

# Pennsylvania Plus (PA Plus)

## Additional Planning Information

SIS™ ID/TRACKING NUMBER

Name _____			Date Completed		
LAST	FIRST	MIDDLE	_____ / _____ / _____		
Address _____			YR	MO	DAY
City _____			Date of Birth		
Phone _____ / _____ / _____		Age _____	YR	MO	DAY
Other Pertinent Information _____					
_____					

Respondents\*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Interviewer \* \_\_\_\_\_



Department of Public Welfare  
Office of Developmental Programs

\* See Supports Intensity Scale™ cover sheet for complete demographic information

**1. How much support does this person need for mobility? (Circle one)**

- 0 None
- 1 Assistive Technology (Wheelchair, walker, braces or cane)
- 2 Occasional personal support
- 3 Extensive personal support (At all times)

**1. A. Does the person have Assistive Technology in place for mobility? (Circle one)**

- 0 Yes (Please specify)
- 1 No, but the person might benefit from Assistive Technology (Please specify)
- 2 Need for Assistive Technology is documented, but is not yet in place or is not used (Please specify)
- 3 No Assistive Technology needed

Comment:

**2. How much support does this person need to transfer? (e.g., from bed to chair, etc.) (Circle one)**

- 0 None
- 1 Assistive Technology/Modifications
- 2 Occasional personal support (On occasion when the person needs to transfer)
- 3 Extensive personal support (Every time the person needs to transfer)

**2. A. Does the person have Assistive Technology in place for transferring? (Circle one)**

- 0 Yes (Please specify)
- 1 No, but the person might benefit from Assistive Technology (Please specify)
- 2 Need for Assistive Technology is documented, but is not yet in place or is not used (Please specify)
- 3 No Assistive Technology needed

Comment:

**3. How much support does the person need with regard to vision? (Circle one)**

- 0 None
- 1 Corrective lenses or surgery
- 2 Requires large print and/or other modifications even with corrective lenses
- 3 Requires personal support to participate in activities requiring vision

Comment:



**4. How much support does the person need with regard to hearing? (Circle one)**

- 0 None
- 1 Hearing aid, cochlear implant or other similar device
- 2 Requires additional modifications in addition to hearing aid or similar device
- 3 Requires personal support to participate in activities requiring hearing

Comment:

**5. How much support does the person need to communicate effectively with a variety of people in a variety of settings? (Circle one)**

- 0 None
- 1 Requires extra time to communicate
- 2 Requires some assistance from familiar persons or technology to communicate
- 3 Requires familiar persons or technology to communicate at all times

**5. A. Does the person have Assistive Technology in place for communication? (Circle one)**

- 0 Yes (Please specify)
- 1 No, but the person might benefit from Assistive Technology (Please specify)
- 2 Need for Assistive Technology is documented, but is not yet in place or is not used (Please specify)
- 3 No Assistive Technology needed

Comment:

**6. How much support does the person need with regard to safety? (Circle one)**

- 0 None
- 1 Person needs occasional or situational support
- 2 Person needs extensive personal support

**6. A. Does the person have Assistive Technology in place for safety? (Circle one)**

- 0 Yes (Please specify)
- 1 No, but the person might benefit from Assistive Technology (Please specify)
- 2 Need for Assistive Technology is documented, but is not yet in place or is not used (Please specify)
- 3 No Assistive Technology needed

Comment:



**7. Does the person require treatments or monitoring specific to his/her health diagnoses? (e.g. administration of medication, testing blood sugar, administration of insulin, etc.) (Circle one)**

- 0 None needed
- 1 Person needs occasional treatments for their health conditions (less than daily)  
(Please specify treatment and purpose)
- 2 Person needs daily treatments for their health conditions (less than hourly)  
(Please specify treatment and purpose)
- 3 Person needs 24 hour treatments for their health conditions  
(Please specify treatment and purpose)

Comment:

**8. Is there a psychiatric diagnosis for this person? (Circle one)**

- 0 Yes
- 1 No

Comment:

**9. If the person takes psychotropic medications, does he/she receive any of the following supports? (Circle all that apply)**

- 0 Not Applicable; person does not receive psychotropic medication
- 1 Psychiatrist
- 2 Psychologist
- 3 Behavioral Support Professional
- 4 Behavior Support Plan
- 5 Takes psychotropic medication but no additional supports received

Comment:

