**Participant Interest Inventory**



|  |
| --- |
| **Optional Photo**  |

 **HCBS SED**

**Today’s Date:**

**What’s Important to Me**

**What People Like and Admire About Me**

**How to Best Support Me**

**My Information**

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Phone Number** |  |
| **My Preferred Pronoun (he, she, they, etc.)** |  |
| **Last PCSP Revision Date** |  |
| **Parents/Legal Guardian** |  | **Phone:** |
| **Other Auth Rep. (indicate type)** |  | **Phone:** |
| **Targeted Case Manager**  |  | **Phone:** |
| **MCO**  |  | **Phone:** |
| **Primary Care Physician** |  | **Phone:** |
| **Emergency Contact** |  | **Phone:** |
| **Informal Supports** |
| **Name** | **Relationship** | **Phone Number** |
|  |  |  |
|  |  |  |
|  |  |  |
| **HCBS Providers** |
| **Provider Name** | **Provider Phone Number** | **Service** |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

My Communication Preferences

My primary mode of communication is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interpreter Services:

 I (child or parents) need services Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I/We do not need services

I have difficulty communicating independently and have someone who provides assistance to me when I’m trying to communicate.

Name of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSON(S) PARTICIPATING IN THIS PARTICIPANT INTEREST INVENTORY

|  |  |
| --- | --- |
| I chose to participate in filling out this PCSP? *(This is the child on the SED waiver)*  | ☐Yes ☐No  |
| To what degree?  | ☐Actively ☐Somewhat ☐Not at All  |
| If anything other than actively, please describe participation level.  |
| Person(s) who primarily provided the Information:  |

About Me

My accomplishments and skills I have that I’m proud of: include comments of what the child and parents feel the child’s strengths and accomplishments are.

(May reference the CAFAS and the strengths section of SNA domains, particularly “Vocational/Educational” and “Leisure/Recreational”)

Does the team feel the current supports provided are meeting the child’s needs? (If the child is newly eligible, put NA)

What My Family, Friends, Teachers, and Others who Support Me Say: Include positive comments from friends, family, teachers, and other team members about the child.

My Lifestyle Preferences Include: This is a description of what the child and parents view as positive in the child’s life now; how the child feels about his/her life; what they hope can change in the future; what the child would like to achieve, and what the barriers to change are. Please comment on areas such as: whether the child is living with his/her natural or adoptive family or an alternative location; whether the child feels safe; whether the child is participating in his/her public school or an alternative location; whether the child has the friends he/she wants; whether the child is able to participate in positive school or community activities the child is interested in; whether the child has hobbies or interests he/she likes or wants to try; whether the child has positive relationships with other family members or adult role models; etc.

 (May reference “Leisure/Recreational,” “Community”, and “Socialization” Domain of SNA)

|  |  |  |
| --- | --- | --- |
| How I Feel About My Life Now  | What I Want in the Future | Barriers to What I Want |
| Home |  |  |
| School |  |  |
| Friendships/Family Relationships |  |  |
| Feelings about Self |  |  |
| Social Activities/Hobbies |  |  |
| Other |  |  |
| Other |  |  |

Choice and Control:

What can my peers typically do that I also have the choice to do? (List choices of items or activities such as: going to movies, going to the mall, spending the night with friends, going to school parties, use the internet, etc.; and list other self-control choices such as choosing how I respond to a negative experience, etc.)

What can my peers typically do that I don’t get to do? (List items and activities that are restricted such as: the internet or computer; access to food, silverware, etc; activities with friends; unsupervised time at home, etc.)

(May reference CAFAS and needs section of SNA domains, particularly “Leisure/Recreational, Community, and Socialization”)

## My Goals

## These are goals the child wants to accomplish, and should support the treatment plan.

|  |  |  |  |
| --- | --- | --- | --- |
| Goal | Outcome Measure | Anticipated Completion Date  | Person/Provider Responsible  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

My Supports

Supports I Need: Check the supports needed related to the Severe Emotional Disturbance that are above and beyond supports needed typical to the child’s age.

(May reference the CAFAS and the “Community,” “Vocational/Educational,” “Health and “Socialization” domains in SNA)

* Household Chores: cleaning, laundry, cooking
* Dressing
* Bathing
* Toileting
* Other Hygiene: toothbrushing, shaving, drying hair, etc.
* Money Management
* Homework
* General Supervision
* Supervision Around Others
* General Reminders to Follow Directions
* Prompts to Assist with Calming Down, Reducing Anger, Fear, Feelings of Loss of Control
* Reminders of Alternatives to Anger/Aggression
* Social Interactions at Work
* Social Interactions at School
* Social Interactions in the Community
* Social Interactions at Home
* Romantic Relationships
* Community Safety Skills
* Staying on Task at School or Work
* Transportation Support
* Scheduling Appointments (Health/Behavioral Health)
* During Health Appointments
* During Behavioral Health Appointments
* Communication with Others
* Organizing My Schedule, Appointments & Activities
* Other:

Risk Assessment & Intervention Plans: Comment on any area of risk for the child, what the risk is, and related supports needed. Include any related to health, safety, financial, decision-making, undesirable behavior, mental health issues, or other risks that may or do require restrictive procedures.

(May reference CAFAS and “Health” domain of SNA)

Potentially Restrictive Interventions: Comment on any potentially restrictive interventions used in home, school or other settings that require parent approval. These may include use of a timeout room, use of restraints, use of behavior control medications PRN. It does not include emergency interventions or typical interventions a parent may use with a child of the same age such as timeout, restricting access to activities, and prescribed, ongoing medications for which the parent has given consent.

Description of Restriction/Limitation/Modification:

Assessed Need:

Potential Risk of the Restriction/Limitation/Modification (long and short term):

Less Restrictive Alternatives Tried:

Safeguards for Protecting My Rights and Safety:

Frequency of Review:

Person/Provider Responsible for Data Collection:

Person/Provider Responsible for the Reviews:

Date Informed Consent Obtained:

Legal or Financial Support: Comment on supports needed with any legal issues and finances appropriate to age, including: applying for Medicaid/SSI, managing personal funds, banking, purchasing items, planning a budget, paying bills, reporting personal income, filing tax returns, planning for the future (savings, trusts, etc.), finding an advocate or guardian, planning for the succession of a current guardian, etc

(May reference CAFAS and “Legal” and “Financial/Economic” domains of SNA)

# My Rights

Information & Training Provided:

Please mark each box after the information has been reviewed.

Note: this is the family’s rights & responsibilities (parents and the child).

☐I have been given information and training to know and exercise my rights, in a manner that I can understand. ☐ I have been given information and training to recognize and report Abuse, Neglect and Exploitation, and how to report it, in a manner that I can understand.

☐ I have been given information and training on how to file an Appeal or Grievance with the MCO if I want, and the process that will be followed.

☐ If I need help to know or exercise my rights, or report ANE, I will contact my Care Coordinator, provider or trusted friend or family member. I understand that my rights cannot be restricted without my consent, a risk assessment, and review and approval of the human rights/behavior management committee.

My signature/ legally recognized unique mark below means that I participated and agree that the information here is what I want in my Participant Interest Inventory.

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| My Signature (Child)  | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| My Parent/Guardian/Lead Agency’s Signature  | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| My Care Coordinator’s Signature  | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Other (indicate title/relationship)  | Date  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| Other (indicate title/relationship)  | Date  |