BrightPath

BrightPath Individual Service Needs - Competency Quiz

Staff Name MUSTAFA NAIM

Program Name OLIVER

Person Name ALI HASSAN

Directions: Review the person's CSSP-Addendum, IAPP, and Self-Management Assessment. **In your own words,** answer the questions below. Allow 30 minutes for this on your BrightPath timecard. Designated Coordinators will move into the "complete" folder.

To view the person's assessments: Once in Google Drive, go to: Shared Drive Client Files Choose the Person's Name Person-Centered Planning Click on specific assessment folder (CSSP-A, IAPP, SMA) Choose date/version of **most recent assessment**

COORDINATED SERVICE AND SUPPORT PLAN ADDENDUM (CSSPA)

Please list the person's desired outcomes (goals) and how staff can help the person accomplish them:

- portion control
- less elopments

Describe what is "Important To" this individual:

Religion, Quran, Family

Describe what is "Important For" this individual:

Tea and Food

Does this person have a restriction of their rights?	Yes	(No)
Does the person use prescribed psychotropic medications?	(Yes)	No
Does this person require the use of permitted actions or procedures? If yes, what are they?	(Yes)	No

INDIVIDUAL ABUSE PREVENTION PLAN (IAPP)

Please choose each area of abuse listed for this person below. (Check all boxes that apply):			
☒ Sexual Abuse	☒ Physical Abuse	☒ Self-Abuse	☒ Financial Exploitation

List specific measures to minimize risk of sexual abuse:

- Monitor behavior towards this abuse

List specific measures to minimize risk of physical abuse:

- check for bruises on occassion

List specific measures to minimize risk of self-abuse:

no self abuse
- client isn't at risk for this

List specific measures to minimize risk of financial exploitation:

Mandated Reporters have 24 hours to report any concerns of abuse to an outside agency?	True	False
Is the program aware of this individual committing a violent crime or act of physical aggression toward others?	Yes	No

SELF-MANAGEMENT ASSESSMENT (SMA)

Please choose each area that the individual is ***not able*** to self-manage his/her/their care (check all boxes that apply):

☒ Allergies	☐ Seizures	☒ Choking	☐ Special Dietary Needs
☐ Chronic Medical Conditions	☒ Self-Administration of Medication or Treatment Orders	☐ Preventative Screening	☒ Medical and Dental Appointments
☐ Sensory Disabilities	☐ Risk of Falling	☐ Mobility	☐ Regulating Water Temperature
☒ Community Survival Skills	☐ Water Safety Skills	☒ Ability to self-manage symptoms or behavior that may otherwise result in an incident.	

By signing here, I'm acknowledging the training above was provided to me:

Name	Title	Signature	Date

	CRS - Staff Member		
SAMSON MBAULU	Supervisor		