

St. Clair County Community Mental Health Authority

Positive Behavior Supports Survey

Person Completing Form: ☐ Individual ☐ Guardian ☐ Family ☐ Advocate

Date: _____

Case Number: _____

HOW WELL IS YOUR SERVICE PLAN WORKING FOR YOU?

Please let us know what you think by checking Yes or No to the questions below. Check N/A if you feel that the question does not apply to you. (Guardian / Family / Advocate please read and respond to the questions as you see them applying to the individual.) Thank you for your help.

Since you started your Service Plan...	Yes	No	N/A
Has your Service Plan been based on Positive Behavior Supports? (Understanding what I really want and how we all can best work together)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Are fewer Restrictive or Intrusive interventions being used? (Fewer things done that take hold of me or my personal space)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Are fewer Emergency Management interventions being used? (Fewer things done that take hold of me or my personal space when I am having a crisis)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Are fewer medications (type of medication, dosage) being given to you to help you control behavior?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Are you doing more in the community and / or doing more things independently?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>
Are you meeting identified goals/objectives	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N/A <input type="checkbox"/>

Comments:
