**SUPPORT STRATEGIES REVIEW MINUTES**

**Name:**       **Case #**

**Primary Monitor of Specialized Supports:**       (Name, e-mail, phone #)

**Submitted by:**

**Period reviewed (mo or qtr & year):**

**Span dates for which specialized supports approved:**       (M/D/YY to M/D/YY)

**1. Target Behaviors/needs and support strategies (summarize)**

|  |  |  |
| --- | --- | --- |
| Identified Need / Defined as \_\_\_i.e., ATO/hitting, pushing | Strategy/Intervention | Location to be Used |
|  |  |  |
|  |  |  |
|  |  |  |

**2. Was data received in a timely manner?** [ ]  Yes [ ]  No

 **Is data to review reliable/valid?** [ ]  Yes [ ]  No

**3. Data and interpretation of skill training/behaviors to increase**

 **a. Goal attainment for replacement skills/other behaviors to increase:**

 **b. Is further behavioral assessment needed?**  [ ]  Yes [ ]  No

 **c. Attach graph to show progress (at least every 90 days).** [ ]  Yes [ ]  No

**4. Are reinforcers still effective?**  [ ]  Yes [ ]  No

**5. Data and interpretation of target behavior(s)/identified need to decrease**

 **a. Summarize frequency, intensity, etc. of target behaviors over review period; %**

 **of days without target behavior; address issues of variability of data; and note any changes in comparison to last month’s &/or baseline data.**

**b. Summarize use of restrictive supports (% change, etc.). Attach graph to show progress** (at least every 90 days).

 **c. Are the restrictive procedures effective?** [ ]  Yes [ ]  No

 **d. Has function of target behaviors/identified need changed?** [ ]  Yes [ ]  No

**6. Has fading criteria been met?**  [ ]  Yes [ ]  No

 **Do fading procedures need to be clarified?**  [ ]  Yes [ ]  No

**7. Frequency/description of other problem behaviors occurring:**

**8. Significant events or changes in the individual’s physical, environmental, or social status (e.g., illnesses, staff changes, loss or illness of significant others, etc.):**

**a. Impact, if any, on target behaviors/identified needs:**

**b. New/different specialized supports to consider:**

**9. Problems which have risen regarding use of specialized supports. Describe any injuries or incidents which have occurred since the last review when using supports:**

**10. Have current implementers been trained?** [ ]  Yes [ ]  No

**11. Indicate need for further in-servicing of staff or others and who will provide/when:**

**12. Should the individual be referred to any specialists or other service providers?** [ ]  Yes [ ]  No

**13. List any changes in psychotropic medications and/or diagnoses since last review:**

 **Any adverse side effects of psychiatric meds?** [ ]  Yes [ ]  No

 **If yes, please specify:**

 **Is there adequate communication with prescribing physician?** [ ]  Yes [ ]  No

**14. What is the individual’s overall response to his/her specialized supports?**

**What does**       **want to say at this review about his/her specialized supports?** **(Please indicate if person was present for his/her review and if not, why.)**

**15. Are any changes proposed in the type of specialized supports for this person?** [ ]  Yes [ ]  No

 **(If yes, explain, reassess, addend ISP, and resubmit for HRC approval before implementing if proposed support is restrictive.)**

**NEXT REVIEW MEETING:**

**General Comments:**

**PLEASE REFER TO SEPARATE PAGE FOR SIGNATURES**