritize what they want to work on right now that will help move toward the life vision.

The "Developing a Vision" tool can be found at the following link: https://www.lifecoursetools.com/planning/

To learn more about this tool, including how to fill it out, refer to the Appendix.

Tip:

Be certain to write down questions, thoughts or needs prior to the meeting to ensure that they get addressed.

LIFE DOMAIN VISION TOOL | INDIVIDUAL

Name of Person Completing: _____ **Date:** _____

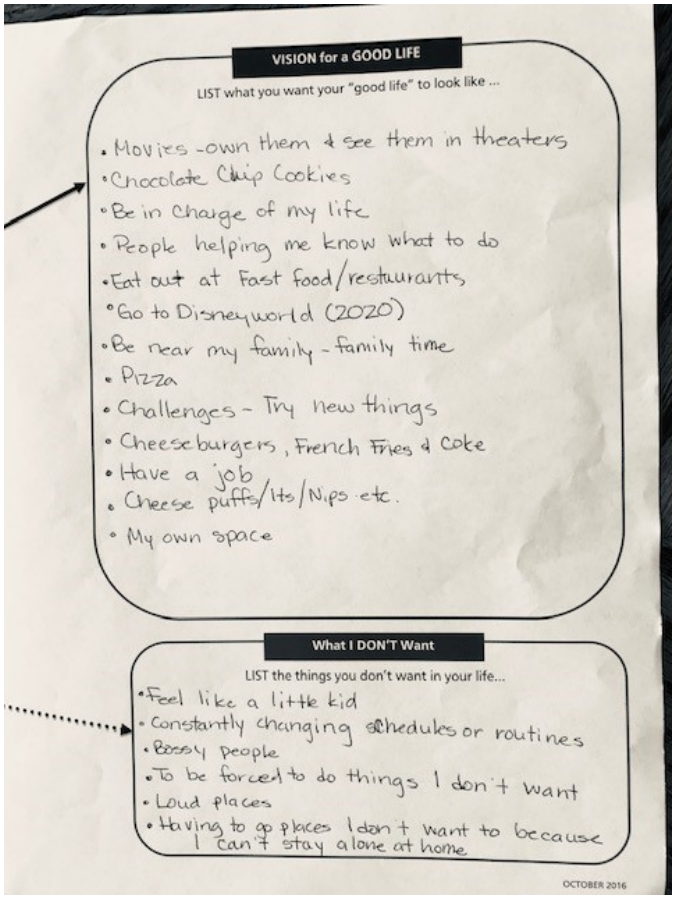
On Behalf of: _____

LIFE DOMAIN	DESCRIPTION	MY VISION FOR MY FUTURE	PRIORITY
	Daily Life & Employment: What do I think I will do or want to do during the day in my adult life? What kind of job or career would I like?		
	Community Living: Where would I like to live in my adult life? Will I live alone or with someone else?		
	Social & Spirituality: How will I connect with spiritual and leisure activities, and have friendships and relationships in my adult life?		
	Healthy Living: How will I live a healthy lifestyle and manage health care supports in my adult life?		
	Safety & Security: How will I stay safe from financial, emotional, physical or sexual harm in my adult life?		
	Advocacy & Engagement: What kind of valued roles and responsibilities do I or will I have, and how can I have control of how my own live is lived?		
	Supports for Family: How do I want my family to still be involved and engaged in my adult life?		
	Supports & Services: What support will I need to live as independently as possible in my adult life, and where will my supports come from?		

Life Trajectory Worksheet

The Life Trajectory Worksheet is used to facilitate an open conversation about what makes a "good life" and picturing a long-term vision for the child or adult with disabilities. It also provides a chance to discuss what they do NOT want in their life. The trajectory lines allow you to document what experiences have occurred that may influence the trajectory to the "good life" or send your child or adult towards what they don't want.

This worksheet is to reflect the child or adult's opinions to the best degree possible. This tool could be used prior to or during a person-centered planning meeting in order to get families, teachers, and staff all on the same page in supporting the child or adult to attain their best life. There are two different versions of the tool: one for families and one for individuals (your child or adult).



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To learn more about this tool, including how to fill it out, refer to the Appendix.

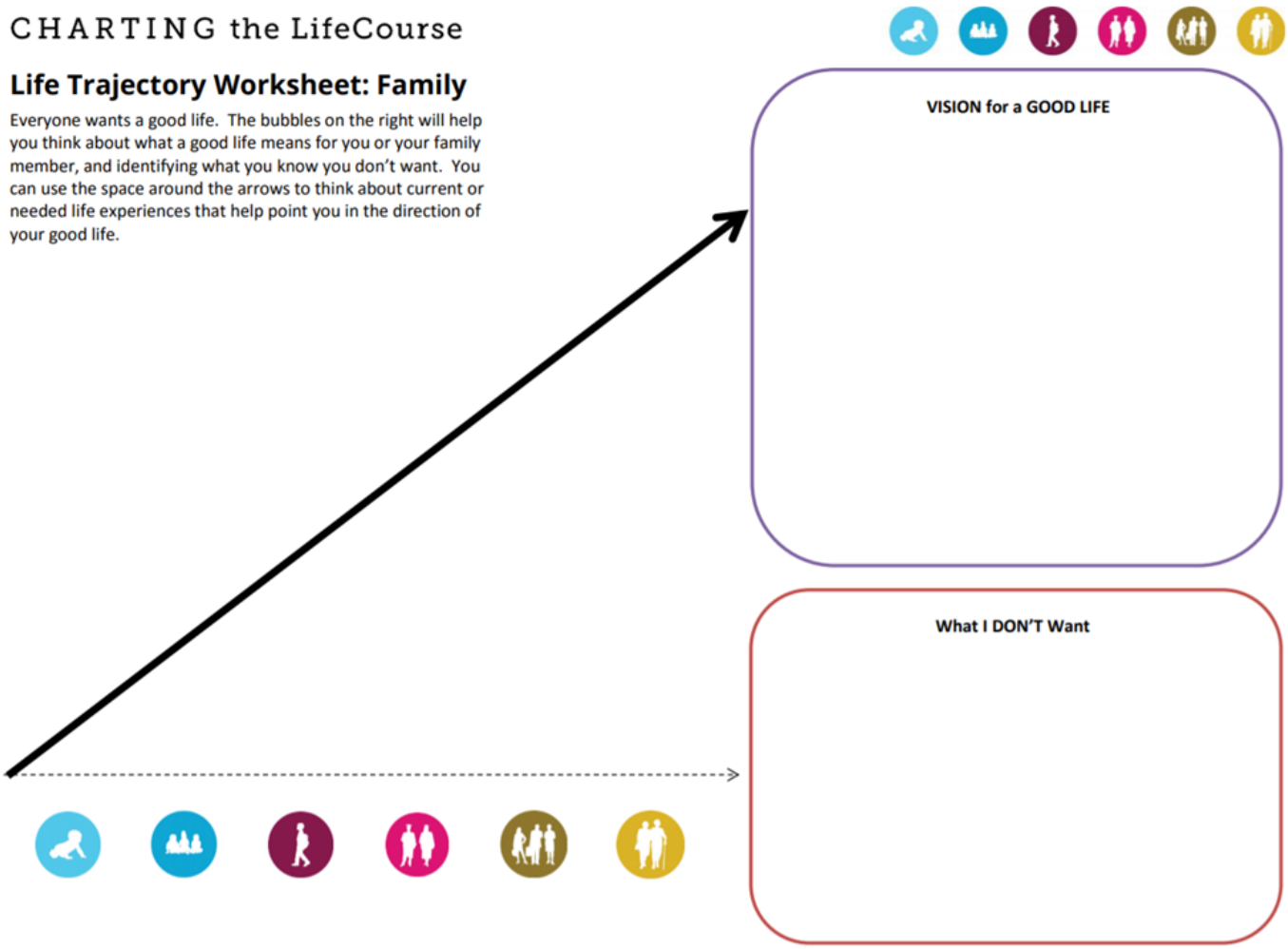
Tip:

Consider things that you think would be the best goal for your child while you involve the child or adult in the Person Centered Support Plan as much as they are able

CHARTING the LifeCourse

Life Trajectory Worksheet: Family

Everyone wants a good life. The bubbles on the right will help you think about what a good life means for you or your family member, and identifying what you know you don't want. You can use the space around the arrows to think about current or needed life experiences that help point you in the direction of your good life.



Developed by the UMKC Institute for Human Development, UCEDD. More materials at lifecoursetools.com

May 2016

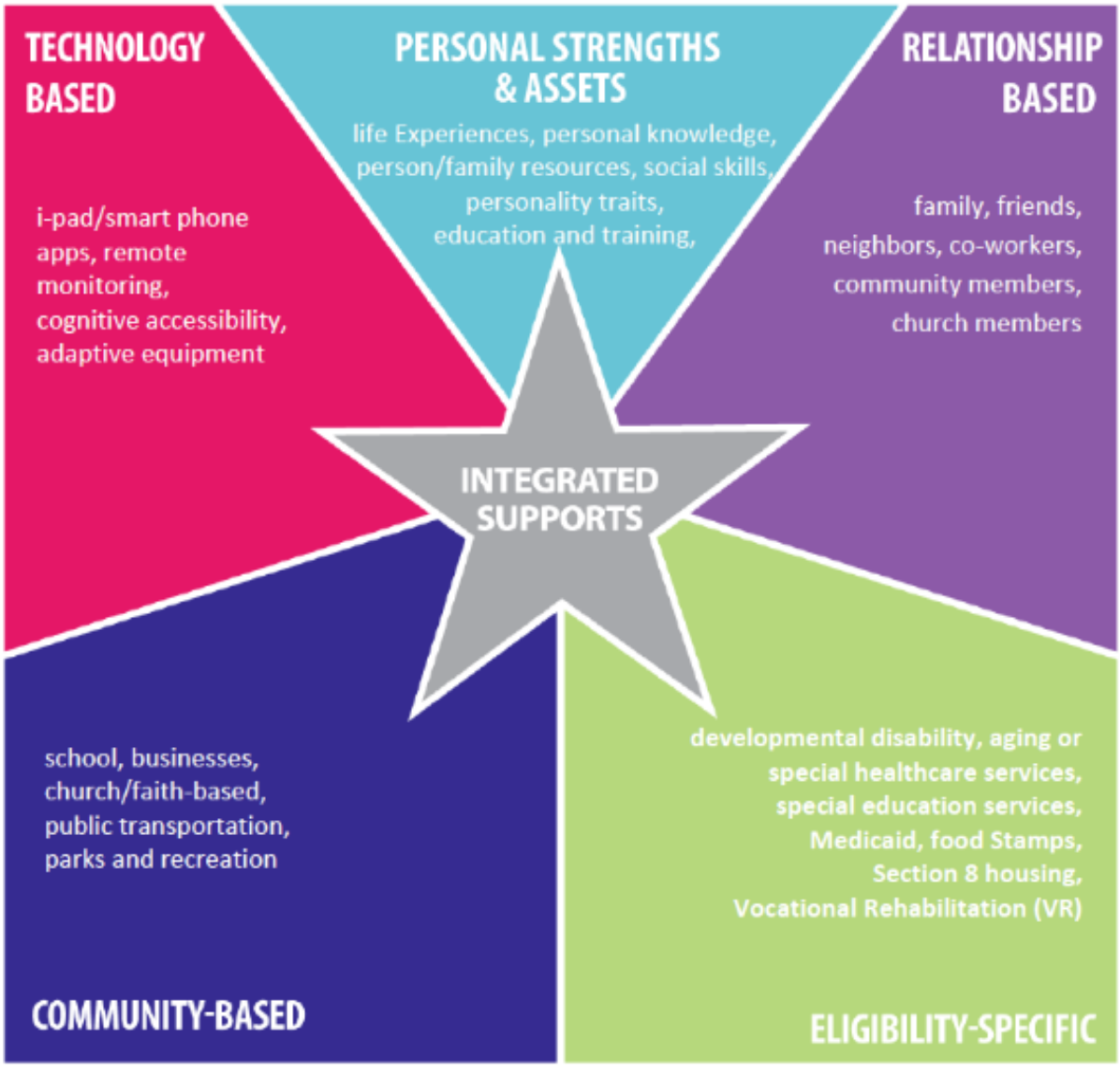
Integrated Supports Star

We all access a variety of supports to get successfully through our day, from things we can do independently, to things we access from others in our family or community. The Integrated Supports Star tool is used to identify the supports a person is already receiving in order to live an inclusive, quality life along with determining where support is lacking.

This tool is also used to identify partnerships where collaboration may work best in achieving a good life for the child or adult with disabilities.

The "Integrated Supports Star" tool can be found at the following link: https://www.lifecoursetools.com/planning/

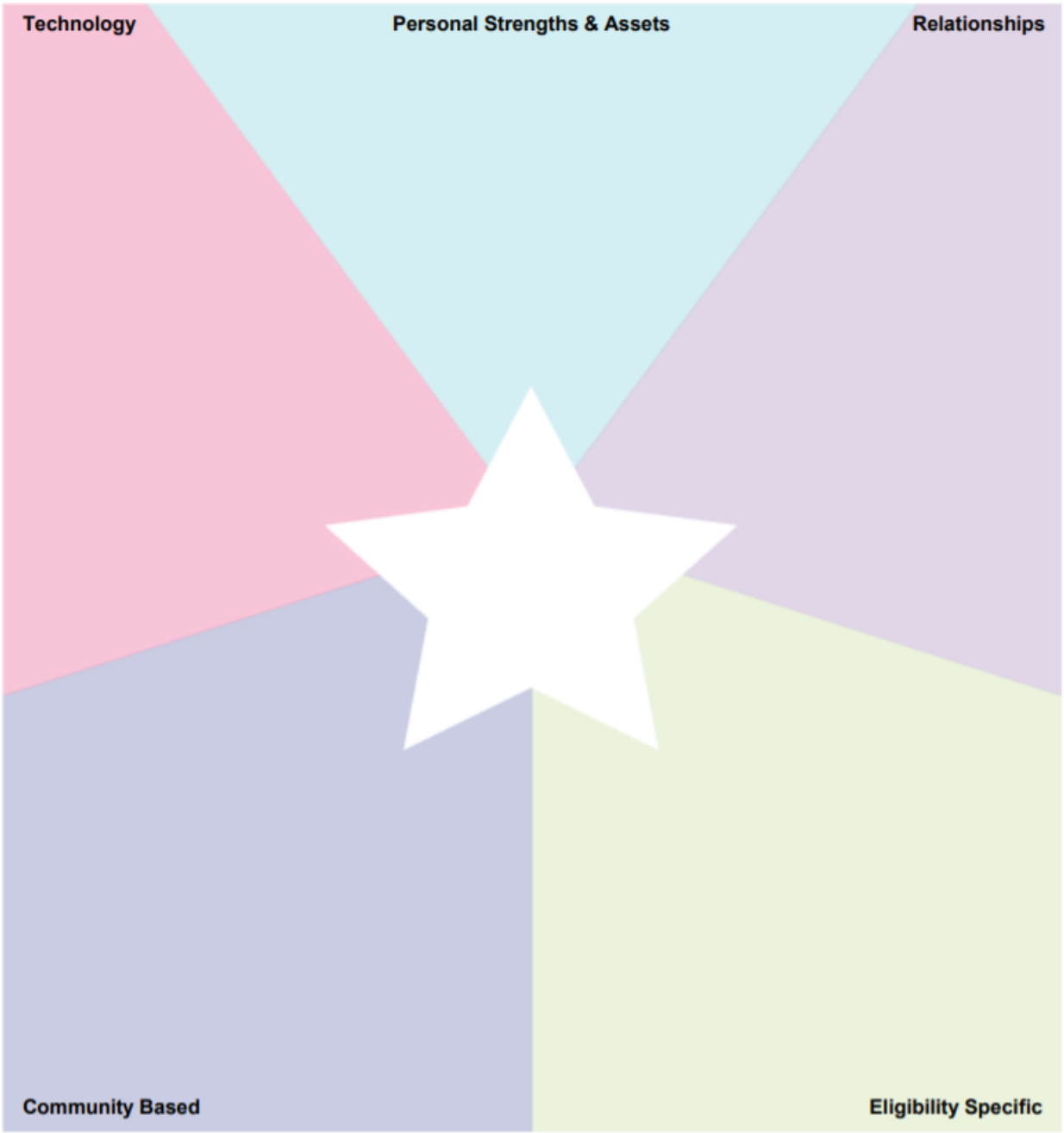
To learn more about this tool, including how to fill it out, refer to the Appendix.



CHARTING the LifeCourse

Integrated Supports

People need supports to lead good lives. Using a combination of lots of different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. This tool will help families and individuals think about how to work in partnership to support their vision for a good life.



Access the LifeCourse framework and tools at lifecoursetools.com

Developed by the UMKC Institute for Human Development, UCEDD. More tools and materials at lifecoursetools.com MAY 2016

Integrated Long-Term Support Needs

The Integrated Long-Term Support Needs tool is used to determine areas where supports could be implemented to make a person's daily schedule and overall life more full. There are five areas of support identified in this tool, all of which are color-coded (similar to the Integrated Supports Star) for better visual representation of which supports are lacking and which are heavily being used:

(1) Personal Assets and Strengths (light blue)

(2) Relationship-Based

A. Primary Caregiver (light purple)

B. Other caregiver, such as a family member, friend, or neighbor (dark purple)

(3) Technology (pink)

(4) Community-Based (dark blue)(

(5) Eligibility Based (green)

The "Integrated Long-Term Support Needs " tool can be found at the following link: https://www.lifecoursetools.com/planning/

To learn more about this tool, including how to fill it out, refer to the Appendix.

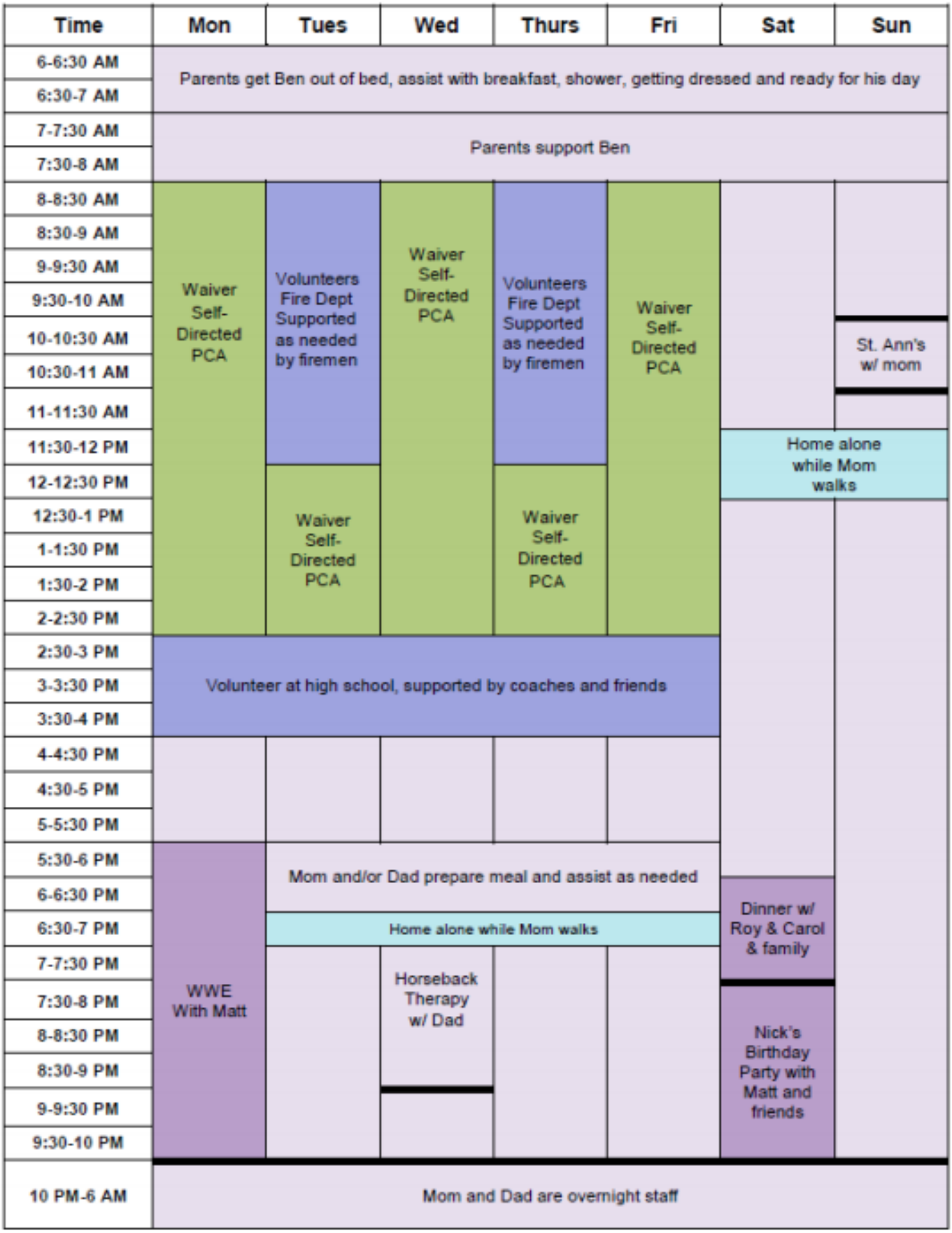
A blank worksheet is below. A completed example is on the following page.

CHARTING the LifeCourse

Integrated Long Term Support Needs

TIME	MON	TUES	WED	THURS	FRI	SAT	SUN
6-6:30 AM							
6:30-7 AM							
7-7:30 AM							
7:30-8 AM							
8-8:30 AM							
8:30-9 AM							
9-9:30 AM							
9:30-10 AM							
10-10:30 AM							
10:30-11 AM							
11-11:30 AM							
11:30-12 PM							
12-12:30 PM							
12:30-1 PM							
1-1:30 PM							
1:30-2 PM							
2-2:30 PM							
2:30-3 PM							
3-3:30 PM							
3:30-4 PM							
4-4:30 PM							
4:30-5 PM							
5-5:30 PM							
5:30-6 PM							
6-6:30 PM							
6:30-7 PM							
7-7:30 PM							
7:30-8 PM							
8-8:30 PM							
8:30-9 PM							
9-9:30 PM							
9:30-10 PM							
10 PM-6 AM							

Developed by UMKC IHD, UCEDD. More materials at lifecoursetools.com MAY 2016


Time
Mon
Tues
Wed
Thurs
Fri
Sat
Sun
6-6:30 AM
6:30-7 AM
7-7:30 AM
7:30-8 AM
8-8:30 AM
8:30-9 AM
9-9:30 AM
9:30-10 AM
10-10:30 AM
10:30-11 AM
11-11:30 AM
11:30-12 PM
12-12:30 PM
12:30-1 PM
1-1:30 PM
1:30-2 PM
2-2:30 PM
2:30-3 PM
3-3:30 PM
3:30-4 PM
4-4:30 PM
4:30-5 PM
5-5:30 PM
5:30-6 PM
6-6:30 PM
6:30-7 PM
7-7:30 PM
7:30-8 PM
8-8:30 PM
8:30-9 PM
9-9:30 PM
9:30-10 PM
10 PM-6 AM
Parents get Ben out of bed, assist with breakfast, shower, getting dressed and ready for his day
Parents support Ben
Waiver Self-Directed PCA
Volunteers Fire Dept Supported as needed by firemen
Waiver Self-Directed PCA
Volunteers Fire Dept Supported as needed by firemen
Waiver Self-Directed PCA
St. Ann's w/ mom
Home alone while Mom walks
Waiver Self-Directed PCA
Waiver Self-Directed PCA
Volunteer at high school, supported by coaches and friends
Mom and/or Dad prepare meal and assist as needed
Home alone while Mom walks
Dinner w/ Roy & Carol & family
WWE With Matt
Horseback Therapy w/ Dad
Nick's Birthday Party with Matt and friends
Mom and Dad are overnight staff

Exploring Decision-Making

The Tool for Exploring Decision Making Supports identifies areas in which a person will or will not need individualized supports to make important decisions. The tool identifies three levels of decision -making:

(1) I can decide with no extra support;

(2) I need support with my decision; and

(3) I need someone to decide for me.

It breaks out the decision levels by Life Domains as identified by Charting the Life Course, with questions in each area to determine how independent someone is in their decision-making process. This tool can help families see where they may need to provide support for decisions, or where they may be able to step back and let the child or adult make the decision on their own. It can show areas where decision-making skills could be practiced to allow for greater independence and can also with decisions surrounding guardianship as a child nears the age of 18.

This tool covers two pages with several questions for discussion in each life domain.

IIf you would like to learn more about guardian-ship as well as alternatives to guardianship, you can learn more at: https://files.constantcontact.com/a36be45c001/188574de-758b-4e5c-9cb4-736174d6c6c8.pdf

The "Exploring Decision-Making" tool can be found at the following link: https://www.lifecoursetools.com/planning/

To learn more about this tool, including how to fill it out, refer to the Appendix.

Tip:

Find the helpers. Find the ones that you connect with and build relationships with to help you.

You constantly hear about the future you have to plan for which is good, but sometimes it is important to always be in the now and to see how it is important too. Always try to stay positive.

CHARTING the LifeCourse

Tool for Exploring Decision Making Supports

This tool was designed to assist individuals and supporters with exploring decision making support needs for each life domain.

Name of Individual: _____

Name of person completing this form: _____

Relationship to individual *(circle one)*: Self Family Friend Guardian Other: _____

How long have you known the individual? _____

For each question below, mark the level of support you need when making and communicating decisions and choices in the Charting the LifeCourse life domains.	**I can decide with no extra support**	**I need support with my decision**	**I need someone to decide for me**
DAILY LIFE & EMPLOYMENT			
Can I decide if or where I want to work?			
Can I look for and find a job (*read ads, apply, use personal contacts*)?			
Do I plan what my day will look like?			
Do I decide if I want to learn something new and how to best go about that?			
Can I make big decisions about money? (*open bank account, make big purchases*)			
Do I make everyday purchases? (*food, personal items, recreation*)			
Do I pay my bills on time (*rent, cell, electric, internet*)			
Do I keep a budget so I know how much money I have to spend?			
Am I able to manage the eligibility benefits I receive?			
Do I make sure no one is taking my money or using it for themselves?			
HEALTHY LIVING			
Do I choose when to go to the doctor or dentist?			
Do I decide/direct what doctors, medical/health clinics, hospitals, specialists or other health care providers I use?			
Can I make health/medical choices for my day-to-day well-being? (*check-ups, routine screening, working out, vitamins)*			
Can I make medical choices in serious situations? (*surgery, big injury*)			
Can I make medical choices in an emergency?			
Can I take medications as directed or follow a prescribed diet?			
Do I know the reasons why I take my medication?			
Do I understand the consequences if I refuse medical treatment?			
Can I alert others and seek medical help for serious health problems?			
Do I make choices about birth control or pregnancy?			
Do I make choices about drugs or alcohol?			
Do I understand health consequences associated with choosing high risk behaviors *(substance abuse, overeating, high-risk sexual activities, etc.)*?			
Do I decide where, when, and what to eat?			
Do I understand the need for personal hygiene and dental care?			

CHARTING the LifeCourse

For each question below, mark the level of support you need when making and communicating decisions and choices in the Charting the LifeCourse life domains.	I can decide with no extra support	I need support with my decision	I need someone to decide for me
SOCIAL & SPIRITUALITY			
Do I choose where and when (and if) I want to practice my faith?			
Do I make choices about what to do and who to spend time with?			
Do I decide if I want to date, and choose who I want to date?			
Can I make decisions about marriage (*If I want to marry, and who*)?			
Can I make choices about sex, and do I understand consent and permission in regard to sexual relationships?			
SAFETY & SECURITY			
Do I make choices that help me avoid common environmental dangers (*traffic, sharp objects, hot stove, poisonous products, etc.)*?			
Do I make plans in case of emergencies?			
Do I know and understand my rights?			
Do I recognize and get help if I am being treated badly (*physically, emotionally or sexually abused, or neglected*)			
Do I know who to contact if I feel like I'm in danger, being exploited, or being treated unfairly (*police, attorney, trusted friend*)?			
COMMUNITY LIVING			
Do I decide where I live and who I live with?			
Do I make safe choices around my home (*turning off stove, having fire alarms, locking doors*)?			
Do I decide about how I keep my home or room clean and livable?			
Do I make choices about going places I travel to often *(work, bank, stores, church, friends' home)*?			
Do I make choices about going places I don't travel to often (*doctor appointments, special events*)?			
Do I decide how to get to the places I want or need to go? *(walk, ask a friend for a ride, bus, cab, car service)*			
Do I decide and direct what kinds of support I need or want and choose who provides those supports?			
CITIZENSHIP & ADVOCACY			
Do I decide who I want to represent my interests and support me?			
Do I choose whether to vote and who I vote for?			
Do I understand consequences of making decisions that will result in me committing a crime?			
Do I tell people what I want and don't want (verbally, by sign, device), and tell people how I make choices?			
Do I agree to and sign contracts and other formal agreements, such as powers of attorney?			
Do I decide who I want information shared with (family, friends etc.)?			

Overview of the PCSP Meeting

Reminder

You do not have to be in DSPD services to have a Person-Centered Planning meeting. Anyone can use the tools and principles discussed in this manual to develop a plan for themselves or someone else.

Who is in attendance?

The main participant in a Person-Centered Support Plan (PCSP) meeting is the individual receiving services from DSPD, or the person for whom the plan is being written.

The person for whom the plan is being written is the one who determines who is in attendance at the meeting and when and where the meeting will be held. The meeting should focus on the child or adult with disabilities' goals, dreams, needs, wants, preferences and priorities. The location should be comfortable, accessible, quiet and provide privacy.

In determining who attends the PCSP meeting, the child or adult may be able to make this decision independently or need some support from the support coordinator, family or others to do so. Those receiving DSPD services should have their Support Coordinator at the meeting as he or she has specific duties to fulfill.

Others who may participate in the PCSP are guardians, parents, other family members, close friends, residential and day support providers, employment providers, therapists, teachers, a significant other, or anyone who provides support (paid or unpaid) to the child or adult.

Changing Your Support Coordinator

If the child or adult does not want their Support Coordinator at the PCSP, they should discuss it with someone they trust. If they are not happy with their Support Coordinator, each support coordination company has a grievance process they can go through. (See "Dispute Resolution" in the Appendix.) They may also change support coordinators at any time.

There is a list of support coordinators and a video on choosing or changing them at

https://dspd.utah.gov/resources/find-a-support-coordinator/.

Preparing for the PCSP Meeting

The support coordinator will invite attendees to join the meeting and prepare an agenda for the meeting. He or she will also send out any necessary paperwork for review by attendees, such as the previous goals, any of the tools that have been filled out, a copy of the personal profile to be updated and a recent medical and social history. The Supports Intensity Scale (SIS) also helps in the development of the PCSP and is an important part of the Person-Centered Planning Process. The SIS is the assessment used by DSPD to measure how much support an individual needs, and is updated every five years. A SIS must be completed before developing a PCSP.

Personal Profile

The Personal Profile is a section of the PCSP which should give any person unfamiliar with the child or adult with disabilities insight into how to provide quality service. It includes a general description of their interests, passions, and values as well as likes and dislikes.

It should state the preferred communication style of the child or adult and their hopes, dreams, fears and personal goals. It should include the relationships and social roles that are important to them and any physical and emotional health and safety information.

Legal issues such as who can speak for your child or adult and any rights restrictions should also be included in the Personal Profile.

The individual, the parent or guardian, the support coordinator or another PCSP team member can review a copy of the previous year's PCSP, if applicable, with the child or adult with disabilities. They may want to talk about what the child or adult would like to have happen in the next year, or longer. The child or adult will be asked to make informed choices at the meeting regarding the services and supports they receive, and who provides them. The parent/guardian, providers or the support coordinator can provide information, experiences, and options for the child or adult prior to the meeting so they will be able to make a truly informed choice.

For example, if the child or adult with disabilities is interested in getting a job, they could do an interest inventory to see what they might want to do, visit some businesses that interest them, or watch videos online of people doing a variety of jobs that fit their skills and abilities.

What Happens at a PCSP Meeting?

The child or adult should lead the meeting to the extent they want to. Their Support Coordinator and their PCSP team should help the child or adult participate in the meeting in whatever capacity they would like. The support coordinator or other team members should facilitate the PCSP process and make sure the meeting focuses on what is important to the child or adult. Providers have an important role in the PCSP process because they are generally the ones who follow the support strategies to help the child and adult reach their goals and often spend a lot of time around them. Providers can offer suggestions and insights into the child or adult's desires, as can family members and friends, and all can ensure that everyone is focused on the needs and wants of the child or adult.

The team will follow the agenda to make sure they discuss everything they need to. The PCSP will include identified goals and desired outcomes to guide supports and services throughout the year. The goals will reflect those specifically chosen by the child and adult as well as any clinical or support needs identified through any assessment completed prior to the meeting. Providers can give input into the support strategies for the goals so that they are written with the child or adult in mind, and are measurable, attainable and relevant. The child or adult must consent to the goals and strategies for reaching them.

GOALS

Writing Goals

Dr. Martin Luther King Jr. said, "I have a dream." He did not say, "I have an annual plan and quarterly goals and objectives."[1]

When getting ready to write goals, it will be helpful to refer to the Person-Centered Support Plan (PCSP) that you have created with the child or adult with disabilities. Pay close attention to these two starting points:

- What they want
- What they don't want

Keeping these points in mind as goals are written will make sure that the PCSP is driving the goals, which then will lead to what services and supports are needed for the coming year. It is important to start the process with what the individual wants, what is most important to them, and by addressing their core values and passions, along with dreams and wishes.

The following is reproduced from North Dakota Center for Persons with Disabilities. (nd). Person Centered Planning. Technical manual prepared by the North Dakota Center for Persons with Disabilities, Minot State University, Minot, ND, with the permission of North Dakota Center for Persons with Disabilities:

"When your child is very small, you will decide what goals and dreams are important to give your child a good life. As your child grows, they will learn to make choices. Your role will gradually change from directing and guiding to assisting and supporting.

Once you have chosen some goals, dreams or outcomes, ask the team to help you find out what skills and abilities your child may have. These strengths are what will really help your child/teen achieve his/her goals.

Early goals may include playing, moving around easily, enjoying meals or making friends. Later goals may be enjoying sports or fitness activities, reading or sending messages, getting a job, living in an apartment/house, going to college and/or taking part in community life.

Finally, invite the team to help you/your child or adult decide what kind of assistance and support you need to build on strengths and achieve goals.

Supports and services begin with the child or adult's dreams, goals, strengths and abilities and NOT his or her disabilities. Services provide what the child needs and NOT what a school, agency or program may typically offer."

[1] Roehl, Anne. An Introduction to Person Centered Thinking: Making a Difference Now. https://www.dhs.state.mn.us/main/groups/county_access/documents/pub/dhs16_191036.pdf. PowerPoint Presentation

SMART Goals

Including SMART goals will help in writing goals that make it clear what the child or adult with disabilities wants for their future.[2]

SMART Goals Guide	
Specific	» What exactly needs to be accomplished? » Who else will be involved? » Where will this take place? » Why do I want to accomplish the goal?
Measurable	» How will I know I've succeeded? » How much change needs to occur? » How many accomplishments or actions will it take?
Attainable	» Do I have, or can I get, the resources needed to achieve the goal? » Is the goal a reasonable stretch for me? (neither out of reach nor too easy) » Are the actions I plan to take likely to bring success?
Relevant	» Is this a worthwhile goal for me right now? » Is it meaningful to me—or just something others think I should do? » Would it delay or prevent me from achieving a more important goal? » Am I willing to commit to achieving this goal?
Time-bound	» What is the deadline for reaching the goal? » When do I need to take action? » What can I do today?

[2] "SMART Goals Guide" found at https://www.pinterest.com/pin/418131146630241336/

Examples of Goals

The written goal must address what the child or adult actually wants to do. For example, if they want to get to know their neighbors, you need a goal that makes it clear what they want. Having a goal that says, "June will go for a walk in her neighborhood several times a week," does nothing to ensure that June meets any of her neighbors. The goal could instead be "June wants to get to know her neighbors." Based on that goal, services could be generated to assist her with accomplishing the goal.[3]

Sometimes the goal will be broader but the support strategies for the goal will address the specific, measurable and time-bound aspects of the SMART goal.

For example, Brandon likes being challenged. He has a job that he has had for a few years. One of his goals might be:

Brandon wants to try new challenges. Brandon will work with his Support Staff through Vocational Rehabilitation to explore new job assignments and expand his job skills by the end of the year.

Brandon's support strategies for this goal might include:

Brandon's Support Staff will identify ways in which Brandon can improve with specific job assignments and develop ways in which Brandon can learn and improve in these areas. They will work with his coworkers to see about expanding his work shifts and other work assignments as well.

More Goal Examples

Ward will improve his written expressive language skills in order to write a book.

Ward's support strategies for this goal:

Ward's Support Staff will help him write his book by practicing writing together. Staff will also assist him in searching for learning experiences on YouTube to improve his language and writing skills.

A goal for Myrtle might be

Myrtle will spend time doing educational activities that are meaningful to her, with support as needed, with staff and family.

Myrtle's support strategies for this goal:

Myrtle will have support to create schedules that may include academics, arts and crafts to improve motor skills, playing educational games and activities that Myrtle chooses.

A goal for June might be

June will move herself around the house in order to be near her siblings and parents.

A Support Strategy for June could include:

June will exercise to maintain and increase her lower body strength and practice mobility.

Another goal for June might be

June wants to be more independent in her personal hygiene.

A support strategy for this goal:

June's Support Staff will teach her how to brush her teeth and track independence level June uses brushing her teeth. [3]

[3] Maine's Person Centered Planning Process: https://www.maine.gov/dhhs/oads/provider/developmental-services/documents/PCPManualpdf.pdf

After the PCSP Meeting

The PCSP may not be finalized in the meeting as everything must be input into the DSPD system software by the support coordinator who will then activate it. As a group, there should be agreement on the desired goals and support strategies that will be used to help the child or adult in reaching their goals. There should be a plan for which supports, paid and unpaid, will be used for each goal listed. It should document the home and community-based settings that were considered by the individual. More information on Person-Centered Planning can be found in the November 2019 Parent Connections newsletter, on the DSPD website: https://dspd.utah.gov/wp-content/uploads/2020/01/PCSP-Newsletter-Nov2019.pdf)

After the meeting has concluded, the support coordinator should make sure that the discussion and decisions are captured in the DSPD software system. A draft PCSP should be generated and sent out to the team to verify that it correctly reflects the discussion and decisions from the meeting. Any changes should be reported to the support coordinator who can update the formal document in the software system. The PCSP should then be finalized and distributed to those involved in creating and carrying out the plan.

The child or adult should be a willing participant in working towards the goals set for the upcoming year. The providers and others who support the child or adult should use the plan to assist them as they work on goals. Progress should be documented and reported at least monthly to the support coordinator. The support coordinator will continue to monitor the child or adult, what the support the plan contains, how they are how their health and safety needs are monitored and maintained, and if any changes are needed in the plan to accommodate any changes in their life. A family member, significant other or a provider may be designated as a "champion," and should also monitor progress, and provide encouragement and information to the child or adult when needed.

Person-Centered Planning is not something that is done once and then is never done again. Remember, those in DSPD services will do it at least once per year. PCP is a starting point that can evolve over time and change as a person's circumstances, interests, skills and vision for the future changes. At any time, you or the child or adult can request a meeting, formal or informal, to discuss any concerns or questions about the PCSP. The PCSP can be changed or updated at any time. To initiate any changes or updates, the support coordinator should be contacted.

The plan can be used to inform other plans, such as IEPs, and serve as a resource for informing family, friends and staff on the child or adult's aspirations, goals, interests, preferences and strengths.

Consider the Person-Centered Support Plan as an important tool for the child or adult to live their vision of a good life!

APPENDIX

Acronyms

The Acronym list on Utah Parent Center website may be helpful as you learn the systems and places to find support. https://utahparentcenter.org/resources/acronyms/

Advocacy

When you are not finding the services that are needed, you can see it as an opportunity for advocacy. Advocacy is speaking up. You may need to advocate for the child or adult with a disability during person-centered planning to talk about what they want, what they do not want and so you are able to help others understand what they are communicating if their communication style is unclear.

You are advocating when you tell those around you what you need. We all advocate for our individual children/family members on a day to day basis. You may want to take it a step further and join with other parents and stakeholders to advocate for systems change. Many of the services now available are there because others before you took the time and effort to speak up or to help educate policymakers: https://utahparentcenter.org/dual-diagnosis-module/about-families-what-they-need-advocacy/

Dispute Resolution

All providers and support coordination companies must have a grievance procedure in place for dispute resolution. It will generally follow a process such as:

1. Contact the person with whom you have a grievance. If that does not resolve the issue, then
2. Contact the person's immediate supervisor. If there are still concerns, then
3. Contact the company owner. If that does not resolve the issue, then
4. Contact the Department of Human Services (DHS) at 801-538-3991

In cases of abuse, neglect or exploitation, you should immediately contact the appropriate protective services agency:

Adult Protective Services 1-800-371-7897
Child Protective Services 1-800-678-9399

APPENDIX-2

Service Delivery Options

There are two main options for administering DSPD services:

- Self-Administered Services (SAS)
- Provider Agency Services

There is a third option for those who need a lot of support, and that is an institutional setting. We will breakdown the services for you.

Self-Administered Services (SAS) allow people with disabilities and their families to select services that are provided within their home. Under the SAS Model, people with disabilities and their families are able to hire, train, and supervise the employees providing support to the person. This gives a person or a person's family more control over who provides supports and services to them, but also requires a greater degree of dedication from the family.

All families who use the SAS model must hire a Fiscal Agent, one of the companies contracted with DSPD who is responsible to provide financial services for the person. The Fiscal Agent assists with things such as payroll, taxes, background checks and keeping you informed of what has been spent and what is available for spending from the budget.

For more information on the SAS Model, you can review the following resources:

- Self-Administered Supports Book - Community Supports and Acquired Brain Injury: https://dspd.utah.gov/wp-content/uploads/2019/10/Self-Administered-Supports-Book-%E2%80%93-Community-Supports-and-Acquired-Brain-Injury-Revised-10.2.19.pdf
- Self-Administered Supports Book - Physical Disabilities: https://dspd.utah.gov/wp-content/uploads/2019/10/SAS-Support-Book-PDW-10.2.19-Revision.pdf
- SPANISH: Self-Administered Supports Book - Community Supports and Acquired Brain Injury: https://dspd.utah.gov/wp-content/uploads/2017/05/Spanish-SAS-Book-CS.ABI3_.pdf
- SPANISH: Self-Administered Supports Book - Physical Disabilities: https://dspd.utah.gov/pdf/Spanish-SAS-Book-PDW.pdf

APPENDIX-3

Traditional **provider agency services** are offered to people on the Home and Community Based and Acquired Brain Injury waivers. The Division has contracts with hundreds of private provider agencies across the state to provide specialized services. If the person with a disability or their parent/guardian chooses this model, then your Support Coordinator will help you choose which provider you wish to work with. The Support Coordinator will arrange for funds from the individual's budget to be allocated to the chosen provider agency. The provider takes care of hiring, training and paying the staff that work with the individual.

DSPD contracts with a large number of privately-owned provider companies that provide a large variety of services across the state. Many provider companies specialize in delivering a particular type of service or meeting the needs of a particular type of disability. It is important to know that you have a choice in selecting a provider and are free to determine what services will provide you or your loved one with the best care for your situation. The state certifies and/or licenses these providers, and DSPD works closely with them to monitor the quality of the services they provide.

Utah State Developmental Center (USDC) is Utah's only state-operated I**ntermediate Care Facility for People with Intellectual Disabilities (ICF/ID)**, which is a 24-hour institutional setting. The Center offers intensive medical, behavioral, psychological and dental services to those over age 18. Admissions are limited and require an intensive screening or a court commitment process. For additional information, please visit USDC's website: https://usdc.utah.gov/

Using the Tools Exercises

Exercise—Relationship Map

https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Documents/Quad.RelationshipMap.pdf

To use the tool, write names into the map accordingly, putting those who may involve larger, more important roles closer to the center of the circle. You could highlight those who the child or adult may want at their Person-Centered Planning meeting as a reference for when you are pre-planning the meeting. When it is completed, study the map. What do you notice? Do you see any patterns or themes? You should be able to easily see where support is solid and where support is lacking. Take time to brainstorm who could fill these gaps and how they could be beneficial to the child or adult.

The Relationship Map is a great tool to use in conjunction with the other Tools, and as a precursor to these other tools and to the PCSP meeting to make facilitating the meeting easier.

APPENDIX-4

Exercise—Developing a Vision

https://www.lifecoursetools.com/planning/

To use this tool, begin by discussing each domain and defining what it means, if necessary. You may need to provide examples, or tour some facilities, etc. to get some ideas of what each domain entails and start thinking of the vision of the future.

Then use the questions provided and add more of your own to further drive the conversation of what each domain will look like at some future point. You may need to take additional tours, take pictures, etc. to determine the vision for the future.

Now, discuss what the current situation is for each domain. For example:

- Does the child or adult already have a set living situation?
- How much of their daily care can they do independently?
- Do they exercise regularly or want to start?

Lastly, you will rank each of these domains in a different priority. Many of these can have the label as "Number One" priority. For instance, someone may want to start exercising as soon as possible as well as begin looking for a job. There are things you can begin to implement right away versus things that may take a while. For example, if you start the process of looking for jobs right away, you may not start actual employment for a long time. You will see what items are of most importance to start working on right away, and which can wait.

The "Things to Work On" may become part of the Person-Centered Support Plan as goals to work towards now or in the future.

Exercise—Life Trajectory Worksheet

https://www.lifecoursetools.com/planning/

When using this tool, think about what makes a life good for someone. Does it involve working? What about education? What about hobbies? What does the child or adult enjoy doing in their leisure time? Where do they hope to live? How or who manages the child or adult's healthcare needs? Because there are many different aspects that involve having a good life, you may need to be creative in order to discuss what a part of a good life is and what is not. Pictures or videos instead of written words might be helpful in conveying what the child or adult envisions for themselves. It is important that they understand what they are choosing to the best of their capabilities.

APPENDIX-5

Fill in the "Vision" box with all of the things the child or adult wants for their good life. Put the things they do not want or want to avoid, in the appropriate box. Along the trajectory lines, write experiences they have had (or need to have) that have led the child or adult towards what they want, or towards what they want to avoid. The experiences they need to have may become goals that can be written into the PCSP.

The Trajectory can inform caregivers, teachers, family and others what the child or adult hopes to have and allows everyone to help support them in reaching that vision. It can be customized to fit almost any time frame including as short as a week or hopes for a distant future. The trajectory can be focused on a specific life domain or life stage or a specific goal. For example, you may use this trajectory to just plan a child's goals for the school year, or an adult's desire to increase their social network or to help them recover from a surgery.

Sometimes it is helpful to have the child or adult fill out the trajectory and then have family members do the same. This can show areas of agreement or disagreement between the various trajectories and opens up a discussion so everyone can get behind or at least try to understand the child or adult with disabilities' perspective. The trajectory is also a great visual tool to show the child or adult the impact of decisions on moving towards the "good life" or what they do not want.

Exercise—Integrated Supports Star
http://www.lifecoursetools.com/principles/integrated-supports/

The Integrated Supports Star tool is used to identify the supports a person is already receiving in order to be living an inclusive, quality life along with determining where support is lacking. This tool is also used to identify partnerships where collaboration may work best in achieving a good life for the child or adult with disabilities.

There are five different sections to the star:

1. Relationships - One person cannot (and should not) do everything, but many people may be able to do one thing, including friends, family, neighbors, community or church groups.
2. Personal Strengths and Assets - This can be life experiences, knowledge and skills, such as riding the bus, making friends, specific education and/or training, or personal characteristics like reliable, or a sense of humor. This could even be a tangible asset, such as a car.
3. Technology - This could be an iPad, cell-phone, specialized adaptive equipment or even low-tech items such as an alarm clock, schedule board or task list.

APPENDIX-6

4. Community-Based - Community-Based supports include places that anyone in the community can access such as schools, businesses (ex: grocery stores), churches, public transportation, parks and recreation, hospitals, etc.
5. Eligibility Specific - This includes supports that have an eligibility requirement to access, such as age, income or disability, and may include Medicaid, food stamps, section 8 housing, or special education services.

Each section represents a type of support a person may already have in place. In order to support a trajectory to an inclusive, quality, vision of a good life, supports for the child or adult should be an integrated combination of personal strengths and assets of the individual and family, relationship-based supports, technology, community resources, and eligibility-based supports. Go through each area of the Star and identify the types of support the child or adult with disabilities has. You can even divide each section in half, list current supports on one side and future support needs on the other.

The Integrated Supports Star is excellent to use before going through the Integrated Long-Term Support Needs tool, described next, to figure out a person's ideal daily schedule. It can also be used as a pre-meeting tool with you the child or adult with a disability and the family or support team to identify areas of discussion for the person-centered meeting to help set the agenda.

Some additional tips for using the Integrated Support Star:

- Use pictures and icons instead of words to fill out the star, whatever kind of pictures the child or adult understands.
- Fill out the Trajectory first then fill out the Star with the various types of support needed to get the child or adult to their vision.
- Use it to understand if there are areas where there are additional supports wanted or if all supports come from one or two areas.
- Use it to plan for the implementation of goals. For example, if a child has a goal to learn to zip up their own jacket, or an adult wants to have control over their spending money, what personal, relationship, paid, community and technology supports can help them reach their goal?
- Use it to determine where the child or adult spends all of their time. Instead of writing in supports in each section, write in the amount of time or time periods during the day they are: in the community, using technology, on their own, with family and with paid supports. It can help you see what areas of the child or adult's life may be over-utilized, or could be used more. o they exercise regularly or want to start?

APPENDIX-7

Exercise—Integrated Long-Term Support Needs
http://www.lifecoursetools.com/planning/

The Integrated Long-Term Support Needs tool is used to determine areas where supports could be implemented to make a person's daily schedule and overall life more full. There are five areas of support identified in this tool, all of which are color-coded for better visual representations of which supports are lacking and which are heavily being used:

1. Personal Assets and Strengths (light blue)
2. Relationship-Based –
   Primary Caregiver (light purple)
   Other caregivers, such as a family member, friend, or neighbor (dark purple)
3. Technology (pink)
4. Community-Based (dark blue)
5. Eligibility-Based (green)

The first step in using the Integrated Long-Term Support Needs tool is to use the calendar provided on one side of the page and write in what the weekly schedule currently looks like. Make sure to detail this part as much as possible and include key members, such as families, friends, or staff, to make the most accurate daily schedule.

The next step is to color in each time-slot to the correlating support that is being used. For example, if the child or adult is going to school or their day program, color in the time-slots green during their time at school/the program. Next, notice which colors are lacking and discuss with the child or adult, and other participants who may be a part of the meeting, how you could make this schedule more colorful.

Some families find it helpful to begin the planning process using the Integrated Long-Term Support Needs tool. After filling in each time slot during the week for the child or adult, then think about what supports, if any, are needed during each time slot. It can help you see what supports are already in place for the child or adult, and what supports are needed to help them get through their day. Used in conjunction with the Integrated Supports Star, this tool becomes a visual representation of the child or adult's day. It can be very helpful for long-term planning or planning for the future.

APPENDIX-8

Exercise—Exploring Decision Making

http://www.lifecoursetools.com/planning/

The Tool for Exploring Decision Making Supports identifies areas in which a person will or will not need individualized supports to make important decisions. The tool identifies three levels of decision-making:

1. I can decide with no extra support;
2. I need support with my decision; and
3. I need someone to decide for me.

It breaks out the decision levels by Life Domains as identified by Charting the Life Course, with questions in each area to determine how independent someone is in their decision-making process. These domains include:

1. Daily Life and Employment
2. Healthy Living
3. Social and Spirituality
4. Safety and Security
5. Community Living
6. Advocacy and Engagement (Citizenship and Advocacy in earlier versions)

Under each of these Domains are questions meant to be answered and spark other questions within each domain that are more unique to each person. This worksheet is a great tool to use during a Person-Centered Planning meeting in order to receive feedback not only from the child or adult but those who have supported them in the past in some of these areas in decision-making.

To use, go through each of the Life Domains and read through the questions. For each, decide if the child or adult can make the decision themselves, need some support to make the decision, or need someone to make the decision for them. Then review the results. Notice the pattern for answers. Is there one area of life for which the child and adult can make their own decisions? Are there areas where they could learn to make their own decisions with some practice? Your child or adult may wish to add some goals into the PCSP to work towards greater independence in decision-making.