PERSON-CENTERED PLANNING:
Pathways to *Your* Future

A toolkit for anyone interested in Person-Centered Planning

Sonoran University Center for Excellence in Developmental Disabilities
Department of Family & Community Medicine, University of Arizona

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ucedd@email.arizona.edu.

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by
Sonoran University Center for Excellence in Developmental Disabilities (UCEDD)
Department of Family & Community Medicine, University of Arizona
PO Box 245052
Tucson, AZ 85724
520.626.0442
FAX 520.626.0081

Contributions made by
Jacy Farkas, MA
Leslie Cohen, JD
Jonathan Howe, MA, MS
Tyler Pierce

It is our desire to provide individuals with developmental disabilities the tools necessary to achieve greater independence and interdependence while at the same time respecting their rights and preferences. The following Person-Centered Planning toolkit is intended to serve both as a reference for individuals already acquainted with Person-Centered Planning (PCP), and as a starting point for individuals new to Person-Centered Planning and Thinking. This toolkit has been designed to be used by individuals with developmental disabilities, and agency personnel and the families with whom they work. For your convenience we have included a glossary at the end of the toolkit along with a list of common acronyms to assist you in understanding this document.

Thank you for your interest in Person-Centered Planning!

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What is Person-Centered Thinking?

Focus on the strengths, abilities and aspirations

When we think about disability and people with disabilities, we tend to think in terms of identifying and labeling problems, and then connecting people with services designed to help solve, manage or accommodate these problems. Coupling this traditional view of disability with our rational approach to solving problems we may find solutions and feel satisfied with our efforts, but the true feelings, hopes and desires of the person with a disability may never become an important, let alone guiding, part of the process. Consequently, this way of thinking all too often leaves the person with a disability feeling labeled, depersonalized, and not listened to.

Did you know…

- The way we label people affects the way we treat them.

- Even our best efforts may be harmful if we see the person's disability as a "problem."

Person-Centered Planning has emerged out of a desire to serve the best interests of individuals with disabilities by first changing the way we think about disability. Person-Centered Thinking is the foundational philosophy of Person-Centered Planning. It is choosing to think about and focus on the strengths, abilities and aspirations of the person with the disability rather than making decisions that are focused on an individual's problems, and guided by an accounting of deficiencies and impairments.

Social and Cultural Context: Where the individual lives and who are involved in the individual's life

As one begins the process of focusing on the strengths, abilities and aspirations of an individual, it is also important to understand the unique social and cultural context in which the individual lives. People from different cultures view and support individuals with disabilities in different ways. Becoming aware of and learning about these different perspectives allows teams to work together more effectively and tap into and cultivate the unique resources and natural supports systems that exist in the individual's family and community.

Taking Risks can lead to Success

Person-Centered Thinking also involves risk, and there is dignity in being able to take risks. Team members should look at their own prejudices and perspectives and determine if their aversion to risk for the person with a disability originates from real danger or is based on certain preconceived but untested notions. As people who want to provide support for individuals with developmental disabilities, we must realize that protection from failure can also mean protection from success.

Did you know…

- Different cultures have their own strengths when it comes to helping people with disabilities.

- Community involvement is essential to successful Person-Centered Planning.

Every individual has feelings, preferences, hopes and aspirations, and those of people with disabilities are just as important and achievable as anyone else's. To achieve these aspirations, however, individuals with disabilities may need the support of others, some of whom may need help in changing the assumptions and perspectives they hold regarding people with disabilities.
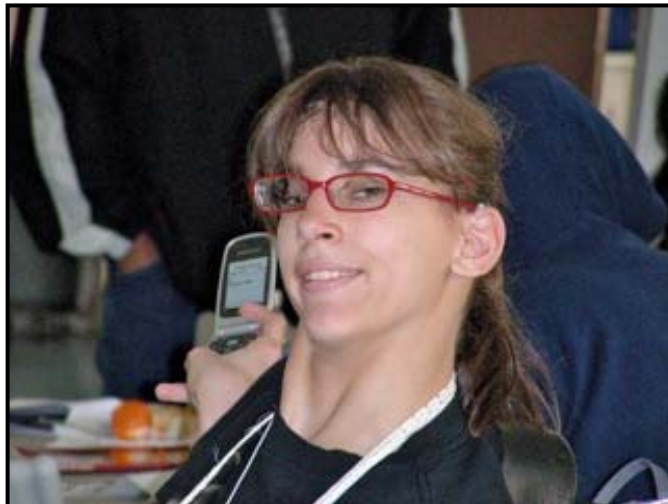
What is a Person-Centered Plan?

Each Person-Centered Plan is an individualized approach that helps the person with a developmental disability discover what he or she really wants. A Person-Centered Plan is transformational, moving from an approach geared towards fixing or solving problems, to one focused on providing opportunities, avenues for self-actualization, personal freedom, meaningful interdependence, and community involvement.

Let's get started…

- What do you want for the future?

- What kind of help will you need?

- Who will support you best?

- Who knows what is best for you? Is it you or someone else?

- Can you ask for what you really want?

Consequently, during this process, it is likely that the individual will ask for things that challenge the family and the service providers in unexpected ways. This is a positive and necessary part of Person-Centered Planning, and with the proper support from family and service providers it can open up new possibilities for everyone involved.

The following tenets of Person-Centered Planning are easily understood but require a commitment from all parties:
(Adapted from (1) Kendrick, M.J. (2000). When people matter more than systems.)

- **To know and to understand**
- **To be of genuine service**
- **To be open to being guided by the person**
- **To be willing to struggle for difficult goals**
- **To be flexible, creative and open to trying what *might* be possible**
- **To be willing to enhance the humanity and dignity of the person**
- **To look for the good in people and to help bring it out** [1]

Did you know…

- Person-Centered Planning involves a willingness to explore difficult subject matter.

- Person-Centered Planning sometimes means taking risks.

- Change can be challenging, but with the right support, anything is possible.

These guidelines apply to everyone involved, not just the person with a disability, or focus person, at the center of the plan. All participants are encouraged to become fully engaged in the process of discovering and understanding the wishes, aspirations and needs of the focus person. By doing so, teams that use Person-Center Planning honor the talents and interests of the focus person and use what they discover to help that person set goals and develop plans to achieve goals that are important and meaningful to them.

So, what if families already do such planning or are already satisfied with their current approach? What if they have other family concerns which they feel are more pressing, or even feel that Person-Centered Planning is not right for them at this time?

That's OK. A Person-Centered Plan can be done at any time, but in order for the process to be meaningful and beneficial, there needs to be some buy-in from the individual's circle of support. We should always encourage families to at least think about whether there may be differences between what they feel is appropriate for their family member with a disability and what that family member may want. Thinking about and reconciling any differences can provide meaningful benefits for all involved, and Person-Centered Planning can be a useful tool for reconciling these differences.

> *Does a PCP have to address every aspect of someone's life?*
>
> *No, it can focus on…*
> *- transition,*
>
> *- housing,*
>
> *- health care,*
>
> *- or any other particular issue.*

Person-centered planning can serve a variety of functions and can address any and/or all aspects of a person's life. More importantly, a PCP can function as a foundational plan that can be used to easily formulate a variety of other service plans - Individual Education Plans (IEP), Individual Support Plans (ISP), and Individual Plan for Employment (IPE). In some instances, the Person-Centered Plan can be used in place of these plans if proper documentation is provided (be sure to discuss this with your case manager). In gathering valuable input from the focus person and his/her team, the result is a document that lays out how best to support the individual to achieve his/her goals and dreams based on preferences and strengths while remaining safe and healthy. For example, a PCP can be referenced when matching support staff or finding a roommate, or introducing the focus person to new staff, teachers, doctors, and others in addition to creating a path to accomplish specific goals.

> *Did you know…*
>
> *- Person-Centered Planning takes extra time and effort in the beginning.*
>
> *- Person-Centered Planning saves time in the long run by getting to the truth of what's really needed.*

Person-Centered Planning Tools

There are many types of planning methods used by Person-Centered Planning teams. All of these different methods are meant to have a similar outcome: Meaningful community participation through participant empowerment and the identification of personally meaningful goals. The selection of the method which might work best depends on the individuals and families involved. Descriptions of four of the more popular methods are contained in this section. After the description of each plan, there is a list of additional resources for finding out more about that particular method.

Examples of the different planning methods are available in Appendix E.

MAPS (Making Action Plans) – Through a series of questions, individuals and organizations using MAPS help the focus person construct a personal history or life story based on personal milestones. After getting to know the focus person better and exploring his or her dreams for the future, the team begins to build a plan to move in the direction of the individual's dreams.

Resources
Common Sense Tools: MAPS and CIRCLES for Inclusive Education
Marsha Forest & Jack Pearpoint
http://www.inclusion.com/artcommonsensetools.html

Making Action Plans: Student Centered Action Transition Planning
Paul V. Sherlock Center on Disabilities, Rhode Island College (2001)
http://www.ric.edu/sherlockcenter/publications/MAPS.pdf

Use of the MAPS Process
University of Kansas, Circle of Inclusion Project (2002)
http://www.circleofinclusion.org/english/pim/seven/maps.html

MAPS: Making Action Plans or McGill Action Planning Systems
David Beukelman
Augmentative and Alternative Communication Centers, University of Nebraska
http://aac.unl.edu/drb/AAC_Assessment/tsld009.htm

Gathering for a MAP
David Hasbury
http://www.cocreation.ca/dave/articles/gatheringmaps.html

PATH (Planning Alternative Tomorrows with Hope) – PATH is a planning tool that has team members start by imagining and then detailing the future that the focus person aspires to. The team then works backward to what they consider should be the first steps towards achieving the future envisioned. It is a very results oriented process, excellent for team building, and has been used to mediate conflicts.

Resources
P.A.T.H. (Planning Alternative Tomorrows of Hope)
Adult Transition Planning
Provincial Integration Support Program British Columbia
http://www.pisp.ca/strategies/strategies61.pdf

Experiencing PATH: Planning Alternative Tomorrows with Hope
By Ontario Adult Autism research and support Network
http://www.ont-autism.uoguelph.ca/PATH-jan05.pdf

Path: Planning Possible Positive Futures
By Jack Pearpoint, John O'Brien, & Marsha Forest
Inclusion Network, Inclusion Press
http://www.inclusion.com/bkpathworkbook.html

ELP (Essential Lifestyle Planning) – ELP is a guided process designed to help an individual discover and attain what matters most to them and identify what supports might be needed. Discussions related to health and safety are an integral part of this process. The discoveries made during this guided process are described so that they are understood by all participants including the focus person and his or her family. (*from Helen Sanderson*)

Resources
The learning community for person centered planning
http://www.learningcommunity.us
The learning community for person centered planning is an organization that helps individuals develop person centered plans and trains interested people in how to write plans and develop the skills needed to implement plans. They also have programs designed to support organizations that want to use person-centered practices. Their website has links to resources, a trainers' network, and a reading room with resources and more information, including information on Essential Lifestyle Planning.
Person Centered Planning in Hampshire
http://www.pcp-in-hampshire.org.uk/resources/

Essential Lifestyle Planning Forms
Delaware Health and Social Services, Division of Developmental Disabilities
Services
http://www.dhss.delaware.gov/ddds/elpforms.html

Course 5b: Michael Smull's Essential Lifestyle Planning
By Michael Smull
Cornell University, School of Industrial and Labor Relations Employment and
Disability Institute
http://www.ilr.cornell.edu/edi/pcp/course05b.html

PFP (Personal Futures Planning) – PFP employs an on-going process in which
planning teams replace system-centered methods with person-centered
methods.   This process is meant to encourage the focus person and those
working with them to become aware of the potential for the focus person to
become an integral, contributing member of the community.

Resources
Part 1: Personal Futures Planning: A Student Driven Process
By Jonathan Drake, MSW
University of New Hampshire Institute on Disability
http://www.iod.unh.edu/pdf/TransitionSeries2_PersonalFuturesPlan_JDrake.pdf

*A Brief Guide to Personal Futures Planning Organizing Your Community to
Envision and Build a Desirable Future with You*
By Kate Moss & David Wiley
Texas Deafblind Outreach, Texas School for the Blind and Visually Impaired
(2003)
http://www.tsbvi.edu/attachments/other/pcp-manual.pdf

Course 5d. Personal Futures Planning
By Beth Mount, PhD
Cornell University, School of Industrial and Labor Relations Employment and
Disability Institute
http://www.ilr.cornell.edu/edi/pcp/course05d.html

Publications by J. O'Brien and C. L. O'Brien
The Center for Human Policy
http://thechp.syr.edu/rsapub.htm
This site provides links to a wide range of informational material on person-centered planning, community building, and innovative services. Most of the material is in Abode "PDF" format.

Moving On: A Personal Futures Planning Workbook for Individuals with Brain Injury, Second Edition
By Beth Mount, PhD, Doug Riggs, Margaret Brown & Mary Hibbard
Research and Training Center on Community Integration of Individuals with TBI, Mount Sinai Medical Center (2003)
http://www.brainline.org/content/2008/11/moving-personal-futures-planning-workbook-individuals-brain-injury.html

Self-Advocacy and Personal Futures Planning
Connecticut State Department of Education/Bureau of Special Education Transition Task Force/Transition Training Manual
http://www.ct.gov/brs/lib/brs/pdfs/guidepostdocs/SELFAdvocacyAndPersonalFuturePlanning.pdf

Group Person-Centered Planning – Group planning promotes community and the use of natural supports using the same basic format for PCP, but provides an additional community connection by bringing the person with a developmental disability and their circle of supports – their family, friends, allies, and service providers – together with like families and their circles of support to develop and implement plans. Each person will do this in conjunction with several other people with disabilities and their circles. The Personal Futures Planning tool is often used for this group process and lends itself for group dynamics and sharing. Families and circles of support have the opportunity to provide feedback and share ideas to other families and to build on-going relationships that can continue as the plans are implemented.

Resources
Chapter: "Large Group Process for Person-Centered Planning" in
Implementing Person-centered Planning: Voices of Experience (Volume II)
By John O'Brien and Connie Lyle O'Brien
2002

Step One: Finding a Facilitator

A facilitator is a person who has been trained to help organize and facilitate the Person-Centered Planning process. Ideally, the facilitator should be a person other than the case manager or support coordinator. The facilitator, however, could be a family member, school staff member, a service provider or a consultant. The important thing is that the individual chosen should be a good listener willing to work diligently and creatively to help the focus person give shape to his or her dreams and discover capacities that he or she has. The facilitator must also be able to identify community resources and be willing to engage and work with community members and organizations. One way to find a facilitator is to talk with a support coordinator or case manager. It is not uncommon for agencies to employ someone trained in Person-Centered Planning. (1)

How to determine that the facilitator is right for your family:

Ask Questions
- What is their experience?

- Have they had training?

- What planning method do they use?

- Is group planning available?

Step Two: Preparing for the Planning Meeting

In preparation for the planning meeting, it is important to determine who should be invited and what planning method might work best for the individual and his or her family. Often, the facilitator, focus person and caregivers have an introductory meeting to become familiar with one another and make these decisions. This initial meeting might include the following:

- ❑ **A determination of who the important people in the focus person's life are in order to invite them to become team members. Identification of a date and time for the initial team meeting.**

- ❑ **A determination of the place that will be the most convenient for everyone, especially the focus person.**

- ❑ **A discussion of strategies that increase the participation of the focus person.**

- ❑ **A decision as to who will take a lead in gathering information during the meeting.**

- ❑ **A decision as to which person-centered method will be used.**

- ❑ **The development of a history or personal life story or profile of the focus person.**

- ❑ **Completion of a caregiver assessment by the parents or other primary caregivers in the focus person's** (see Appendix D for an example assessment tool)**.**

- ❑ **A description of the quality of the focus person's life by exploring the following: community participation, community presence, choices/rights, respect, and competence.**

- ❑ **A description of the focus person's personal preferences** (see Appendix D for an example preference tool – *My Interests, Hopes and Dreams*)**.**

Step Three: The Planning Meeting(s)

When the planning meeting takes place, it should be in a comfortable setting chosen by the focus person and his or her family. The facilitator is there to coordinate the discussion, not to make decisions for the person or any other participant. The primary goal of the planning meeting is to identify what can be accomplished and put a plan into action. At the planning meeting, the participants may:

> ❑ **Review the personal profile or other tools already completed, and make additional comments and observations.**
>
> ❑ **Identify ongoing events that are likely to affect the person's life, such as conditions that promote or negatively affect health.**
>
> ❑ **Share visions for the future: Through brainstorming, imagine ways to increase opportunities.**
>
> ❑ **Identify obstacles and opportunities that give the vision a real-life context.**
>
> ❑ **Identify strategies and action steps for implementing the vision.**
>
> ❑ **Create an action plan. Action plans identify what is to be done, who will do it, when the action will take place. It is best to identify action steps that can be completed within a short time.**
>
> ❑ **Decide when to meet again.**

Step Four: Planning and Strategizing at Follow-up Meetings

As the participants begin working on their individual assignments as specified in the action plan developed in Step 3, it is important to remember and appreciate that implementing the plan requires perseverance, problem solving, and creativity. The team should meet periodically during this time to discuss what parts of the plan are working and what parts are not. The action plan can be revised during these meetings. If the action plan is revised, the team should once more identify what needs to be done going forward and who will be responsible for doing the different things that need to be done. A timeline for when these things should be accomplished should also be agreed upon. Finally, the team must decide when they will meet again.

Make sure that at each follow-up meeting the team:

- ❑ **Establishes the time and place of the next follow-up meeting.**
- ❑ **Establishes the list of participants.**
- ❑ **Review the Action Plan/To Do List from the previous meeting**
- ❑ **Lists all activities that occurred in the past.**
- ❑ **Lists all of the barriers/challenges that occurred.**
- ❑ **Brainstorms new ideas and strategies for the future.**
- ❑ **Sets priorities for the next agreed upon time period (6 months/12 months).**
- ❑ **Establishes renewed commitment by those participating.**
- ❑ **Lists five to ten concrete steps for the team to follow.**
- ❑ **Always celebrates the successes!**[2]

Note: While some facilitators stay involved, families are ultimately responsible for making sure plans move forward and are implemented.

There are three major aspects necessary for a successful Person-Centered Plan and overall planning process:
1. Participation in the Planning Process
2. Developing Natural Supports
3. Taking Action and Follow-up

This section will explain the necessary steps for each of these key aspects.

Participation in the Planning Process

It is essential for the focus person to actively participate in the planning meetings. Some advance preparation will help to make his or her participation meaningful and productive. This may include asking the focus person "**to talk individually with each team member before the meeting or helping the focus person craft a written invitation for each team member.**

It is very easy for team members to take over, making the focus person a passive observer instead of a leader in the process. The team must make conscious efforts to provide the person with ways to express his or her own dreams for the future, agree or disagree with other members of the team, and be actively involved in the team's ongoing efforts".[2]

Active participation means being present and engaged. **The focus person does not need to be able to communicate verbally to be an active participant.** It is important that the planning process allows for the individual to use their preferred mode of communication – whether that's sign language, writing, an augmentative communication device, pictures, or anything else he or she is comfortable with and can be empowered by using. Remember, we all communicate without words on a daily basis. Body language, gestures and changes of mood are all ways we let others know how we feel and what we think.

Developing Natural Supports with Person-Centered Planning

Professionals and service providers are important members of Person-Centered Planning teams; however, it is also essential to include individuals who are familiar with the abilities, interests, and needs of the focus person. They can be family members, friends, neighbors, former teachers, or other caring and knowledgeable individuals who know the focus person. Team members may also change over time in order to provide support for the person as his or her goals evolve and change. The more people involved the better. This can lighten the support load for each person, while at the same time, expands the social network of the focus person. Some examples of people that might provide valuable informal support to help a person achieve his or her goals include**:**

- **A neighbor who helps the focus person find restaurants on nearby bus routes;**
- **A relative who talks with co-workers about job or internship opportunities for a focus person who wants to work in an office setting; and**
- **Friends or family members who help find clubs or classes—such as photography, sports, art, or book—related to the focus person's interests.**

Did you know…

- People in your community can provide support in ways that formal services cannot.

- You might already know someone who can help you achieve your goals.

- Family, friends and neighbors know you and can help you help yourself.

"The insight of family and friends can complement and enhance the expertise that professionals bring to the team. Relatives and friends can also help families develop a 'safety net' of informal community supports and assist a person" as they begin to develop a full community-based life.[2]

From Meeting to Action

There is no specific number of meetings that has been established as optimal for helping an individual identify and attain his or her goals. The number of meetings should be based on need, and the team should feel comfortable meeting as often as necessary. Follow-up meetings should be scheduled at appropriate intervals to discuss progress towards goals, evaluate the continued relevance of previously identified goals and make modifications of goals as necessary.

Did you know…

- A plan is just a piece of paper until it is put into action.

- The team should meet as often as needed to find out if the person's goals are being achieved.

The facilitator or any other team member can enhance the effectiveness of each meeting by:
- ❑ identifying and formulating questions;
- ❑ identifying and organizing important points from discussions;
- ❑ and delegating responsibilities to other team members during team meetings.

One way to make sure that the plan leads to real action is to have each of the action items discussed at each meeting. It is also important and helpful to have someone responsible for follow-up on action items. This person may be a parent, the facilitator, or the case manager, but the person who is chosen should be someone who is able to connect with other members of the team to see how they are progressing on the action items for which they are responsible.[2]

A Person-Centered Plan is a working document. As with anyone else, the focus person's interests, relationships and goals will change over time – and those changes should be reflected in the plan.   Some facilitators may stay involved after the initial meeting but may not be available for all plan updates. If a facilitator is not meeting the needs of the team, the team may seek out a new facilitator. At the same time, it is ultimately the responsibility of the family to move the plan forward. And the family can and should gather the team, including new members if necessary, to revisit and revise the plan as needed.

What if the Focus Person Has an Unrealistic Goal?

The team should try not to dismiss the focus person's goals and dreams even if they seem impossible. Sometimes the team will need to "peel the onion" to determine the underlying reasons for the person's interests. Through this process the team can often find creative ways to develop and incorporate these interests as part of the person's vision for their future. In this way, the focus person will be able to hold onto his or her interests, and use these interests to guide decisions and choices they make about their life.

Did you know…

- Sometimes the goals we choose for ourselves turn out to be wrong.

- Being allowed to make mistakes is an important part of life.

- Exploring and learning about one's self is what matters most.

"Remember, a person with a disability who is protected from failure is also protected from potential success. Helping people with disabilities pursue challenging goals provides them with invaluable opportunities for self-discovery, as well as the opportunity to surpass expectations and succeed in achieving their goals."[2]
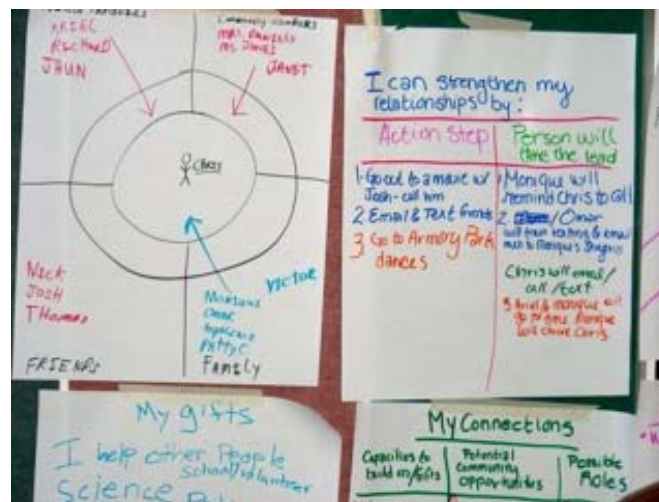
Final Thoughts on Person-Centered Planning

It is important to remember that a Person-Centered Plan is a starting point in a process intended to promote self-guided positive change. It can also be used to facilitate and provide information for other plans such as an IEP, ISP, and IPE. The knowledge gained through Person-Centered Planning can also be useful to new service providers who may benefit from the detailed information about the person and the personal goals that the plan contains. Having information about the focus person's aspirations, interests, preferences, and strengths, all in one place, also can serve as a resource that can be reused and updated as the person's goals, interests, and preferences change. We encourage you or someone you know to consider Person-Centered Planning as a useful tool with proven benefits for the individual.

Good luck and happy planning!

Person-Centered Planning And Transition
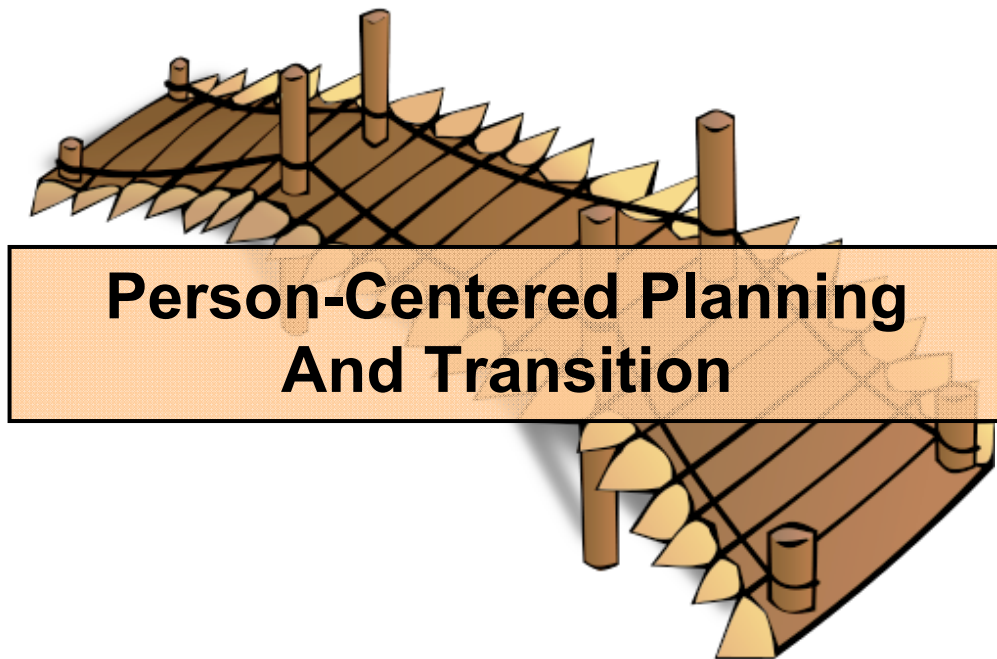
Person-Centered Planning as a Tool for Transitions

Perhaps the most important aspect of Person-Centered Planning is its ability to help individuals working with someone with a disability to determine what the focus person wants for his or her future. This is particularly meaningful during times of transition, when the focus person is moving from one phase of their life into another. For example, moving from the K-12 school system to adult life is a major transition for anyone, and is sometimes more complicated for the person with a disability whose options may appear to be constrained. The following pages contain a discussion of various topics related to transition along with notes on where to find additional resources. Although the focus here is on transitions from school to adult life, it is important to remember that other transitions can occur later in adult life as well. Transitions continue to appear beyond the high school graduation (mid and later adulthood). For example, often some individuals are not ready for employment or an independent living arrangement but might but ready when he/she gains confidence in his/her mid age. Person-Centered Planning can be helpful in planning for these transitions, too.

Topics covered include:

- Education Beyond High School
- Employment and Training
- Independent Living
- Health Care and Transition
- Community and Meaning

Did you know…

- Life after high school will be different and this transition deserves careful consideration.

- Person-Centered Planning can help plan for big changes at any stage of life.

Transition to Adulthood

An important time of transition occurs when someone gets ready to leave high school and go out in the world as a young adult. Person-Centered Planning can help with this transition. Remember, transition planning isn't just a good idea; the Individuals with Disabilities Education Act (IDEA) requires it.

> *Let's get started…*
>
> *- What do you think it means to be a successful adult?*
>
> *- What help will you need to become responsible for yourself?*
>
> *- What gift will you give to the world?*

"A Quick Summary:

- **Transition services are intended to prepare students to move from the world of school to the world of adulthood.**
- **IDEA requires that transition planning start by the time the student reaches age 16.**
- **Transition planning may when the student is younger than 16, if the IEP team decides it would be appropriate to do so.**
- **Transition planning takes place as part of developing the student's Individualized Education Program (IEP).**
- **The IEP team (which includes the student and the parents) develops the transition plan.**
- **The student must be invited to any IEP meeting where postsecondary goals and transition services needed to reach those goals will be considered.**
- **In transition planning, the IEP team considers areas such as postsecondary education or vocational training, employment, independent living, and community participation.**
- **Transition services must be a coordinated set of activities oriented toward producing results.**
- **Transition services are based on the student's needs and must take into account his or her preferences and interests".[3]**

Education Beyond High School
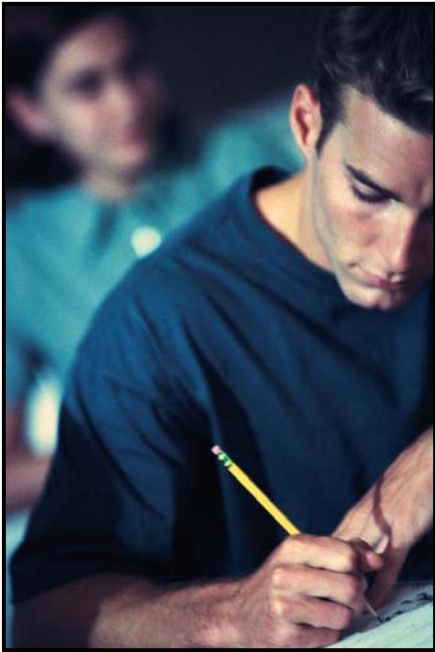
Education beyond high school should be a part of the discussion during a student's transition planning in high school. In keeping with the options specifically mentioned in IDEA, when planning for this transition, the student and the educational team may focus on:

- postsecondary education at a college, university, or community college;
- continuing and adult education; and
- vocational education to learn a trade or specific job skill. (3)

Postsecondary Education

Formal education beyond high school may be an exciting option for a person with a disability in that it can provide an opportunity for the person to take part in structured learning while being immersed in a diverse social setting where a person's abilities are the catalyst for growth. The student will also be able to choose areas of study that interest him or her and will do so at a pace that they find appropriate. Again, Person-Centered Planning can assist the student in discovering what matters most to them and help them make informed choices from the beginning.

Did you know…

- You may be able to continue your education after high school.

- Further education can provide social opportunities as well as important job skills.

Continuing and Adult Education

Continuing and adult education beyond high school can serve many purposes. It can help build skills for employment, culminate in a degree or certificate, maintain or enhance credentials already obtained or provide personal enrichment and growth.

In addition, classes may be offered at your local community center. Though these classes may not be offered for credit, they may provide training in specific skills or areas of interest and have the added benefit of providing the student with valuable social opportunities.

Did you know…

- You don't have to pursue a degree to benefit from higher education.

- Community colleges provide wonderful opportunities geared toward adults of all ages and abilities.

For more information about postsecondary and continuing education, please visit our resources section in Appendix A.
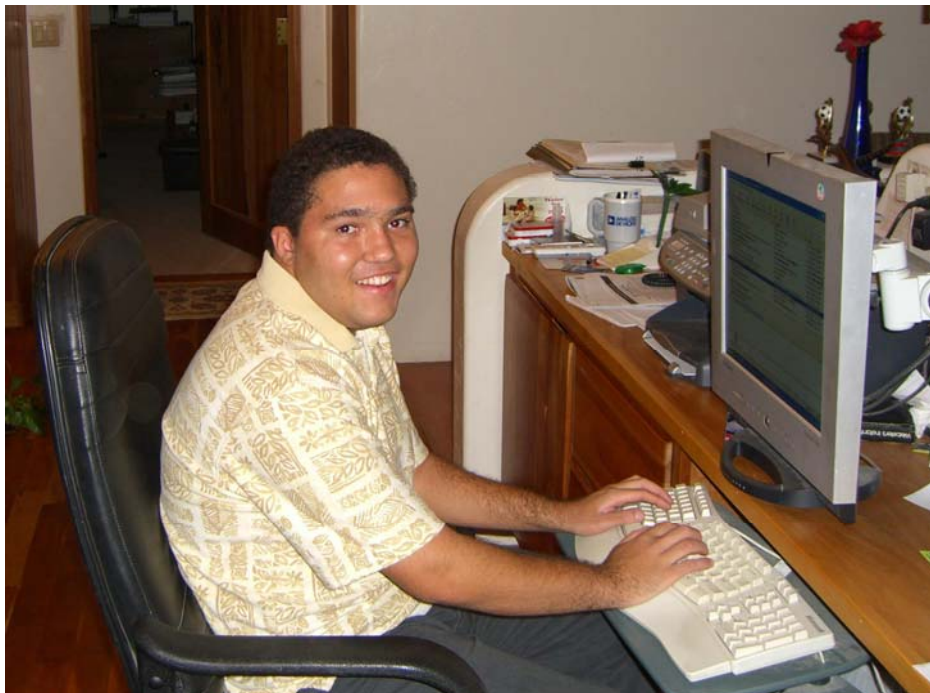
Employment and Training

For many youths with disabilities leaving high school, employment is an immediate and important concern. Transition services must be carefully matched to the employment goals that have been determined to be appropriate. The Person-Centered Planning process can assist the focus person specify what kind of work he or she desires and help him or her and the team develop a clear plan for achieving employment goals.(3)

Let's get started…

- How might you contribute to your community and earn money doing it?

- Do you already have job skills? Would you like to learn some new ones?

- What does the word "work" mean to you?

What to consider during the person-centered planning process for work related goals:
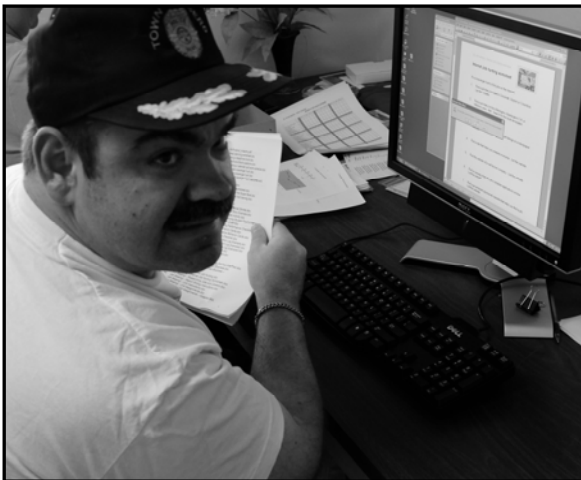
- **What are the focus person's interests?**
- **What are the individual's talents and skills?**
- **Is training needed?**
- **What type of supports may be needed?**
- **Are resources available (vocational rehabilitation, DDD, trade school, etc.)?**
- **Benefits – how will working affect SSI, AHCCCS, etc.?**

It is important to remember that the reasons for employment will vary from person to person. The goal of Person-Centered Planning is to help the person discover his or her personal motivations for becoming employed and what aspects of employment he or she expects will be the most rewarding.

Independent Living

Independent living is about being able to make choices, taking care of one's own affairs, and pursuing talents and interests as independently as possible. We all would like to see our young people grow to adulthood, find their place in the world and have the autonomy and support needed to lead a fulfilling and successful life.

Person-Centered Planning can play a valuable role when it comes to helping the focus person discover their unique strengths and develop his or her abilities to help make independent living a reality. These capacities can be explored as part of the planning process and can help the focus person, family members and

Let's get started…

- Are you living at home now? Have you ever thought about living on your own or with a roommate?

- What would it take to live independently?

- Would independent living make life easier, or more difficult?

providers understand what is required for successful independent living. A major part of this is figuring out the support network the individual will need both physically and emotionally whether they include paid or unpaid supports, roommates or family and friends.

General questions to consider:
- What skills does the focus person have?
- What skills need more development?
- What is the focus person interested in learning?
- What supports are needed?
- What assistance, if any, does the focus person need to complete certain tasks?

Health Care and Transition

As young people with disabilities become adults, both health care providers and health care benefits often change. When they were children and adolescents, a pediatrician could serve as their primary care doctor. When they become adults, however, a family doctor or an internist may become their primary doctor instead. Also, after leaving school, many health resources previously available to them may cease to be available because of their age. For example, benefits for children under the Arizona Health Care Cost Containment System (AHCCCS) are greater than those available to adults. These issues and others make it important to think about and plan for the transition into adult health care as soon as possible, so that the transition between adolescent health care and adult care will be seamless. Parents also will need to help educate their child in ways to advocate for themselves in the event that he or she must make important decisions about his or her health.

Part of good transition planning involves identifying what changes are likely to occur as an individual reaches adulthood, including:

- changes in health care insurance or benefits
- changes in the doctors or other health care providers caring for the individual
- changes in health condition requiring additional or different approaches (including prevention and wellness)

Everyone is entitled to see and have copies of their own medical records. Each individual will have to evaluate his or her potential health care needs and make educated decisions about the future. For example, a person with disabilities may have specific health issues requiring specialized treatment and it is important to have an up-to-date record of:

1) diagnoses,
2) diagnostic tests,
3) medications or other treatments,
4) allergies,
5) emergency information,
6) nutritional information,
7) dental records,
8) personal supplies and equipment needed.

Other considerations might include transportation – how the focus person can get to and from the doctor.

The following pages contain lists to help you think about health care as it applies to you or someone you know.

Is the person…

- ❑ **able to describe his/her condition to others?**
- ❑ **able to determine when condition is worsening?**
- ❑ **active enough or exercising to maintain physical fitness ?**
- ❑ **able to understand the basics of nutrition?**
- ❑ **working with parents/caregivers in doing self-care related to medications and treatments?**
- ❑ **able to answer questions from medical providers about his or her condition?**

Does the person…
- have someone to talk to about concerns?
- have a plan for emergencies?
- carry a list of medications, a list of health care providers?
- carry a copy of insurance/medical card & summary medical information?
- know how his or her condition and treatment affects physical, mental and sexual development?
- know how smoking, drinking, chewing, drugs affect his/her body and condition?
- understand sexuality, pregnancy, and birth control?
- see a doctor for some time privately?
- manage his or her own medication and treatment regime; notify caregiver of need for medication refills?
- know what their equipment does and how to fix minor problems?
- know the side effects of medication and interactions with food, alcohol, etc.?
- know how to use their health insurance/medical card?
- have adult health care providers?
- have a signed release to transfer records?
- have a copy of his or her own records?

Has the family…

- considered whether the young adult (age 18 or older) has the capacity to make decisions regarding health care, including informed consent to treatment? (If not, consider guardianship; health care power of attorney.)
- made plans for adult health care providers (primary, specialty, dental, DME, pharmacy, therapy, mental health)?
- made plans for adult health insurance?

Community and Meaning

Community Participation

Every person, regardless ability, deserves full involvement in his or her community. Seeking out and finding new ways to be part of one's community is important not only for the person with a disability but also for the community as a whole. By becoming involved in the community, individuals with disabilities are able to find greater purpose and meaning while creating and strengthening natural supports. Person-Centered Planning can identify and encourage a person's natural desire to be involved in the community, and find inclusion in groups, including those **not** specifically created for persons with disabilities.

Questions to ask:
- **What are the individual's interests?**
- **What does the focus person like to do?**
- **Where in the community can the person's likes and interests match?**
- **Who can help the person seek out opportunities in the community?**
- **Are supports needed to participate?**

The sky is the limit on activities you might enjoy. If you enjoy doing something, chances are someone else does, too. Don't be afraid to try something new!

Appendix A:
Resources Organized
By Subject

Updated December 2011
To Be Updated Quarterly

Person-Centered Thinking & Planning

Autism Advocate
By K. Davis, 2007
Autism Society
http://www.autism-society.org/site/PageServer?pagename=life_lifespan_self

Helen Sanderson Associates
http://www.helensandersonassociates.co.uk
Helen Sanderson Associates stated purpose is "to work with people to achieve person centered change and social justice." Their website includes links to other resources, a reading room, a blog and training opportunities and courses.

Inclusion Press
http://www.inclusion.com
Offers Person-Centered Planning and resource materials in addition to other media, workshops and events regarding inclusion.

Increasing Person-Centered Thinking: Improving the Quality of Person-Centered Planning: A Manual for Person-Centered Planning Facilitators.
By A. Amado and M. Mc Bride, M. (2001),
Minneapolis, Minnesota: University of Minnesota,
http://rtc.umn.edu/docs/pcpmanual1.pdf
Provides guidance for facilitators and references to the many different approaches and methods used to facilitate effective person-centered plans.

Listen to Me!
USARC/PACE
http://www.allenshea.com/listentome.html
A workbook that allows an individual and their family begin to think about the person's life and lead their own person-centered plan. This process doesn't need a facilitator.

PACER Center
http://www.pacer.org
"Parents helping parents" – PACER is a parent organization located in Minnesota but provides services nationwide. It is an organization of parents with children with disabilities for parents with children with disabilities. PACER sponsors a number of projects and provides individual assistance, workshops, publications, and other resources.

Parent Brief, Person Centered Planning: A Tool for Transition
National Center on Secondary Education and Transition
University of Minnesota, 2004
http://www.ncset.org/publications/viewdesc.asp?id=1431
This site provides: An outline of the Person-Centered Planning process with legislative history and background. Additional resources and links to other sites are provided.

Person Centered Planning Education Site
Cornell University, School of Industrial Relations, Employment and Disability Institute
http://www.ilr.cornell.edu/edi/pcp
This site provides: A person-centered planning process overview and a self-paced on-line course that helps you learn about basic processes used in Person-Centered Planning.

Sonoran University Center for Excellence in Developmental Disabilities Education, Research and Service (UCEDD)
http://sonoranucedd.fcm.arizona.edu/projects/person-centeredplaningmodelprogram
This organization is a center at the University of Arizona and provides information on Person-Centered Planning, facilitator training sessions, and links to resources.

What Really Matters: A Guide to Person Centered Excellence
Council on Quality and Leadership (CQL)
http://www.thecouncil.org/pceguidedisability.aspx
CQL has developed a series of products around person-centered services
- Application for Services for People with Disabilities:
  http://www.thecouncil.org/pceguidedisabilities.aspx
- Application for Services for Older Adults:
  http://www.thecouncil.org/pceduideforolderadults.aspx
- Application for Services for People with Mental Illness and People with Substance Use Disorder:
  http://www.thecouncil.org/pceguideforminandsubstanceabuse.aspx

Ask your DDD Support Coordinator or service provider for help with finding a facilitator.

<u>Education</u>

Arizona Department of Education
http://www.ade.az.gov
- Exceptional Student Services
  http://www.ade.az.gov/ess
  Information regarding special education in Arizona

The Short-and-Sweet IEP Overview
National Dissemination Center for Children with Disabilities
http://www.nichcy.org/EducateChildren/IEP/Pages/overview.aspx
US Department of Education
- Office of Special Education and Rehabilitative Services (OSERS)
  http://www2.ed.gov/about/offices/list/osers/index.html
- Office of Special Education Programs (OSEP)
  http://www2.ed.gov/about/offices/list/osers/osep/index.html

Individuals with Disabilities Education Improvement Act (IDEA) Website
http://idea.ed.gov

Postsecondary Education Institutions in Arizona

<u>Public Universities</u>

- University of Arizona
  www.arizona.edu
  Disability Resource Center – http://drc.arizona.edu
  Outreach College – www.ceao.arizona.edu

- Arizona State University
  www.asu.edu
  Disability Resource Center – www.asu.edu/studentaffairs/ed/drc

- Northern Arizona University
  www.nau.edu
  Disability Resources – http://www4.nau.edu/dr

Community Colleges and Technical Schools

- Allen School – http://online.allenschool.edu
    - Online Medical Billing Program
    - Phoenix – Medical Assistant Flex Program
      http://online.allenschool.edu/online/utilities/flex

- Argosy University – http://www.argosy.edu/locations/phoenix
    - Phoenix

- Arizona Automotive Institute – http://www.aai.edu
    - Glendale

- Arizona Culinary Institute – http://www.azculinary.com
    - Scottsdale
- Arizona Western College – http://www.azwestern.edu
    - Yuma

- Arizona School of Massage Therapy – http://www.arizonasmt.com
    - Phoenix
    - Tempe

- The Bryman School – http://www.brymanschool.edu
    - Phoenix

- Carrington College – http://carrington.edu
    - Mesa
    - Phoenix
    - Phoenix Westside
    - Tucson

- Central Arizona College – http://www.centralaz.edu
    - Apache Junction – Superstition Mountain Campus
    - Casa Grande
        - Casa Grande Center
        - Corporate Center
    - Coolidge
        - Coolidge Center
        - Signal Peak Campus
    - Florence – Florence Center
    - Maricopa – Maricopa Center
    - Queen Creek – San Tan Center

- o SaddleBrooke – SaddleBrooke Center
- o Winkelman – Aravaipa Campus

- Cochise College – http://www.cochise.edu
  - o Benson – Benson Center
  - o Douglas – Douglas Campus
  - o Fort Huachuca – Fort Huachuca Army Education Center
  - o Nogales – Nogales/Santa Cruz Center
  - o Sierra Vista – Sierra Vista Campus
  - o Willcox – Willcox Center

- Coconino Community College – http://www.coconino.edu
  - o Grand Canyon – Grand Canyon Learning Center
  - o Flagstaff
    - Lone Tree Campus
    - Fourth Street Campus
  - o Page
    - Page/Lake Powell Campus
    - Freedonia Campus
    - Diné College Tuba City Campus Extension
  - o Williams – Williams Campus

- Collins College – http://www.collinscollege.edu
  - o Tempe

- Cortiva Institute School of Massage Therapy – http://www.cortiva.com
  - o Scottsdale
  - o Tucson

- DeVry University – http://www.devry.edu
  - o Glendale
  - o Mesa
  - o Phoenix

- Diné College – http://www.dinecollege.edu
  - o Chinle Site
  - o Ganado Site
  - o Kayenta Site
  - o Tsaile Campus
  - o Tuba City Site
  - o Window Rock Site

- Eastern Arizona College – http://www.eac.edu
  - Thatcher

- Everest College Phoenix – http://www.everestcollegephoenix.edu
  - Mesa
  - Phoenix

- ITT Technical Institute – http://www.itt-tech.edu
  - Phoenix
  - Tempe
  - Tucson

- Kaplan College – http://phoenix.kaplancollege.com
  - Phoenix

- Le Cordon Bleu College of Culinary Arts – http://www.chefs.edu/Scottsdale
  - Scottsdale

- Maricopa Community College District – http://www.maricopa.edu
  - Chandler-Gilbert Community College
    - Chandler – Pecos Campus
    - Sun Lakes – Sun Lakes Center
    - Mesa – Williams Campus
  - Estrella Mountain Community College – Avondale
    - Main Campus
    - Southwest Skills Center
  - GateWay Community College – Phoenix
    - Main Campus
    - Maricopa Skills Center
  - Glendale Community College
    - Glendale
      - Main Campus
      - North Campus
    - Surprise - Communiversity @ Surprise
  - Mesa Community College – Mesa
    - Red Mountain Campus
    - Southern & Dobson
  - Paradise Valley Community College
    - Phoenix – Main Campus
    - Scottsdale – Black Mountain Campus
  - Phoenix College – Phoenix
  - Rio Salado Community College

- Avondale – RSC @ Avondale
- Glendale – Rio West Valley – Luke AFB
- Mesa – Rio East Valley
- Phoenix – Rio North – Paradise Valley
- Surprise
  - Lifelong Learning Center
  - Rio @ Surprise (Communiversity)
- Tempe – RSC @ Tempe
    - Scottsdale Community College – Scottsdale
    - South Mountain Community College
      - Guadalupe – Guadalupe Center
      - Phoenix
        - Ahwatukee Foothills Center
        - Main Campus

- Mohave Community College – http://www.mohave.edu
  - Bullhead City – Bullhead City Campus
  - Colorado City – North Mohave Campus
  - Kingman – Neal Campus
  - Lake Havasu City – Lake Havasu City Campus

- Northland Pioneer College – http://www.npc.edu
  - Eager – Springerville-Eagar Center
  - Holbrook – Painted Desert Campus
  - Kayenta – Kayenta Center
  - Keams Canyon – Hopi Center
  - Show Low – White Mountain Campus
  - Snowflake/Taylor – Silver Creek Campus
  - St. Johns – St. Johns Center
  - Whiteriver – Whiteriver Center
  - St. Johns – St. Johns Center

- Pima Community College – http://www.pima.edu
  - Tucson
    - Campuses
      - Community
      - Desert Vista
      - Downtown
      - East
      - Northwest
      - West
    - Continuing Adult Education – www.pima.edu/ceu/index.shtml

- - Eastside Learning Center
  - El Pueblo Liberty Learning Center
  - El Rio Learning Center

- Pima Medical Institute – http://pmi.edu
  - East Valley – Phoenix
  - Mesa
  - Tucson

- Prescott College – http://www.prescott.edu
  - Prescott – Campus
  - Tucson – Center

- Refrigeration School – http://www.refrigerationschool.com
  - Phoenix

- The Art Institute – http://www.artinstitutes.edu
  - Phoenix
  - Tucson

- Tucson College – http://www.tucsoncollege.edu
  - Tucson

- Universal Technical Institute – http://www.uti.edu
  - Avondale
    http://www.uti.edu/Campus-Locations/UTI-Phoenix
  - Phoenix – MMI Motorcycle
    http://www.uti.edu/Campus-Locations/MMI-Phoenix

- University of Advancing Computer Technology – http://www.uat.edu
  - Tempe

- University of Phoenix – http://www.phoenix.edu
  - Chandler
  - Mesa
  - Nogales
  - Phoenix
    - Northwest
    - Phoenix
    - West Valley
  - Tucson
    - Southern Arizona

- Tucson
  - Yuma

- Yavapai College – http://www.yc.edu
  - Camp Verde – Camp Verde School Complex
  - Chino Valley – Chino Valley Agribusiness & Science
  - Clarkdale – Verde Valley Campus
  - Prescott
    - Career & Technical Education Center
    - Prescott Campus
  - Prescott Valley – Prescott Valley Campus
  - Sedona – Sedona Center for Arts & Technology

Employment

Career Planning Begins with Assessment
http://www.ncwd-youth.info/resources_&_Publications/assessment.html

Job-Center Website
http://www.youthhood.org/jobcenter/index.asp
Information on the basics of work presented in a way that is designed to be attractive and interesting to youth.

State

Arizona Health Care Cost Containment System (AHCCCS)
http://www.azahcccs.gov
AHCCCS application form is available through this site. Also an individual can apply to the Arizona Freedom to Work AHCCCS buy-in program allowing those who are disabled and working to buy in to AHCCCS based on countable income.

Employment Support Services (ESS) – Rehabilitation Services Administration
https://www.azdes.gov/main.aspx?menu=32&id=1304
The purpose of the ESS Program is to assist individuals with severe disabilities to maintain successful employment.

Vocational Rehabilitation (VR) – Rehabilitation Services Administration
https://www.azdes.gov/rsa/VR
The VR Program helps people with disabilities become or remain economically independent through work.

Project SEARCH | Arizona
http://projectsearch.sonoranucedd.fcm.arizona.edu
Project SEARCH is a business-led collaboration that enables young adults with disabilities to gain and maintain employment through training and career exploration. Project SEARCH | Arizona is an initiative to pilot the program locally in Tucson with the goal of replicating statewide. Website includes a resource page regarding disability and employment.

National

Employment programs for persons with developmental disabilities
Department of Health and Human Services
http://oig.hhs.gov/oei/reports/oei-07-98-00260.pdf

National Collaborative on Workforce and Disability (NCWD for youth)
http://www.ncwd-youth.info/about
This organization assists state and local workforce development systems to better serve youth with disabilities and other disconnected youth.

National Information Center
http://www.nichcy.org/EducateChildren/transition_adulthood/Pages/employment.aspx
This site is designed to help youth with disabilities explore important aspects of going to work.

Plan for Achieving Self-Support (PASS)
http://www.passplan.org/Learn/default.htm
PASS allows a person with a disability to put aside income and/or resources to pursue and achieve a specific work goal. This site has information on and outlines of PASS Plans and procedures, PASS plan application form, and some examples of PASS Plans.

US Office of Disability Employment Policy (ODEP)
http://www.dol.gov/odep
This site provides information on public education strategies, outreach, and evidence-based policy research and demonstrations geared towards employers, business, and the disability community. Information is provided on the most effective ways to tap the talents of workers with disabilities.
- *Job Accommodation Network, (JAN)*
  http://askjan.org/links/about.htm
  JAN is a service provided by the U.S. Department of Labor's Office of Disability Employment Policy (ODEP). It is a source for guidance on workplace accommodations and disability employment issues.

US Social Security – The Work Cite
http://www.socialsecurity.gov/work
Provides information on Social Security's regulations as well as Work Incentive and Ticket to Work information.
- *Ticket to Work*
  http://www.yourtickettowork.com
  http://www.chooseworkttw.net
  The Ticket to Work and Self-Sufficiency Programs are employment programs for people with disabilities designed to remove barriers that may influence their decisions about going to work such as concerns over losing health care coverage or other benefits and increase opportunities to obtain employment, vocational rehabilitation (VR), and other support services.

Health Care

Arizona Medicaid – Arizona Health Care Cost Containment System (AHCCCS)
http://www.azahcccs.gov/applicants/categories/disabled.aspx

Health Care Transitions Website
http://hctransitions.ichp.ufl.edu
- Health Care Transition Web Videos
  http://www.ichp.ufl.edu/videos
- *When Your 18 – A Healthcare Transition Guide for Young Adults,* Institute for Child Health Policy at the University of Florida, 2009
  English: http://hctransitions.ichp.edu/pdfs/cms_wy18_lowres_09.pdf
  Spanish:
  http://hctransitions.ichp.ufl.edu/pdfs/cms_wy18_lowres_spanish_09.pdf

Health & Wellness Information Resource Center
http://health.sonoranucedd.fcm.arizona.edu
Sonoran UCEDD has a Health & Wellness Information Resource Center for individuals with developmental disabilities, families, friends, and caregivers.

Healthy & Ready to Work National Resource Center
http://www.hrtw.org
"This site focuses on understanding systems, access to quality health care, and increasing the involvement of youth. It also includes provider preparation plus tools and resources needed to make more informed choices!"

When You're 18 — A Health Care Transition Guide for Young Adults
Institute for Child Health Policy (ICHP), University of Florida
http://hctransitions.ichp.ufl.edu/pdfs/cms_wy18_lowres_09.pdf

Independent Living

Arizona Statewide Independent Living Council (SILC)
http://www.azsilc.org
The Arizona SILC mission is to facilitate systemic change that promotes independence, inclusion, non-discrimination, and dignity for all people with disabilities in Arizona. The goal of the independent living movement is integration and full inclusion of individuals with disabilities into the mainstream of society.

Centers for Independent Living are non-residential, non-profit corporations that are consumer-controlled, community-based. They provide a variety of programs and services that support independent living for people with all types of disabilities. They also provide support and information for families.
Centers in Arizona:
- ABIL – Arizona Bridge to Independent Living (Phoenix)
  www.abil.org
- ASSIST! to Independence (Tuba City)
  www.assisttoindependence.org
- DIRECT Center for Independence, Inc. (Tucson)
  www.directilc.org
- New Horizons Independent Living Center (Prescott Valley)
  www.newhorizonsilc.org
- S.M.I.L.E. - Services Maximizing Independent Living Empowerment (Yuma)
  www.smile-az.org

Cybercil
http://www.cybercil.com/aboutcybercil.asp
This is a virtual center for independent living. CyberCIL of Arizona exists completely in cyberspace. Their goal is to promote and enable independence for individuals with disabilities and through their virtual environment make information as accessible as possible and help remove some of the barriers that can constrain people's access to traditional resource centers such as rural nature of some communities, transportation difficulties, or economic barriers.

Independent Living Rehabilitation Services (ILRS) – Rehabilitation Services Administration
https://www.azdes.gov/rsa/ILRS
The purpose of funds authorized under this program is to assist states in providing services to individuals who may benefit, to enable them to live and function more independently within their home or community.

Making the Move to Managing Your Own Personal Assistant Services (PAS): A Toolkit for Youth With Disabilities Transitioning to Adulthood
The National Collaborative on Workforce and Disability for Youth, HeiTech Services, Inc., Concepts, Inc
http://www.pueblo.gsa.gov/rc/odep/Making_the_Move.pdf

Building Community and Finding Meaning

AZ Community Information & Referral
http://www.cir.org/index.html
AZ Community Information & Referral is a resource for information on health, human, and emergency services provided in Arizona communities.

Special Olympics Arizona
http://www.specialolympicsarizona.org
Through year-round sports training, competitions and support programs, Special Olympics Arizona's goal is to help Arizonans with intellectual disabilities be healthy, productive, and respected members of society.

Meet Up: Do something • Learn something • Share something • Change something
http://www.meetup.com
A website to meet people with similar interests in your community. You can also start your own meet up group for people to join you in your interests.

*Public libraries and local neighborhood/community centers are also excellent places to look for activities and events. The most important things are to be proactive and seek out social opportunities in your community. To find more information on your local libraries and centers, check your county and/or city websites.

Advocacy

Arc of Arizona
http://www.arcarizona.org
The Arc of Arizona is part of a nationwide Arc organization. It is an advocacy organization of and for individuals with cognitive, intellectual and developmental disabilities dedicated to improving systems of supports and services, connects families and influence public policy. There are nine local chapters throughout the state.

Arizona Autism Spectrum Support, Information and Strategies for Transition (AZ ASSIST)
http://azassist.wetpaint.com
AZ ASSIST is a community of families of teens and young adults on the autism spectrum, as well adults and professionals with autism who generously share their time and expertise. Their mission is to provide education, strategies, and support related to transition into the community after high school to parents of teens and young adults on the autism spectrum and to provide transition education and create opportunities for social skill development for teens and young adults on the Spectrum.

Organized Advocates for Special Individuals in Society (OASIS)
With support from the ARC, this organization was formed and is lead by self-advocates in Safford, AZ. Members are adults with developmental disabilities, many of whom are from group residential settings. The group holds their own board meetings and plans both social and training events.

Partners in Policy Making
http://www.pilotparents.org/partners.htm
Partners in Policymaking is an innovative leadership training program offered by Pilot Parents which teaches people to be community leaders, and to affect systems and policy change at the local, state and national levels. The program is designed for individuals who have a disability and for parents raising children with a disability. Partners provides the most current information and education about disability policy, the legislative process, and local, state and national issues that affect individuals with disabilities.

People First of Arizona (PFAz)
pfirstofarizona4@msn.com
People First is a self-advocacy movement by and for people with disabilities offering experience through participation. It is part of the nationwide Self Advocates Becoming Empowered (SABE) self-advocacy organization. PFAz has a chapter in both Phoenix and Tucson, and its members are adults with disabilities who live in the community-many on their own with or without services. PFAz promotes Self Advocacy & Self Determination through:
- Leadership Opportunities
- Personal Growth and Financial control
- Customer Driven Programs and Supports
- Education and Training

Self-Advocacy Coalition of Arizona (SAC of AZ)
http://sacofaz.org
The SAC of AZ is a statewide organization, comprised of nine self-advocacy groups and individuals, with a statewide 15 member board that enhances the rights and responsibilities of individuals with disabilities by establishing and maintaining working partnerships with individuals and advocacy groups.

Youth Action Council of Arizona (YAC-AZ)
http://www.meetup.com/Youth-Action-Council-of-Arizona
YAC-AZ is an organization that links AZ youth and emerging leaders together for the purposes of advocacy, self-determination, and friendship. The mission of YAC-AZ is to empower youth to take personal responsibility to improve quality in their lives as they learn how to be better self-advocates. In conjunction with the Southwest Institute for Children and Families, YAC-AZ created a social networking and learning site for youth and young adults with special needs and their friends: http://yakkit.org

Other Resources

Arizona Department of Economic Security
https://www.azdes.gov/main.aspx?menu=8&id=58
- Division of Developmental Disabilities
  https://www.azdes.gov/ddd
  Young Adult Transition Training Program Available
- Rehabilitation Services Administration
  https://www.azdes.gov/rsa

US Social Security
http://www.socialsecurity.gov
- Disability & SSI – http://www.ssa.gov/dibplan/d&s1.htm

Arizona Developmental Disabilities Network
- *Arizona Developmental Disabilities Planning Council (DDPC)*
  http://www.azgovernor.gov/ddpc
  Arizona DDPC is a 23-member council comprised of individuals with developmental disabilities, family members of individuals with disabilities and representatives of state agencies that provide services to individuals with developmental disabilities. DDPC engages in advocacy, capacity building and systemic change to increase inclusion and involvement in the community.

- *Arizona Center for Disability Law (ACDL)*
  http://www.acdl.com
  With offices in Phoenix and Tucson, the Arizona Center for Disability Law serves as the state's designated protection and advocacy system for individuals with disabilities. The Center provides a wide range of services in the areas of special education, health care, mental health services, access to community services and employment. In addition to offering individual legal representation, the Center provides information and referral, brief assistance and educational workshops on the rights of persons with disabilities in a variety of areas such as the educational setting and the workplace. *Institute for Human Development – Arizona UCEDD*
- Northern Arizona University
  http://www4.nau.edu/ihd
  The Institute provides the bridge between the rich resources that an academic institution has to the developmental disability service delivery system. The mission of the Institute is to enhance the capacity of a statewide system of support of persons with disabilities and their families. The Institute implements its mission through the conduct of interdisciplinary training, promotion of exemplary community service programs, provision of technical assistance at all levels of the service delivery system, and the conduct of research and evaluation that is disseminated to targeted groups in the field.
- *Sonoran UCEDD*
  University of Arizona
  http://sonoranucedd.fcm.arizona.edu
  Sonoran UCEDD is based on the vision of a community benefiting from the full participation of all members, with recognition of the strengths brought by diversity in abilities, culture, age, and life-experience. The Sonoran UCEDD will facilitate a state-wide collaboration in support of full participation by people with developmental disabilities in all aspects of community life. It will focus on developing new knowledge, best practices, dissemination and training, and public policy to support effective transitions through adulthood for people with developmental disabilities and their families, and improved services to Hispanic/Latino individuals with developmental disabilities and their families, and to rural and border populations.

Appendix B: Glossary of Terms

Caregiver A person who cares for someone else's physical and emotional needs. Often a family member, friend or someone hired for the purpose of caregiving.

Case Manager See "Support Coordinator"

Choice The right, power, or opportunity to choose. An informed choice is when a person is informed of all the options that are available and understands these options and the impact of his or her choice.

Circle of Support A group that has been designated by the person to assist him or her to accomplish personal life goals and to support decision-making. The group usually consists of 3 or more people.

Facilitator A person chosen to coordinate a planning meeting, usually someone not already part of the Circle of Support.

Focus Person The person at the center of a Person-Centered plan. The person for whom the plan is created. The focus person leads the planning meeting with assistance from a facilitator.

Formal Services or Supports These are services generally provided for a fee. Nursing, transportation, and assistance finding a job are examples of these types of services.

Independence The right to live with dignity and with appropriate support in one's own home, fully participate in one's community, and control and make decisions about one's life.

Individual Support Plan (ISP)	An individual's plan for supports and actions to be taken during the year to lead toward his or her desired outcomes. It is developed by the individual and partners chosen by the individual to help. It is directed by the individual's vision of a good life, his or her talents and gifts, what's important to the individual on a day-to-day basis and in the future, and finally, what's important for the individual in order to be healthy and safe and remain a member of communities.
Informal Supports	See "Natural Supports"
Meaningful Activities	Activities that individuals indicate are personally meaningful to them.
Medicaid	Medicaid is a health insurance program administered and funded through a state-federal partnership. It is generally available to people who meet low income guidelines, States establish eligibility standards, determine what benefits and services to cover, and set payment rates.
Natural Supports	Natural supports are not paid supports, but are typical, naturally occurring supports that any community member might have such as family members, church, neighbors, coworkers and friends. Natural supports should be developed, utilized and enhanced whenever possible. It is important that purchased services not be used instead of or to replace natural supports, but rather should supplement them. Natural supports are the same as "Informal Supports".

Personal Profile   A personal description of the individual. A profile is a tool to help focus on what's important to the individual, what needs to stay the same and what needs to change for the individual to have a good life.

Person-Centered Planning   Person-Centered Planning promotes self-determination and community inclusion through focusing on the needs and preferences of the individual. It provides support in a way that empowers individuals in defining and controlling the direction of their own lives.

Person-Centered Thinking   Person-Centered Thinking is the foundational philosophy for Person-Centered Planning. It is the mindset of viewing, listening to, and supporting a person with a disability based on their strengths, abilities, aspirations and preferences rather than focusing on "problems," impairments and deficiencies in making decisions to maintain a meaningful, healthy and safe life.

Preference   When an individual selects one thing over another, all person-centered practices and the planning process find and assure individual preference.

Self-determination	There are five basic principles of self determination. 1. Freedom: This means freedom to, with assistance, create and pursue connections and involvement in community life that is meaningful and self directed. 2. Authority: Individuals have authority to control financial resources, determine what support is needed and who provides this support. 3. Support: Formal and informal resources are available to assist the individual in developing and pursuing their dreams and aspirations. 4. Responsibility: With greater control comes greater responsibility. The individual is responsible to contribute personal resources to their own support, use any public assistance efficiently and make contributions to the community as responsible citizens. 5. Confirmation: The individual should play a leadership role in the new system and support the self-advocacy movement.[4]
Support	Support is often used in place of the term "service" in order to connote a partnership or more collaborative model of interaction.
Support Coordinator	A Support coordinator works with individuals with disabilities and their families to develop service and support plans, based on the individual's needs and wishes, and to coordinate and monitor the services and supports that are provided to the individual.

Appendix C: List of Acronyms

ADD   "Administration of Developmental Disabilities"

ADE   "Arizona Department of Education"

AHCCCS   "Arizona Health Care Cost Containment System"
Arizona's Medicaid Agency

ALTCS   "Arizona Long Term Care System"
Arizona's state program for implementing the Federal
Medicaid program

DD   "Developmental Disability"

DDD   "Division of Developmental Disabilities"

DES   "Department of Economic Security"

DHS   "Department of Health Services"

DOE   "Department of Education"

ELP   "Essential Lifestyle Plan" or more generally "Essential
Lifestyle Planning"

IDEA   "Individuals with Disabilities Education Act"

IEP   "Individualized Education Program"

IPE   "Individualized Plan for Employment"

ISP   "Individual Support Plan"

MAPS   "Making Action Plans"

PATH   "Planning Alternative Tomorrows with Hope"

PCP   "Person-Centered Plan" or more generally "Person-
Centered Planning"

RSA   "Rehabilitation Services Administration"

Section 504	"Section 504 of the Rehabilitation Act"
SSI	"Supplemental Security Income"
UCEDD	"University Center for Excellence in Developmental Disabilities"
VR	"Vocational Rehabilitation"

Appendix D:
Assessment Tools

Family Caregiver Assessment Tool

Name of Caregiver: _____

Name of Individual Receiving Care: _____

Relationship to Individual: _____

Date I completed this survey: _____

The purpose of this survey is to assess how you, as the caregiver, feel about your caregiving role, your needs as a caregiver and future caregiving for the individual in your life. This survey is just a tool to begin to explore these issues for yourself and can help to bring up your thoughts as you move through the Person-Centered Planning process. In order to apply this survey to the many different people who will go through the Person-Centered Planning process, this form refers to the person you provide care to as the "individual."

1. ***What type of care do you currently provide? (Check all that apply)***
   - ☐ I do not provide any care to the individual
   - ☐ Medical decision-making (i.e. Medical Power of Attorney)
   - ☐ Financial management and decision-making (i.e. Financial Power of Attorney)
   - ☐ Lifting
   - ☐ Bathing
   - ☐ Feeding
   - ☐ Transportation
   - ☐ Grocery shopping
   - ☐ Reminders to complete daily tasks (i.e. hygiene)
   - ☐ Other: _____

2. ***Do you need to provide supervision to the individual?***
   - ☐ Yes
     - ○ For personal safety
     - ○ For medical reason
     - ○ Other: _____
   - ☐ No
   - ☐ Not applicable

3. ***How often do you provide care? (Check all that apply)***
   - ☐ I do not provide hands-on care
   - ☐ I provide care 24 hours per day
   - ☐ Every day for a few hours
   - ☐ A few days per week
   - ☐ Other:
     _____

4. ***Who helps you to provide care? (Check all that apply)***
   - ☐ I provide care on my own
   - ☐ A family member
   - ☐ A friend
   - ☐ A paid provider
     - ○ Respite
     - ○ Attendant Care
   - ☐ Other: _____
   - ☐ Not applicable

5. ***How would you describe your level of stress associated with the care of the individual?***
   - ☐ I am stressed out on a daily basis
   - ☐ I feel stressed out every now and then
   - ☐ I do not feel any stress regarding the care of the individual
   - ☐ Other: _____

6. ***Have you begun to think about how you plan to provide care for the individual in the long-term future?***
   - ☐ Yes
   - ☐ No

7. ***If so, how much care do you plan to continue to provide in the future?***
   - ☐ I plan to provide more care
   - ☐ I plan to provide the same level of care in the future as I do now
   - ☐ I plan to provide some care in the future
   - ☐ I do not plan to provide care in the future
   - ☐ Other: _____

8. *In the event you pass away or are unable to provide care for other reasons, have you begun to think about who else could or will provide care in the future?*
   ☐ Yes
   ☐ No
   ☐ Not applicable

9. *Have you begun to think about what other supports will be needed to provide care in the future? This could include the option for a residential placement (from a group home to independent living, bringing additional supports in to your home, etc).*
   ☐ Yes
   ☐ No
   ☐ Not applicable

10. *Do you know where to find information about possible supports that you will need to provide care in the future?*
    ☐ Yes
    ☐ No
    ☐ Not applicable

11. *Have you begun to discuss any of these options with the individual you provide care to?*
    ☐ Yes
    ☐ No
    ☐ Not applicable

12. *Have you begun to discuss any of these options with others in your life? This could be a family member, friend, a case manager or any other person.*
    ☐ Yes
    ☐ No
    ☐ Not applicable

13. *How worried are you about the future care of the individual?*
    ☐ I worry every day
    ☐ I worry sometimes
    ☐ I never worry
    ☐ Other: _____

14. *Do you talk to anyone in your life about your worries about the future care of the individual?*
    ☐ Yes
    ☐ No
    ☐ Not Applicable

15. *If you do talk to someone in your life about your worries, who is this person or people?*
    ☐ A family member
    ☐ A friend
    ☐ A paid provider
    ☐ A support coordinator or case manager
    ☐ Other: _____
    ☐ Not applicable

16. *Do you have any health issues (medical, mental health or others) that might prevent you from providing care in the future?*
    ☐ Yes
    ☐ No
    ☐ Not applicable

17. *Are you worried about how any of these health issues might affect the care you provide?*
    ☐ Yes
    ☐ No
    ☐ Not applicable

18. *Are you worried about how you will be able to afford to continue to provide care in the future?*
    ☐ Yes
    ☐ No
    ☐ Not applicable

19. *Are you familiar with financial resources that may be available to you or the individual you care for?*
    ☐ Yes
    ☐ No
    ☐ Not applicable

20. *Do you know where to find information about possible financial resources?*
    ☐ Yes
    ☐ No
    ☐ Not applicable

Created by the Sonoran University Center for Excellence in Developmental Disabilities at the University of Arizona, Dept. of Family & Community Medicine for the Southern AZ Person-Centered Planning Model Program

My Interests, Hopes and Dreams

An Exploration Tool and Guide to My Personal Preferences

This Workbook Belongs to:

_____

My Interests, Hopes and Dreams is a workbook for an individual to explore and express their likes, dislikes and desires. It is important that the person whom this workbook is about is not only the center of focus, but that it is completed **with** the person as a **valued partner**. Remember, everyone's skills, interests and aspirations change over time. So, be sure to revisit this workbook periodically to make sure it's up to date and matches where the person currently is in their life.

What this workbook is about…

My Interests, Hopes and Dreams is a tool that lets you and the people who know and care about you to think about your life and what's important to you. The different worksheets help you explore and record what your skills and interests are, what you like and don't like, new things you might like to try, the places you like to go, and the kind of people with whom you like to spend your time.

Once you have gathered all of this information about yourself, you can share it with others so they can learn more about you and your preferences. This tool can be a great starting point to help guide and inform any of the following:
- Person-Centered Plan or Description
- Individualized Education Plan (IEP)
- Individual Support Plan (ISP)
- Individualized Plan for Employment (IPE)
- One Page Profile
- Resume for finding employment
- Finding a good match for a roommate or direct support staff

A few things to think about as you start working on *My Interests, Hopes and Dreams*…
- **Who do you want to help you complete the worksheets?** You can invite family members, friends, support staff or anyone else who knows and cares about you to provide input and help you fill them out.

- **Where do you want to work on this tool?** Pick a place that is comfortable for you – this can be at home, at school, at a park or any place you feel most comfortable.

- **Make sure someone leads the discussion and someone writes down what everyone says on the worksheets.** This can be you or you can ask someone to do either task. Ask the person writing everything down to go over each worksheet with you to make sure it's exactly how you want it.

- **Have fun and be positive!**

My People

Who are the people in your life? Who are the people closest to you? Who do you hang out with or spend most of your time with? Who do you talk to? Who do you go to when you need help or advice? Who cares about you? Who is important to you?

Think about all the people you know and who you care about. On the next worksheet write down the names of these people in the section they best fit. Try not to write down the same person in more than one section. Your name is in the center of all of the circles. The people who you feel closest to should have their name closer to you in the circles. For example, if you have a closer relationship with your cousin than you do with you brother, your cousin's name should be written closer to the center than your brother's name in the family section.

There are four sections on your people map: family, friends, community members, and service providers.

❖ **Family** – includes anyone who is related to you: parents, siblings, cousins, grandparents, step-parents, aunts and uncles, etc.

❖ **Friends** – includes anyone who is not paid to spend time with you and who likes to hang out with you: classmates, co-workers, neighbors, teammates, etc.

❖ **Community Members** – includes people in your community who may be paid to do what they do, but are available to anyone: teachers, doctors, mail man, librarian, preacher, store clerk, hair dresser, etc.
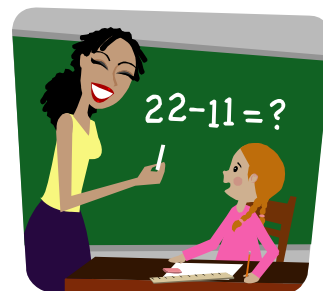
❖ **Service Providers** – includes people who are paid to support you: case manager, occupational therapist, physical therapist, support coordinator, one-to-one aide, etc.

My People

Family

Friends
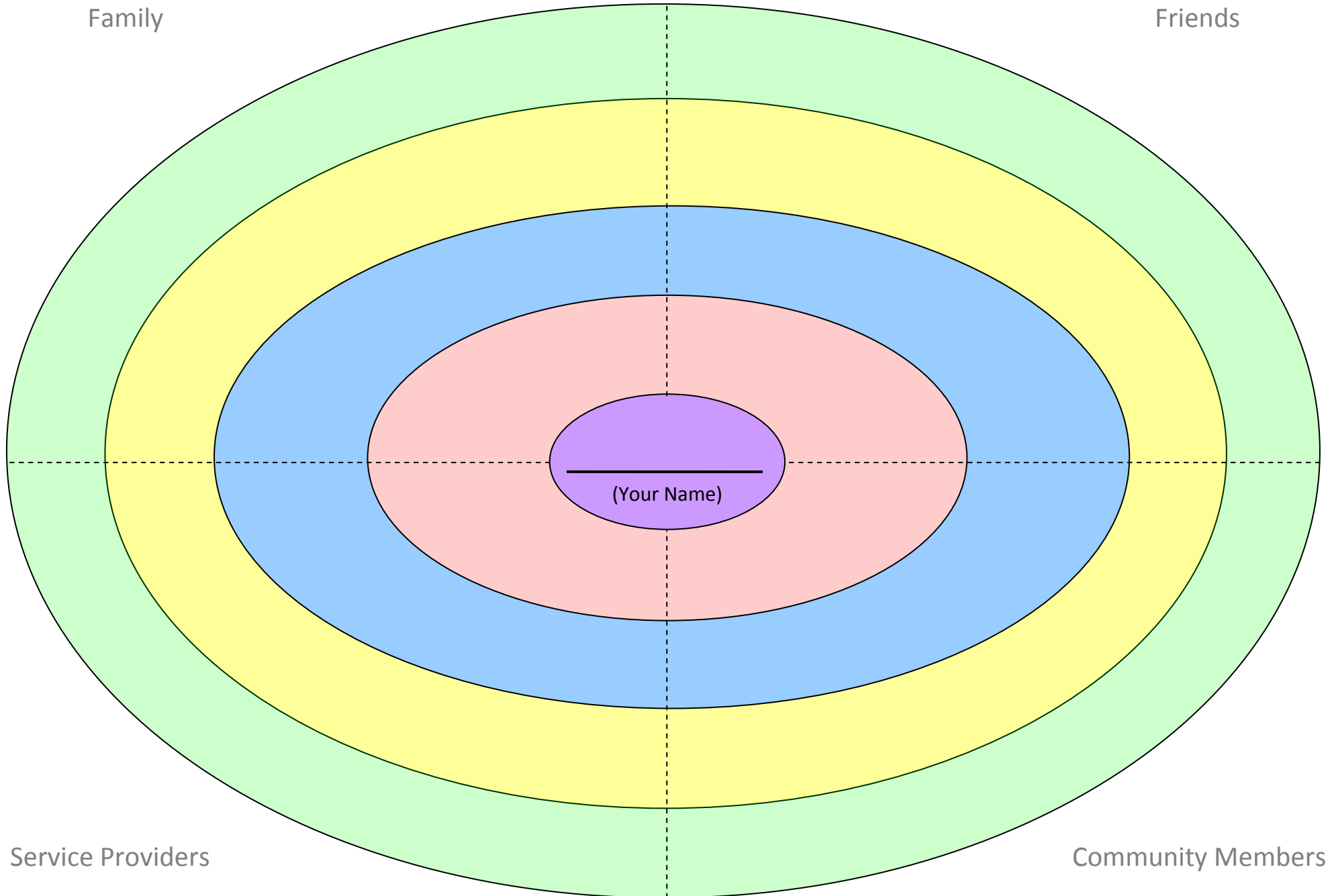
Service Providers

Community Members

(Your Name)

People I Like to be Around

What are the characteristics of people you like to spend time with? Those you don't like to spend time with? This section can be used to determine what kind of people you would like as a roommate or someone who provides you with support. List the personality traits, behaviors and interests you would like the person to have.

Characteristics I Like or Want in the Person	Characteristics I Don't Like or Want in the Person

My Gifts & Strengths

What are some of the great things about you? What do people like and admire about you? What do you like about yourself? What are some of the positive things people say about you? What are you good at? What are your skills, abilities and talents?

Great things about me…	What I'm good at…

My Style

What do you like to do? What are your interests and hobbies? What are some of your favorite things? What works for you? What keeps you interested and energized? What makes you feel alive? What doesn't work for you? What makes you upset or puts you off? What bores you or shuts you down? What don't you like or like to do? Are there things you haven't tried or done that you would like to?

What I like or like to do… What works for me…	What I <u>don't</u> like or like to do… What <u>doesn't</u> work for me…	New things I'd like to try or do

My Places

Where do you spend your time? Do you go to school or work? Where do you go in your community – church, library, stores, or restaurants? Where are you favorite places to go? Are there places you haven't been to in your community that you would like to go?

Where I spend most of my time	My Favorite Places	Places I <u>Don't</u> like to go	New Places I'd like to go

How I Communicate

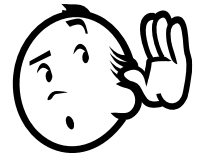Whether you communicate with words, sign language, or an augmentative device, everyone communicates with their gestures, behaviors and actions. How we react and behave often speaks louder about how we feel and what we want than our words.

This section lets you and those who know and care about you describe what you are telling people through your behavior and actions. How do we know when you're happy or upset? How do you let people know what you like or don't like? What you want or need? What are some of the things that you do that are important for people to recognize and understand? It is important that we listen to behaviors, learn their meaning, and respond appropriately. Once you complete the chart, you can share it with others so that they can better understand you.

How to fill out the chart:

❖ **What is happening** – describe the situation or circumstance which seems to affect what the person does. For example, this can be a setting, place, noise, people or activity.

❖ **When (person's name) does this** – describe the behavior, action, gesture, look, etc. of the person in this particular situation. Make sure that someone who has never seen this reaction would be able to understand and recognize what's being described. A single behavior can be associated with more than one instance in the "What is happening" column.

❖ **We think it means…** – describe the meaning of the behavior. More than often, a single behavior can have more than one meaning – be sure to list all of them.

❖ **And we should…** – describe what someone supporting the person should do in response to the behavior. Include any steps that may need to be taken to rule out certain meanings and/or how to respond.

What is happening	When _____ does this	We think it means…	And we/others should…

My Vision of the Future

What are your hopes and dreams? What would you want your life to look like? Everyone has an idea of where they would like to see themselves in the future – where they would like to live, how they spend their time and with whom they want to share their life.

This section will let you describe your idea of a great life that you want for yourself:

❖ **Home** – describe what home means to you. Where do you want to live – in the city? A house or apartment? With family, roommates, pets or by yourself?

❖ **Day/Work** – describe how you see spending your day. Are you going to school? What kind of classes? Work? What kind of job?

❖ **Community** – describe how and where you want to spend your free time. What do you want to do in your community? Who do you want to spend your time with? What are the activities you want to do and places you want to go?   This can be anything – playing sports, movies, the mall, church, shopping or the library.

Remember, everything can't be achieved over night. It takes time, commitment and support from you and all of the people around you. Knowing what you want is the starting point for figuring out how you can make it happen. The next step is working with the people who care about and support you to plan out the steps it will take to get there

My Hopes & Dreams

Community

Home

Day/Work

Other things I'd like to share about me:

Appendix E:
Examples of Person-Centered Plans

An Essential Lifestyle Plan for Joey

Initial plan date: 6/29/09

Significant revision dates:

Table of Contents

Purpose of this plan:

To plan for a placement outside of his grandmother's home

People who contributed to this plan (give name, relationship and how long they've known each other):

NAME	RELATIONSHIP	TIME
Joey	Self	Whole Life
Carolyn	Maternal Grandmother	Whole Life
Susan	Paternal Step Grandmother	Whole Life
Kimberly	Behavioral Health Case Manager	5 Days
Joey O.	Behavioral Health In-home Worker	2 Mos.
Elisa	DDD Support Coordinator	2.5 Mos.
Brett (7/17/09)	Brother	Whole Life
Erica (via report)	Therapist	3 Yrs
Roger (pending return phone call)	Family Friend	Whole Life

Who still needs to be asked to contribute? (give name, relationship and how long they've known each other)

NAME	RELATIONSHIP	TIME
Ashley	Sister	16 Yrs
JJ	Friend	15 Yrs
Jessica	Friend from School	
Ryan	?	
Sean	Friend from School	
Miss Swaney	Teacher	
Mr. Russell	Teacher	
Miss Knight	Teaching Assistant	

My Story

9/24/90
I am born
UMC 8 lbs
Full term
Healthy
baby

3 Years
Talked late

Late 1993
Placed in
Foster Care

1994
Family
Re-united

First 3 years
Had frequent
ear infections

1994
Suffered a
serious head
injury
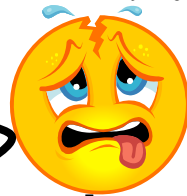
1995
Children
Removed
Again

1997
Began 1st
Grade at
Roberts

1998
Went to live
with
Grandma &
Grandpa

1998
Had surgery
To place tubes
In ears
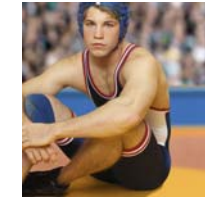
2003 - 2005
Flowing
Wells Middle

14 Years
X-Country Trip
in Semi w/
Aunt, Uncle&
Cousin

1998 – 03
Attended
Richardson
Elementary

16 Years
Heartbroken
Mom dies of an
enlarged heart

Joey and his
Siblings have
vowed to stay away
from drugs

7/09
PCP done to
find right
placement

Fall 2009
Jr at Flowing
Wells HS

2/2009
Went to
Disneyland
w/ Grandma
Susan

Pre-teen to Present
Multiple psychiatric
hospitalizations &
step down placements

PEOPLE IN MY LIFE

Elisa
DDD Support Coordinator

Grandpa Larry

KELLK

Grandma Susan

JJ

Sean

Ashley
(Sister)

Keith
(Brett's
Friend)

Roger

school
friends

Joey

Joey

Grandma Carolyn   Brett (Brother)

Erica

Joey O.
(Direct Support Staff)

Jessica
School Friend

Kimberly
Behavioral Health Case Manager
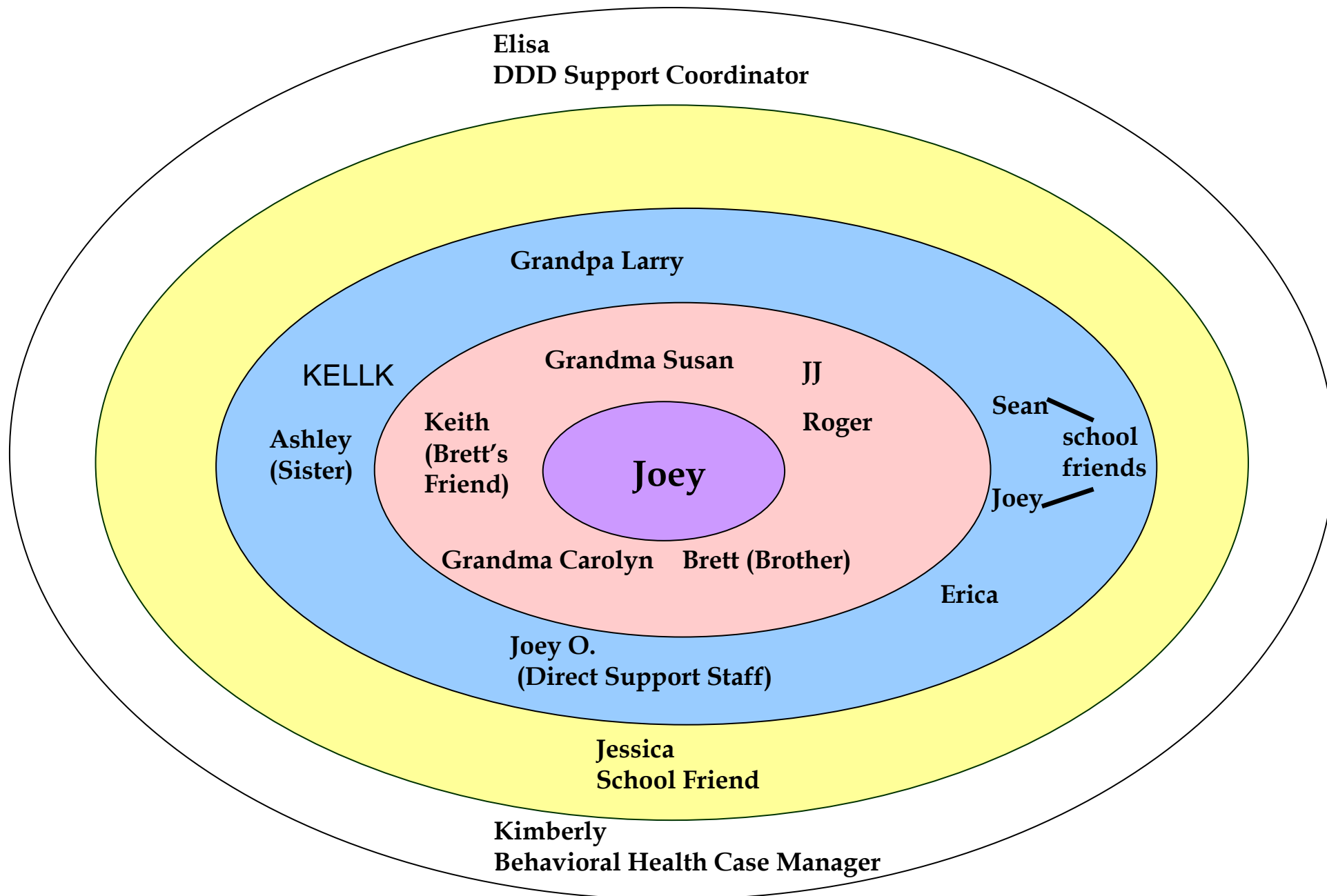
What people like and admire about JOEY.

(JOEY's Positive Reputation)

No drugs or alcohol in his life because he has seen its impact first hand

Willingness to talk so openly with new Support Coordinator

He is goal oriented-he wants to do mechanical work or video game testing and development

He is polite and well mannered

He gives great hugs

He is very loveable

He doesn't mind going to new places/trying new things

He meets people easily

He is good with people who have multiple disabilities

He has a good sense of humor

He has hidden talents

Speaks up for himself

What's Important <u>TO</u> Joey: Most Important

Coffee w/ flavored creamer at least 2 Xs per day

(Mocha, Irish cream, Vanilla, Amaretto, etc)

Action/Horror videos (Assassin's Creed, Orange Box, Overlord Brothers, Fallout 3, Dead Rising, etc)

Going out to eat (Subway=veggie, meatball, chicken teriyaki; Quiznos= Grilled Chicken Sub

Playing Nick.com at Grandma Susan's (Left for Dead)

Family- able to see them often once he moves

Having his own TV & gaming system in his room

Be able to make phone calls

Be able to watch "R" rated movies

Have a little "pocket money with me to buy stuff

I like to have free range of the house (not be restricted to my room during shift changes)

What's Important <u>FOR</u> Joey: Most Important

Listening to rock 'n roll or country music to calm him

Taking his meds on time: Zoloft, Geodon & Trazidone

Getting out more meeting new people

Getting plenty of sleep

What's Important TO Joey:
Second Most Important

Watching TV (South Park, Family Guy, Robot Chicken, Futurama)

His bunny, Sophie

Going to the Gym

Having his own room

Rock n' roll music available to listen to

What's Important FOR Joey:
Second Most Important

Going to the Gym as an outlet for frustration/energy

Characteristics of People Who Support Joey Best	**Characteristics of Potential House Mates**
Be a good Listener	Respect my property-Don't touch unless you ask for permission
Give gentle reminders vs nagging	No nagging
Use calm voice	Do things with me, but not all things
Tell me the truth	Respect closed doors
Keep promises	
Do things with you like go out to eat, cook, etc	
Have a good sense of humor	

<div style="border:1px solid black">

Definite Don'ts

Yelling
Hurting others, especially those I love
Stealing
Lying
Telling "Your Mama" jokes
Pranks where I am made fun of
Threats of violence/killing
Hitting girls (sister or friends in particular)
Being around drunk/high people
Thinking/talking about past abuse

</div>

What People Need to Know and Do to Support Joey/Me

Be a good Listener

Sometimes I say I will do things, but I haven't yet or I forget.

Getting up in the morning is hard for me

I am not fond of pranks or teasing where I am the brunt of the joke

No drugs or alcohol allowed! Don't want to see, hear about it.

Tell me the truth

Keep promises you make to me.

Dishes are not my favorite chore

I like to cook pizza, quiche, omelets, chicken teriyaki, stir fry

I like to swim and go to the gym

Motivate with video games but may take a while

My Coping Skills/Activities

Playing video games

Helping Grandma (I like helping others-it makes me feel good)

Cooking

Listening to music (AC DC, Beatles, Nightmare Before Christmas)

Eating

Spending time w/ brother (playing video games, weight-lifting)

Weight-lifting

Drinking Coffee

Making rubber band balls

Collecting knives

Humor-laughing, people saying funning things

Getting out of the house

Swimming

How to Keep Joey Healthy and Safe:

Needs plenty of sleep (10 hrs)

Take his meds on time

See his counselor, Erica 1X per week

See Dr. Fernandez-Turner c̲ 3 mos. for med. monitoring

See Dr. Walsh, PCP at least annually for physical

Needs to live somewhere else (Can't live with Uncle)

Caregivers need to know that Joey has made an attempt to take his own life a year ago. He has Post Traumatic Stress Syndrome as well as diagnoses of bi-polar and schizophrenia

Joey doesn't like that the medication "dulls him out", make him feel "empty" or that he "can't feel anything".

Keep sharps restricted

Things to Figure Out

Where he can live

How he feels about his brother leaving to join the Marines

How to hang out with others his own age

Wants more to do

He'd like to live where there were both guys and gals

How ___JOEY____ Communicates

What is happening…	_____ does this…	We think it means…	And we should…

Joey is able to express himself well.

Joey's

Team TO DO List

What	Who	When	Done
Get input from people not at meeting	Deni	7/17/09	7/17/09
Write up PCP	Deni	7/17/09	7/17/09
Prepare Placement Packet	Elisa	7/17/09	
Look into getting Power of Attorney	Nana	8/29/09	
Mail Respite list to Carolyn	Elisa	7/3/09	
Look into guardianship process	Susan & Carolyn	This year	
Register to vote	Joey & Nana	9/30/09	
Visit possible placements	Joey et al	ASAP	

Hopes & Dreams for Joey

Residential
-Small group setting
-Males & females
-24 hr supports
-Variety of Activities available
-Likes apartment settings
-Pool & Rec room
-Basket ball court/gym
-Prefer own room
-Needs to be able to protect his
 stuff

School/Work
-Stay at Flowing Wells High School
-Wants a job where he can use
 mechanical talents/video game
 knowledge, etc.

Family
-Wants regular unrestricted
 contact with his family

Example:

PERSONAL FUTURES PLAN

Person Centered Plan

For

CODY

May 2010

INTRODUCTIONS

The initial PCP planning session was conducted on Saturday, February 27, 2010 @ the family home in York Valley. In attendance were:

- **Cody**
- **Terry**   Cody's Mother

Notes:

Cody's DES/DDD support coordinator, Bonnie was unable to attend the scheduled planning session due to illness.

Cody and his mother were apprised that they could invite anyone else that they wanted to be part of the PCP planning process.

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Saturday, April 17, 2010:

The person centered planning (PCP) team met again at the family home to continue the initial planning process. In attendance were:

- Cody
- His mother Terry,
- His older brother Scooter, and
- his DES/DDD support coordinator Bonnie

The PCP team reviewed the first draft of the information gathered at the prior planning meeting. Revisions were made and additional information was provided by Cody's brother – "Scooter". Cody's short term and long term goals were discussed and an initial action plan was started towards the identified goals. It was agreed to meet again to review all the information and finalized the initial PCP planning process.

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Friday, April 30, 2010:

The person centered planning (PCP) team met again at the family home to complete the initial planning process. In attendance were:

- Cody
- His mother Terry,
- His older brother Scooter, and
- his DES/DDD support coordinator Bonnie

The PCP team reviewed the revisions/updates made to the PCP document and the initial implementation plan. Mrs. Montoya also provided a written history for inclusion in the plan document, It was agreed that the PCP team would meet again towards the end of June 2010 to review the status of the identified action items.

Bill – PCP facilitator (DES/DDD)

HISTORY

Cody's mother provided the following information regarding his life growing up.

04-25-2010

History

- Born 08/09/1991 in Safford, Arizona.

- He is the youngest of three children.

- No issues at birth or related to pregnancy.

- At 13-17 months of age, mom started to compare him to the other siblings in the way of development. Cody never crawled; he only rocked back and forth and head banged. At this time, Cody was not developing as the others were at that age.

- All Cody could do at 14 months was that I (mom) would have to sit him up, then he would just sit there and stare at what was happening around him. He would not make any noise or attempt to play or grab things. Cody would just sit where I placed him and stare.

- At the age of 3 years old, Mom got him into Child Find and Cody was able to get speech therapy. The speech pathologist taught Cody some sign language so he would not become so frustrated when attempting to communicate. In addition, he received occupational therapy, early child development and DDD services.

- Cody said his first word at age seven.

- When Cody started school, he was completely non-verbal. He started his school career in Morenci at the Accommodation School.

- Cody transferred to Duncan Elementary when he was in the 5th grade.

- At the present date, Cody's vocabulary is 50 -70 words. He does not speak in complete sentences and only answers to "yes" and "no" questions.

- Cody is shy when he is alone and not with people he is familiar with.

Cody
March 10, 2010

People in Cody's Life

FAMILY	COMMUNITY
➢ **Terry** Cody's Mother ➢ **"Scooter" (Anthony)** Cody's older brother (20 yrs old) ➢ **AJ (Alyx)** Cody's sister (22 yrs old) ➢ **Grandmother** (Mother's side of the family) - *lives up the hill from Family home.* ➢ Cody's maternal grandfather is deceased. *(Died in July 2009 - Cody was very close to his grandfather.)* ➢ **Zach** Cody's nephew - 2 yrs of age ➢ **Emily** Cody's niece - 4 months old Cody has 3 Aunts: ➢ **Jodi** Lives in Tucson ➢ **Patricia** Lives in Morenci ➢ **Jennifer** Lives with Cody's Grandmother ➢ **"Body"** Cody's uncle (Mom's brother) ➢ **Jason** Cousin - 19 yrs of age - lives in Yuma. ➢ **Jacob** Cousin - 10 yrs of age - lives w./ his grandmother ➢ **Keeli** Cousin - 9 yrs of age - also lives w. / his grandmother.	**Rob H.** Neighbor across the canyon. His children come over and play video games with Cody. Goes grocery shopping @ Thrifty's *(Family lives in a rural area called York Valley which is approximately 12 miles southeast of Clifton and 20 miles northwest of Duncan.)*
FRIENDS	STAFF
Donald Graduated from school 2 years ago. Lives in Duncan. Cody has known him for 5 years. **Ricardo** BEST FRIEND Cody has known him for approx 9 yrs. Attends school with him. **Doria** GIRL FRIEND Has been going with her for 1 month. Younger than Cody.	Duncan High School Staff **Mr. Sesate** Special Education Teacher *(Also, Special Education Director for the Duncan Public School.)* **Mrs. Swapp** Home Economics Teacher

Cody
March 10, 2010

PLACES

HOME	DAY/WORK	COMMUNITY
Cody lives with his mother in a double wide trailer in York Valley.	Cody currently attends the Duncan High School and is in 12th grade.	Due to living in a very rural area (York Valley), there are not a lot of activities for someone of Cody's age to participate in, unless one is able to drive.
(York Valley is in Greenlee County and is approximately 12 miles southeast of Clifton and 20 miles northwest of Duncan.)	He is scheduled to graduate from high school in May 2010.	*(Cody wants to learn how to drive. Mom thinks that he could do so.)*
• Their home is located next to the Gila River.	• Cody has attended the public school program in Duncan since 5th grade.	• No employment opportunities.
• His older brother (Scooter) also lives in the home with his girlfriend.	• Prior to attending school in Duncan, he attended school in Morenci.	• Goes to the movies and bowling.
• His maternal grandmother lives up the hill from their home.	• Within school, he currently participates in a special education program but is mainstreamed for his courses in reading and mathematics.	• Was involved in a bowling league and won some money.
• Cody and his family have lived in York Valley for the last 10 years.		• Also, participates in Special Olympics.
• Prior to living in York valley, the family lived in Clifton.	• Last summer, he worked at the Blake – Main Street Café in Safford.	*For the last 5 years, he has participated in track and field and bowling in Morenci.*
		Will be going with his High School class for the senior trip to Phoenix in May 2010 – Current plans include attending a Diamondback's game, Visiting Golf Land and going shopping.

Cody
March 10, 2010

CHOICES

CHOICES THE CODY MAKES	CHOICES MADE BY OTHERS

• Going skate boarding.
 	
• What he is going to wear each day; he has his "own style".
 	
• Hair style – had longer hair until recently, but gave himself a "buzz" hair cut.
 	
• How he keeps and decorates his bedroom.
 	
• What he orders when he goes out to eat.
 	
• Types of videos that he watches – *Likes watching videos involving action, car racing, and skate boarding.*
 	
• Video games that he plays.
 	
• Playing WII
 	
• Movies that he attends.
 	
• When he works, he gets to keep and spend his money as he chooses.
 	
   - Buys his own clothes for school.
   - Hats and "Shades".
   - "Ear Rings"
   - Tattoos - has 2 tattoos - one on his forearm and one on his upper arm.
 	
• Who he considers as "his friends".
 	
• To have a girl friend. (Currently has a girlfriend.)
	• Not allowed to purchase or play video games that are "X Rated".
	
	• Age of the girls he can date.
	
	• To stay out all night - *Must be home by 12:00 midnight; required to call his mother if he is going to be late.*
	
	• Can't leave the house without letting his mother' know where he is going and when he will return. He is required to call his mother if he is going to be late.
	
	• To have friends over when his mother is not home.
	
	• Must finish school.
	
	• Once he graduates from school, he must get a job; he will not be allowed to just stay home.
	
	• He is not allowed to smoke, drink and do illegal drugs.
	
	• Can't drive a vehicle without his mother's permission and a driver's license.

Cody
March 10, 2010

PREFERENCES

What Works for Cody	What Does Not Work for Cody
• Being asked to do things rather than being told.	• Being "demanded" or told to do something.
• Being kept busy.	• Being "yelled at".
• Is a "visual" learner -→ If he sees something done, he is better able to complete the assigned task/activity in the future.	• People "joking" around. *He tends to think the "joking" is being oriented at him; that others are "teasing" him.*
• Has a definite interest in skateboarding.	• Situations where there are "lots of distractions".
• Likes to cook and sew.	• Not being able to wear his cap.
• Like to say "*You owe me.*"	• Having his ears tugged in that they have "gauges".
	• Using devices that require "key punching" (computers, calculators, etc.)
	• Work tasks that involve "detailed" work and/or close attention (i.e.; welding, setting up his "X-Box", etc.)
	• Being made to "dig holes" to plant bushes and trees.
	• Having to feed animals. *Though he likes to have animals, he doesn't like to be responsible for feeding them.*
	• Having to do his laundry if it involves the use of bleach.
	• Utilization of a gas stove to cook.
	• When others do not understand him when he is talking.

Cody
March 10, 2010

RESPECT

WAYS CODY GAINS RESPECT	WAYS CODY LOSES RESPECT
• Makes and sews quilts, decorative pillow cases and other craft projects (hanging dice, etc.) • Had to put a water-line in for his mother • He is a hard worker; in his employment situation during the summer @ the Blake Main Street Café, He was always looking for work that needed to be done. • Is able to get ready for school and on the school bus every day on his own. • Though he doesn't like feeding the dogs, he does it when he told. • Helps care for his niece and nephew – holds them, prepares their bottles, feeds them and is willing to change their soiled diapers when needed. • Takes care of his nephew and takes him "4-wheeling" and swimming. • Takes on the responsibility of caring for the younger members of the family. • Is a very caring individual. • Takes care of his hygiene needs with minimal reminders. *Shaves independently with a razor.* • Dresses himself every day. • Upon arriving home from school, he gets the mail, sorts and stops and gives his grandmother her mail. • Prepares the coffee each night so his mother can turn it on in the morning.	• Doesn't wake up and get up in the morning until his mother wakes him up. • Though he knows how to brush his teeth, he does needs some remainders to brush them. • Though he is able to "shower himself", needs reminders to do so.

Cody
March 10, 2010

RESPECT

WAYS THE CODY GAINS RESPECT	WAYS CODY LOSES RESPECT
• Upon arrival home from school, he is able to keep himself occupied until his mother gets home from work. *(Usually makes himself a snack and watches some television. When he his mother arrives home, he goes out and helps her carry in her stuff.)* • On the nights that Cody is "in charge of making dinner' he usually makes sandwiches or eggs, • Has basic cooking skills. *Is able to cook using an electric stove.* *Is able to cook simple meals such as sandwiches, Ramaan noodles, scrambled eggs, toast, salads, mac&cheese from the box, spaghetti, etc.* *Is able to measure ingredients with use of visual cues.* • Knows how to use the dishwasher. *Takes dirty dishes to the sink and rinses them and puts them in the dishwasher.* *Know how to turn on the dishwasher.* *Unloads and puts dishes away.* • Does the laundry when needed. *Does his laundry usually when he reaches in the drawer and there no clean clothes.* *Washes his family's clothes to make a load.* *Able to use the washing machine - uses cold water, measures 1 scoop of detergent, turns it on.* *Dries clothes with use of "hanging on line" or the clothes dryer.* *Puts his clothes in his dresser.* • Knows how to make his bed.	• Does not wash "whites" when doing laundry - scared of spilling the bleach. • Doesn't always make his bed.

<div align="right">
Cody
March 10, 2010
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RESPECT

WAYS CODY GAINS RESPECT	WAYS CODY LOSES RESPECT
• Takes out trash. • Helps dust the furniture. • Will vacuum the floor if told to. • Assists his mother with grocery shopping. *Gets sale brochures out of newspaper and circles items that he wants to buy or eat.* *Helps compile the grocery list.* *Goes with his mother to the grocery store and helps retrieve items on the grocery list.* • Has good basic money management and budgeting skills. *Knows 4 quarters equal 1 dollar.* *Knows values of the coins.* *If given a mixture of change, he is able to determine the total value (Sorts coins by denomination, then adds to determine total value.)* *Has his own savings account.* *His mother helps him fill out the deposit slip.* *Signs his paycheck and copies his account number from his savings book,* *With assistance, he is able to balance his savings account using his monthly statement.* *Pays the monthly bill for Direct TV.* • Can read some simple words and phrases. • Can write (print) his name. • Is able to recite his physical address and phone number with the utilization of his ID card which he always carries in his wallet.	• Needs to learn to maintain his checking/savings account without assistance. • Needs to increase his reading and comprehension skills.

RESPECT

WAYS CODY GAINS RESPECT	WAYS CODY LOSES RESPECT
• Is able to copy his address and phone number. • Has his own "pay as you go" phone. *Is able to "load his own minutes" on his phone and keep track of his utilization.* • Has his "favorite" and important telephone numbers stored on his cell phone for easy reference. • Loads music selections on his I pod. • Is able to use the family personal computer. ### EMPLOYMENT *Cody worked for the Easter Seals, Blake Foundation "Main Street Café'" in Safford last summer. The following information was provided as to his work related skills and capacities:* • Learns new skills very quickly and was considered a valuable member of the team within the café' • Always gives 100% and is always eager to complete any task given to him. • Was highly respected and admired by both his co-workers and staff. • Very efficient in his work habits and always looked for work needing to be completed. • Kept himself busy at all times.	

Cody
April 30, 2010

RESPECT

WAYS CODY GAINS RESPECT	WAYS CODY LOSES RESPECT
His work responsibilities and tasks at the "Main Street Café" included: • Making drinks and smoothies. • Preparing salads and sandwiches for customer orders. • Was also involved in catering events. • Food preparation • Food portioning and packaging. • "Clean-up" activities such as washing dishes, sweeping and mopping floors, etc.	• Lacks "patience" sometimes when involved in tasks or activities that involve detailed work or long periods of concentration. Has been known to come out with some "expletives". • Can sometimes become very frustrated or agitated when things don't go the way he thinks they should. • Can use some profanity when his sport team is losing or he breaks something. • Can become very "nervous" in situations that are "new" or that involves individuals that he may not know – particularly if one of his immediate family is not present. • Can get nervous and/or anxious when family members are sick or hurt. • Has difficulty with others joking or fooling around. *Tends to automatically think the joking is directed towards or about him.*

Cody
April 30, 2010

RESPECT

WAYS CODY GAINS RESPECT	WAYS CODY LOSES RESPECT
	• Becomes very nervous and/or concerned after watching television programs involving law enforcement, emergency and fire personnel. NOTE: *Cody can become very nervous and uncomfortable when in the presence of law enforcement. At a young age, he witnessed his biological father arrested and removed from the family home. At the time, his mother was not present; only his older brother.*

COMMUNICATION

Cody had very limited → no speech until approximately 2 years ago.

- Started receiving speech therapy at age 3.

- Augmentative communication systems were utilized with Cody in the past – communication board, sign, etc.

- Significant progress has been made over years to increase Cody's ability to communicate verbally.

- The break-through in his verbal speech and language development became apparent after he started the utilization of head phones when listening to his music. The repetitive listening to music significantly aided in his speech and language development.

  Note: *This is strongly evidenced by the fact that if Cody's mother had not provided this historical information, the PCP facilitator would not have known. Cody actively participated in providing various pieces of information regarding this person centered plan verbally through short phrases and/or answering inquiries from the facilitator.*

- Cody still receives speech therapy through the public school and the Division.

  (Receives 1 hour per month consultative speech therapy funded through the Division.)

  Note:

  Cody can become very frustrated and angry when others do not understand what he is saying.

Cody
March 10, 2010

CODY' S GENERAL DAILY ROUTINE

6:00am   Mom starts to wake him up.

6:10 – 6:15am   Cody finally gets up and starts his morning routine.
                 Usually has a cup of coffee.
                 Picks out his clothes and gets dressed.
                 Brushes his teeth (with reminders from his mother.)

6:35 am: Leaves the house for the school bus.
                 Usually stops and see his grandmother.
                 Then walks out to the road and waits for the school bus.

7:00am   Picked -up by the school bus.

7: 45am Arrives at school.

                 SCHOOL

3:00pm   Takes bus home from school.

4:15pm   Arrives back at his bus stop
                 Gets mail and sorts (Grandmother's vs. Mom's)
                 Stops and visits his grandmother – gives her mail.
                 Then walks home.
                 Turns on television and fixes himself a snack.

5:00pm   Mom arrives home.
                 Helps mom bring her stuff into the house.
                 Then brings her a glass of ice tea.
                 Feed and waters dog

                 Family takes turns with making dinner.
                 On the nights that Cody is "in charge" with making dinner, he usually makes
                 sandwiches or eggs.

6:00pm   Clean-up from dinner –
                 Puts dishes in dishwasher.
                 Turns on dishwasher.

7:00pm   Relaxation

8:00pm   Takes shower and shaves.

9:00pm   Goes to bed.

Cody
April 17, 2010

HEALTH

HEALTH	THERAPIES	ADAPTIVE EQUIPMENT
Very good health	DDD: Speech Therapy *(1 time per month)* Through School: Speech Therapy Occupational Therapy *Currently, focus of the occupational therapy is the development of his writing skills.*	Weighted Vest and Blanket *Sensory Integration Program*
MEDICATIONS	**DIAGNOSIS**	**CURRENT SERVICES**
Melatonin prescribed to assist with his ability to sleep at night. *Had been formerly on Straterra and Adderal* **Aroma Therapy** Utilized as part of his sensory integration program.	At age 5, Cody was diagnosed by Michael Germaine as having: Autism ADHD Also, has a diagnosis of "oral aproxia" <u>Note:</u> As a child, had exhibited "rocking" and "head banging" behaviors.	NONE *During the summer months, had been receiving employment support services* *(Group Supported Employment and Transportation)*

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Cody
April 30, 2010

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"VISION OF THE FUTURE"
for Cody's Life

Home	Work/School	Community
Short Term:/Immediate Goals: _Note:_ _Cody will be graduating from high school on May 21, 2010._ o To continue to live with my mother and family in Duncan. o To get my driver's license. **Future Goals:** _If I am unable to continue to reside in my family's home, then I would like to live in my own home with some help:_ **Requirements:** o Want to live somewhere close to a "skate park" If not, would need to have one built in my back yard. o Within walking distance from my work situation. o May want a room mate to share basic living expenses. o Home would need to have a dishwasher, refrigerator and microwave. o Big flat screen television is very important, as well as access to video games. o Accommodations for a washer and dryer. _If not, home should be within walking distance of laundry facilities._ o Large bath/garden tub.	Attend Eastern Arizona College (EAC) and learn upholstery. _(Would like to re-upholster the furniture within his family's home.)_ To have a full-time job that pays good money. Potential job opportunities to be pursued include: o Working in grocery store stocking shelves and gathering shopping carts. o Working in a restaurant – likes to cook and to prepare meals. o Furniture or auto upholstery restoration.	o <u>NEEDS TO HAVE A SKATE PARK.</u> o Availability of laundry facilities within walking distance. o Fast food restaurants o Grocery store within walking distance. o Bowling alley o Movie Theaters o Golf course and/or miniature golf facilities. o Have availability of public transportation.

Cody
April 17, 2010

"VISION OF THE FUTURE"
for Cody's Life

Continuation

Home	Work/School	Community
o Availability of exercise facilities including swimming pool & hot tub **Potential Needed Supports:** Will need some assistance with managing his monthly finances and expenditures. - Bank accounts. - Rent and Utilities. - Groceries - Cell phone - Personal computer - Car payment and insurance. - Clothes - Spending allowance for other leisure activities. Help with scheduling and attendance at medical and dental appointments. Assistance with grocery shopping Assistance with large purchases.		

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Cody
April 30, 2010
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RESOURCES/BARRIERS

| RESOURCES	BARRIERS

➢ Cody has a very supportive family.
 	
➢ His mother wants her son to succeed at whatever he chooses to do with his life.
 	
➢ Last summer, he worked at the Blake – Main Street Café in Safford, plus has the potential of working part-time at the local Bashas in Morenci.
 	
   Thus, he already has potential employment situations until he finds another employment opportunity that may be more in line with what he wants.
	➢ Due to living in a very rural area (York Valley), there are not a lot of activities for someone of Cody's age to participate in, unless one is able to drive.
	
	   Thus, will need to rely on others until he gets his own driver's license and car.
	
	➢ Very limited employment opportunities

Cody
April 30, 2010

IMPLEMENTATION PLAN

| WHAT	WHO	BY WHEN
Upon Graduation from High School		
1. **Pursue feasibility of working @ Blake – Sage ice cream/coffee shop in Morenci to increase employment skills.**	Cody /Bonnie	May 21, 2010
2. **Attend EAC to learn upholstery.** Research availability of course and associated enrollment costs.	Cody / Mom	June 30, 2010
Talk to RSA – Vocational Rehabilitation Services to determine if there is any available financial assistance with attending college to learn upholstery.	Cody / Mom	June 30, 2010
3. **Learn how to complete a job application and the job interview process.**	Cody	June 30, 2010
4. **Pursuance of gaining driver's license.** Research out how one gains their driver's license.	Cody	June 30, 2010

Example of Best Practice: PATH
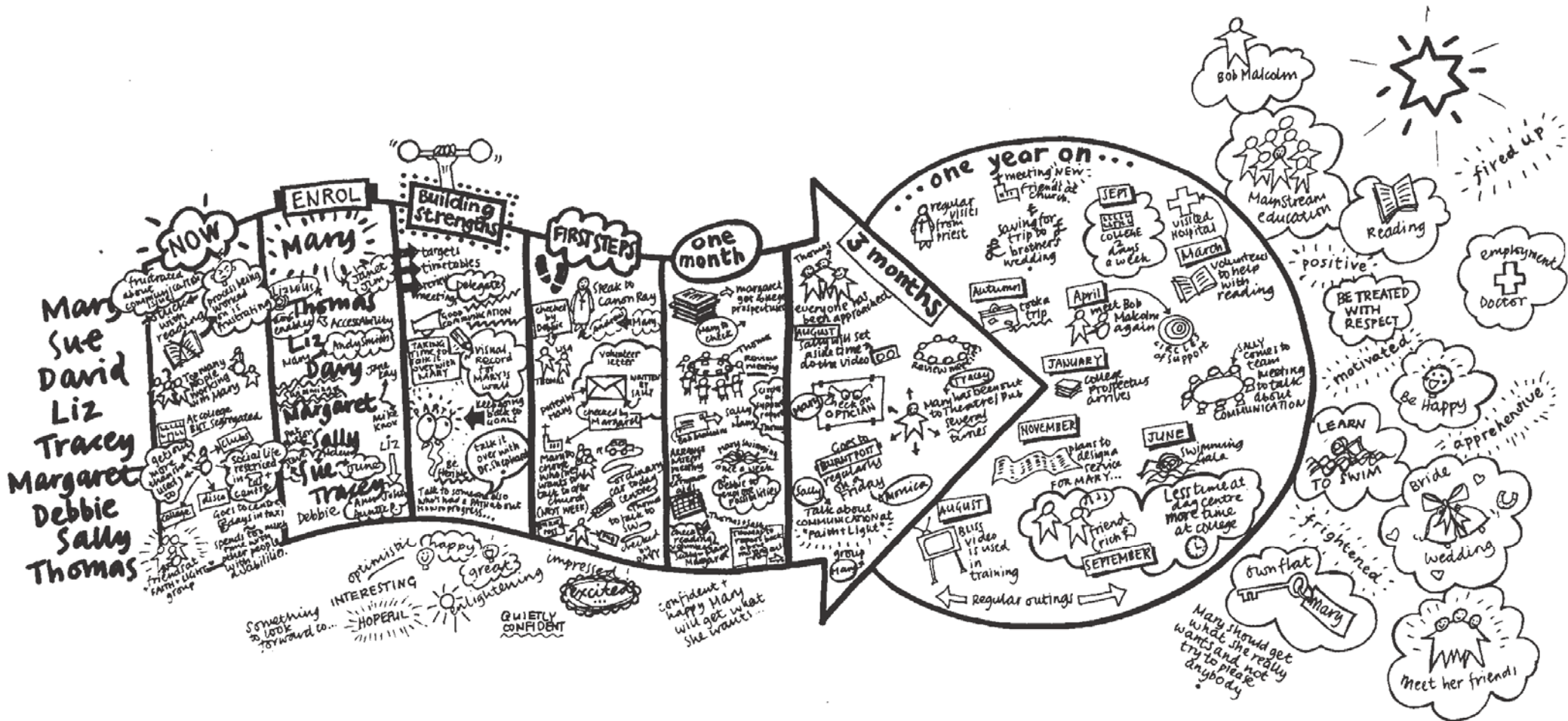
From Helen Sanderson Associates, Examples of Best Practice(5)

Example: PATH

From Cincibilty Blog Post: Positive & Possible[6]

Example of Best Practice: MAPS
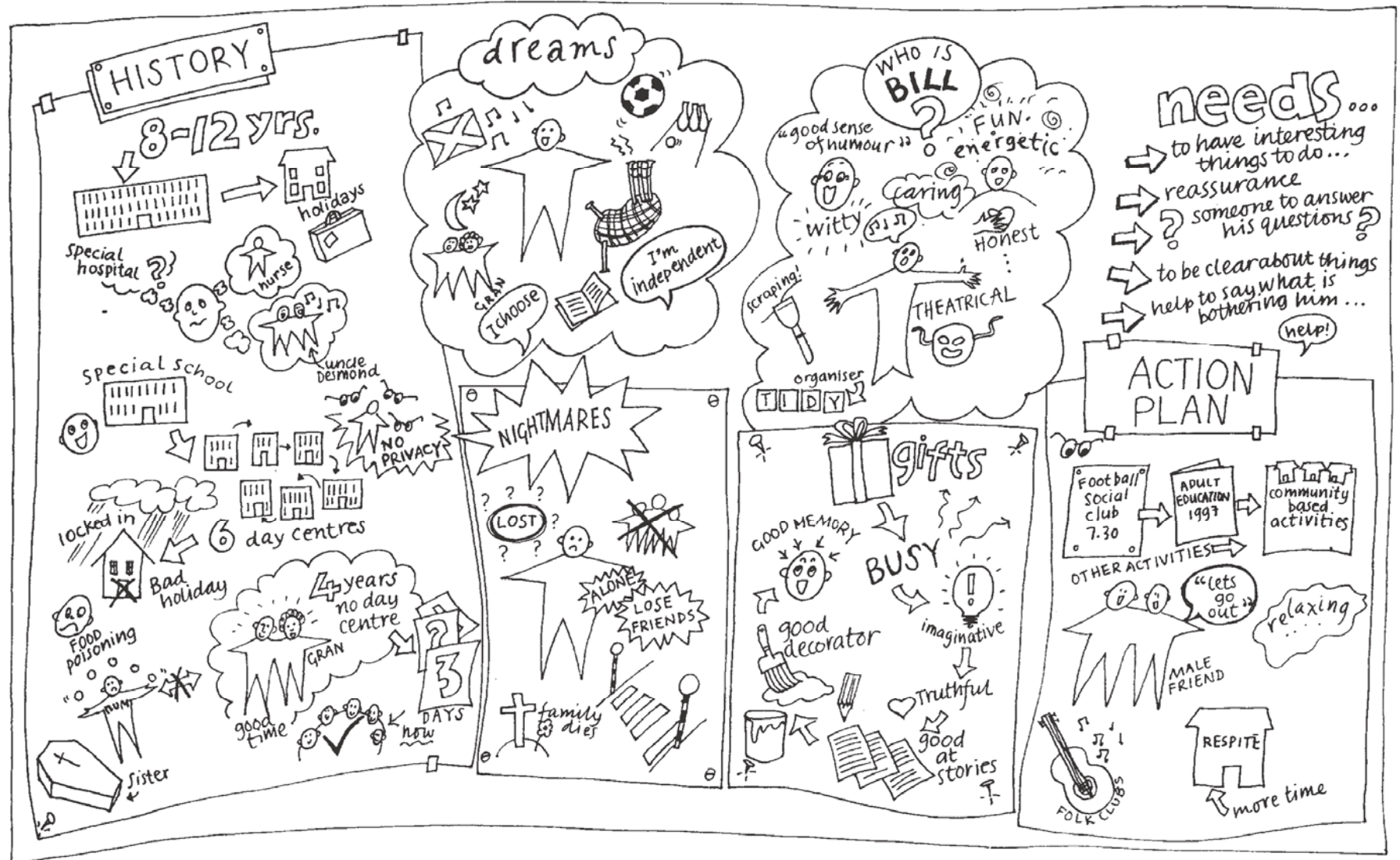
From Helen Sanderson Associates, Examples of Best Practice(7)

Example: MAPS

IAN'S
MAP
CONTRIBUTORS:
IAN
Ian'S – Mother
Ian's- FATHER
Ian's – Keyworker (day centre)
Ian's – CARER
PROCESS FACILITATOR: Jo
GRAPHICS FACILITATOR: Sue
COMPLETED: 24 JUNE 2004
REVIEWED: _ _ _ _ _ 2004
UPDATED: _ _ _ _ _ _ _ _
UPDATED: _ _ _ _ _ _ _ _

Purpose: to be shared with people of IAN's choosing and service providers to ensure that IAN's MAP is implemented.
To be a living document that is added to as IAN wants.

From Helen Sanderson Associates, Examples of Best Practice(8)

Appendix F: References

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