PERIODIC REVIEW
DEVELOPMENTAL SERVICES

SELF-CARE:

1) What supports do you need to take care of your personal care needs throughout the day such as bathing, dressing, toileting, eating, etc.?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____
2) What supports do you need to take care of things in your home such as cooking, doing your laundry, cleaning your house, etc.?____________________________
   ____
   ____
3) What supports do you need to meet your needs in the community such as banking, purchasing clothing, grocery shopping, etc.?______________________________
   ____
   ____
4) What supports do you need to maintain your job such as assistance with lunch, help communicating with co-workers, etc.?________________________________
   ____
   ____
5) What supports do you currently have to meet these needs?___________________
   ____
   ____
6) Which support needs of yours are not currently being met?__________________
   ____
   ____
7) What will happen if you do not have these support needs met?________________
   ____
   ____
8) Is there any thing else we should know about your self-care needs?____________
   ____
   ____

NAME_______________________________DATE_______________
PERSON RECORDING_____________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

HEALTH CARE/MEDICAL:

1) What supports do you need to take care of your health and medical needs throughout the day such as taking or getting medications, tube feedings, making or getting to doctor's appointments, assisting with a special diet, etc.?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____
2) What type of special equipment do you need such as a wheelchair, lift, monitor, etc.?____
   ____
   ____
3) Do you need supports or a nurse to meet any major or chronic medical conditions such as diabetes, asthma, seizures, etc.?______________________
   ____
   ____
4) What supports do you currently have to meet these needs?________________
   ____
   ____

6) Which support needs of yours are not currently being met?________________
   ____
   ____

7) What will happen if you do not have these support needs met?_____________
   ____
   ____

8) Is there any thing else we should know about your health or medical needs?____
   ____
   ____

NAME______________________________DATE______________
PERSON RECORDING____________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

BEHAVIORAL/MENTAL HEALTH:

1) What supports do you need throughout the day to manage your emotions and/or behavior?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____
2) Do you need or have you had a need for supports to keep yourself or others safe?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____
3) Have you had involvement in the criminal justice system?________________
   ____
4) What supports do you currently have to meet these needs?________________
   ____
   ____
5) Which support needs of yours are not currently being met?________________
   ____
   ____
6) What will happen if you do not have these support needs met?______________
   ____
   ____
7) Is there any thing else we should know about your behavioral or mental health needs?____
   ____

NAME________________________________DATE________________
PERSON RECORDING______________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

MOBILITY:

1) What supports do you need to get around throughout the day such as a walker, wheelchair, personal assistance, accessible public transportation, accessibility modifications, etc.?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____

2) Does your home or work environment currently require modification? _______
   ____

3) What supports do you currently have to meet these needs? ________________
   ____
   ____

4) Which support needs of yours are not currently being met? ________________
   ____
   ____

5) What will happen if you do not have these support needs met? _____________
   ____
   ____

6) Is there any thing else we should know about your mobility needs? _________
   ____

NAME_______________________________DATE_______________
PERSON RECORDING_____________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

SLEEPING:

1) What is your typical sleep pattern?____________________________________
____
2) Do you sleep through the night?_______________________________________
3) How often do you wake during a night and does that occur every night or just now and then?____
____
4) How long are you awake once you wake up and do you need support when you are awake?____
____
5) Do you have problems getting up in the morning?________________________
____
6) What supports do you currently have to meet these needs?________________
____
____
7) Which support needs of yours are not currently being met?_______________
____
____
8) What will happen if you do not have these support needs met?_____________
____
____
9) Is there any thing else we should know about your sleep needs?____________
____
____

NAME_______________________________DATE_______________
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PERIODIC REVIEW
DEVELOPMENTAL SERVICES

SUPPORT/SAFETY:

1) What supports do you need throughout the day to ensure your safety such as personal assistance, safety modifications, etc.?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____
2) Can you spend time alone, and if so, for how long at a time?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____
3) What supports do you currently have to meet these needs? _________________
   ____
   ____
4) Which support needs of yours are not currently being met?________________
   ____
   ____
5) What will happen if you do not have these support needs met?______________
   ____
   ____
6) Is there any thing else we should know about your safety/support needs?____
   ____
   ____

NAME_________________________________DATE________________
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PERIODIC REVIEW
DEVELOPMENTAL SERVICES

COMMUNICATION:

1) What supports do you need to communicate with people throughout the day?
   a) At home____
   ____
   b) At work____
   ____
   c) In the community____
   ____
   d) In a respite setting____
   ____
2) What type of special communication devises do you need such as a computer, communication board, etc.?____
   ____
   ____
3) What training do your support staff need such as sign language, foreign language, facilitated communication?_________________________________
   ____
   ____
4) What supports do you currently have to meet these needs?_________________
   ____
   ____
5) Which support needs of yours are not currently being met?________________
   ____
   ____
6) What will happen if you do not have these support needs met?_____________
   ____
   ____
7) Is there any thing else we should know about your communication needs?____
   ____
   ____

NAME________________________________DATE________________
PERSON RECORDING______________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

RESPITE (For paid providers):

1) What sort of breaks does you support provider need to ensure they can continue to support you?____
____
____

2) What supports do you currently have to meet these needs?_______________
____
____

3) Which support needs of yours are not currently being met?_______________
____
____

4) What will happen if you do not have these support needs met?____________
____
____

5) Is there any thing else we should know about your respite needs?__________
____
____

NAME______________________________DATE_______________
PERSON RECORDING____________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

NEED FOR STRUCTURE:

1) What supports do you need to follow your daily routine such as verbal reminders, visual cues, or a personal assistant?
   a) At work____
   ____
   b) In the community____
   ____
2) What supports do you currently have to meet these needs?_______________
   ____
   ____
3) Which support needs of yours are not currently being met?_______________
   ____
   ____
4) What will happen if you do not have these support needs met?____________
   ____
   ____
5) Is there any thing else we should know about your need for structure?________
   ____
   ____

NAME______________________________DATE_______________
PERSON RECORDING____________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

STABILITY / COMPLEXITY/ SUPPORT SYSTEM:

1) How stable are the following areas of your life or your family's life?
   a) Friendships____
   ____
   b) Family relationships____
   ____
   c) Marriage/partners____
   ____
   d) Living arrangement____
   ____
   e) Work____
   ____
   f) Health____
   ____
   g) Financial situation____
   ____
   h) School____
   ____
   i) Other____
   ____

2) Are there things impacting your life or your family's lives in the following Areas?
   a) Friendships____
   ____
   b) Family relationships____
   ____
   c) Marriage/partners____
   ____
   d) Living arrangement____
   ____
   e) Work____
   ____
   f) Health____
   ____
   g) Financial situation____
   ____
   h) School____
   ____

i) Other____
____

3) What agencies are currently providing supports such as SRS, guardian, school, vocational rehabilitation, etc.?____
____
____

4) What supports do you currently have to meet these needs?__________________
____
____

5) Which support needs of yours are not currently being met?_________________
____
____

6) What will happen if you do not have these support needs met?_______________
____
____

7) Is there any thing else we should know about your needs?__________________
____
____

NAME_________________________________DATE________________
PERSON RECORDING____

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

CLINICAL:

1) What supports do you need from specialists?
   a) Psychotherapist____
   ____
   b) Psychiatrist____
   ____
   c) Occupational Therapist____
   ____
   d) Physical Therapist____
   ____
   e) Speech Therapist____
   ____
   f) Other____
   ____
2) How often do you need supports?
   a) Psychotherapist____
   ____
   b) Psychiatrist____
   ____
   c) Occupational Therapist____
   ____
   d) Physical Therapist____
   ____
   f) Speech Therapist____
   ____
   f) Other____
   ____

3) Do you take medications that need to be monitored?_______________________
____
____

4) What supports do you currently have to meet these needs?_________________
____
____

5) Which support needs of yours are not currently being met?_________________
____
____

6) What will happen if you do not have these support needs met?______________
____
____

7) Is there any thing else we should know about your clinical needs?___________
____
____

NAME________________________________DATE________________
PERSON RECORDING_______________________________________

PERIODIC REVIEW
DEVELOPMENTAL SERVICES

Complete relevant section of Needs Assessment or similar document if there is a change.

NAME________________________________DATE________________
PERSON RECORDING_______________________________________

SELF-CARE: _____No Change_____See Update

HEALTH CARE/MEDICAL:_____No Change_____See Update

BEHAVIORAL/MENTAL HEALTH: _____No Change_____See Update

MOBILITY:_____No Change_____See Update

SLEEPING:_____No Change_____See Update

SUPPORTS/SAFETY:_____No Change_____See Update

COMMUNICATION:_____No Change_____See Update

RESPITE:_____No Change_____See Update

NEED FOR STRUCTURE:_____No Change_____See Update

STABILITY/COMPLEXITY/SUPPORT SYSTEM:_____No Change_____See Update

CLINICAL:_____No Change_____See Update

I/We have provided information regarding my/our view of support needs for myself, my child, or a person for whom I/we are legally responsible. I/We understand that the information provided is not intended to reflect what services will be provided and/or funded. Rather this information will be reviewed along with other information. Based on review of all information, a decision will be made as to whether the service needs meet a System of Care priority for funding, and if so, the information will be further utilized in establishing the level of service and funding.

____________________________________ ____________________
Signature Date

____________________________________ ____________________
Signature Date

11-00