



**COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM –  
INTENSIVE SUPPORT SERVICES**

Name of person served: Lorinda (Lori) Boer

Date of development: 11/19/21

For the annual period from: November 2021 to November 2022

Name and title of person completing the *CSSP Addendum*: Leah Ference, Designated Coordinator

Legal representative: Pete and Bev Boer

Case manager: Sarah Maurice/Southwest Health and Human Services

The license holder must provide services in response to the person's identified needs, interests, preferences, and desired outcomes. Services will be provided according to MN Statutes, chapter 245D and the applicable waiver plan for the person served. The following information will be assessed and determined by the person served and/or legal representative and case manager and other members of the support team.

Dates of development:

- Within 15 days of service initiation, the license holder must complete the preliminary *CSSP Addendum*.
- Before providing 45 days of service or within 60 calendar days of service initiation.
- Annually, the support team reviews the *CSSP Addendum*.
- 

**Services and supports**

The scope of the services to be provided to support the person's daily needs and activities include:

Hope Haven provides residential services, including activities of daily living, community activities, assistance with learning appropriate behavior management skills

The person's **desired outcomes** and the methods or actions that will be used to support the person and to accomplish the service outcomes (*Service Outcomes and Supports*):

Outcome: *TBD by Team Discussion. Lori has in the past set health-related goals reflecting her current medical needs.*

A discussion of how **technology** may be used to meet the person's desired outcomes has occurred:  Yes  No

Provide a summary that describes decisions made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made: Lori has her cell phone when she his home alone or out in the community. The team does not wish to further pursue other uses of technology at this time.

Describe the **general and health-related supports** necessary to support this person based upon the *Self-Management Assessment* and the requirements of person centered planning and service delivery:

**Seizures (state specific seizure types):** controlled, staring spells: Staff will document any seizure activity. Staff will provide this information as needed for medical appointments.



**Chronic medical conditions (state condition):** Tuberos sclerosis with lymphangioleiomyomatosis (LAM): Staff will follow-through with any physician's orders for this condition.

**Self-administration of medication or treatment orders:** Staff are will observe Lori as she sets-up her daily med planner for accuracy. Staff will administer new or comfort (PRN) medications as needed.

**Preventative screening:** Staff will follow-through with any physician's orders.

**Medical and dental appointments:** Staff take Lori to appointments as requested and will follow-through with any physician's orders. Hope Haven staff will seek medical care for Lori in an emergency according to the Authorization to Act in an emergency until her family can be reached.

**Community survival skills:** Staff will be with Lori in community locations outside of Edgerton.

**Sensory disabilities:** Lori's parents take her to her vision exams. No action is required by staff in this area.

**Mental or emotional health symptoms and crises (state diagnosis):** depression/anxiety: Staff listen to Lori's concerns and provide reassurance when she is anxious.

The person's **preferences** for how services and supports are provided including positive support strategies and how the provider will support the person to **have control of their schedule:**

Lori likes being "in charge" of her life. She likes her room as a place to get away and enjoy her music, and really prefers keeping it "how she likes it." She also likes to be able to do word searches and puzzles. Lori shared that she likes to "get in trouble" (in other words, not always doing what is expected of her by her parents or staff.)

**Positive support strategies include:**

- Staff will listen to Lori's concerns. Staff will offer support and help talk through problems.
- Lori has a private space in her room for activities she enjoys: puzzles, reading, music, computer, etc.
- Staff encourage Lori's social relationships and natural supports, which are many: family, housemates, co-workers, community members and church friends.
- Staff will support Lori to be physically active, such as walking or bike riding.

Is the current service setting the **most integrated setting available and appropriate** for the person?

Yes  No If no, please describe what will be done to address this: Lori could live in a smaller setting with more independence. She has talked about this in the past, but says that she does not want to at this time because of her medical issues.



What are the opportunities to develop and maintain **essential and life-enriching skills, abilities, strengths, interests, and preferences**? Lori has excellent verbal and reading skills. She uses her computer independently. Staff encourage Lori to express her preferences. Lori has unsupervised time at home and in the community to pursue her individual interests.

What are the opportunities for **community access, participation, and inclusion** in preferred community activities? Lori expresses her interests in preferred activities, which typically include community events such as church dinners and school sporting events. Lori also enjoys going out to eat, shopping and movies. She does these either with family, community friends or staff.

What are the opportunities to **develop and strengthen personal relationships** with other persons of the person's choice in the community? Lori has a close relationship with her parents and extended family. She attends church and knows many people in the Edgerton community. Lori enjoys activities with her housemates, as well as a special friend. Lori uses her phone and social media regularly to stay connected.

What are the opportunities to seek **competitive employment** and work at competitively paying jobs in the community? Lori receives work services through Progress, Inc. She has worked a variety of jobs and completes an annual Workforce Innovation and Opportunity Act (WIOA) review. Lori expresses that she would consider the right job if it came along, but that she likes her current situation.

How will services be **coordinated across other 245D licensed providers and members of the support team or expanded support team** serving this person to ensure continuity of care and coordination of services?

Lori will have semi-annual support team meetings, with additional meetings, as needed. Hope Haven and Progress, Inc. have a communication log book going back and forth between them. The Designated Coordinators for each provider discuss issues by phone.

If there is a **need for service coordination** between providers, include the name of service provider, contact person and telephone numbers, services being provided, and the names of staff responsible for coordination:

**Vocational Provider:**

Progress, Inc. / Brook Albright  
101 4<sup>th</sup> Ave. NE  
Pipestone, MN 56164  
507-825-4120 (phone)  
507-825-2369 (fax)

**Case Manager:**

Southwest Health and Human Services / Sarah Maurice  
1091 Hiawatha Ave. N.  
Pipestone, MN 56164  
507-825-6720 (phone)  
507-825-6727 (fax)  
sarah.maurice@swmhhs.com



The person currently receives services in (check as applicable):

- Residential services in a community setting controlled by a provider
- Day services
- Neither

Provide a summary of the discussion of options for transitioning the person out of a community setting controlled by a provider and into a setting not controlled by a provider (residential services): Lori and her family understand they have other options, but are satisfied with Lori's current services.

Provide a summary of the discussion of options for transitioning from day services to an employment service: Lori and her family understand they have other options, but are satisfied with Lori's current services.

Describe any further research or education that must be completed before a decision regarding this transition can be made: NA – Lori and her family understand they can talk to the case manager about changes at any time.

Does the person require the presence of staff at the service site while services are being provided?  Yes  No

If no, please provide information on when staff do not need to be present with this person (include community, home, or work) and for the length of time. If additional information regarding safety plan is needed, also provide:

Lori may be unsupervised at home for 4 hours. Lori may be alone in the community for one hour. Lori will let staff know her plans before leaving.

Does the person require a restriction of their rights as determined necessary to ensure the health, safety, and well-being of the person?  Yes  No

If yes, indicate what right(s) are restricted: Not applicable

If rights are being restricted the Rights Restrictions form must be completed.

Can this person use dangerous items or equipment?  Yes  No

If yes, address any concerns or limitations: Lori may access all household appliances and cleaners without limitations.

Has it been determined by the person's physician or mental health provider to be medically or psychologically contraindicated to use an emergency use of manual restraint when a person's conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety?  Yes  No

If yes, the company will not allow the use of the behavioral intervention/manual restraint to be used for the person.



**Health needs**

Indicate what **health service responsibilities** are assigned to this license holder and which are consistent with the person's health needs. If health service responsibilities are not assigned to this license holder, please state "NA":

Hope Haven staff are trained in medication administration and will assist Lori as needed. Hope Haven staff will administer PRN medications that have been approved by her physician. Lori's parents schedule and take her to medical and dental appointments. Hope Haven staff will report any changes or observations to Lori's parents. Hope Haven will complete any treatments according to doctor's orders.

If health service responsibilities are assigned to this license holder, the case manager and legal representative will be promptly notified of any changes in the person's physical and mental health needs affecting the health service needs, unless otherwise specified here:

The following information will be reported to the legal representative and case manager as they occur, unless otherwise indicated here:

- Any report made according to 245D.05, subdivision 2, paragraph (c), clause (4)
- The person's refusal or failure to take or receive medication or treatment as prescribed.
- Concerns about the person's self-administration of medication or treatments.

If the license holder is assigned responsibility for medication assistance or medication administration, the license holder will provide medication administration or assistance (including set up) according to the level indicated here:

Medication set up     Medication assistance     Medication administration

Lori sets up and self-administers her daily medications. Staff will observe each set-up and assist Lori if she has issues or problems at any times with medications. Staff will administer medications for pain or discomfort (PRNs).

**Psychotropic medication monitoring and use**

Does the license holder administer the person's psychotropic medication?     Yes     No

If yes, document the following information:

1. Describe the target symptoms the psychotropic medication is to alleviate:  
Lori is prescribed Zoloft by Dr. Judy Chesley for mild depression and anxiety. Symptoms noted in the past are isolating (in her room) and panic attacks.
2. Does the prescriber require documentation to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medications?  
 Yes     No

If yes, please indicate the documentation methods to be used to collect and report on medication and symptom-related data according to the prescriber's instructions:

Dr. Chesley does not require daily tracking of symptoms for this medication. Lori's parents see her on a regular basis and take her to doctor's appointments. They will report any concerns to Dr. Chesley.

**Permitted actions and procedures**



On a continuous basis, does the person require the use of permitted actions and procedures that includes physical contact or instructional techniques:

1. To calm or comfort a person by holding that person with no resistance from the person.  
 Yes  No If yes, explain how it will be used: Staff may use touch to comfort Lori, such as holding her hand or a brief shoulder hug.
2. To protect a person known to be at risk of injury due to frequent falls as a result of a medical condition.  
 Yes  No If yes, explain how it will be used:
3. To facilitate a person's completion of a task or response when the person does not resist or it is minimal:  
 Yes  No If yes, explain how it will be used:
4. To block or redirect a person's limbs or body without holding or limiting their movement to interrupt a behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.  
 Yes  No If yes, explain how it will be used:
5. To redirect a person's behavior when the behavior does not pose a serious threat to self or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.  
 Yes  No If yes, explain how it will be used:
6. To allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment.  
 Yes  No If yes, explain how it will be used:
7. Assist in the safe evacuation or redirection of a person in an emergency and they are at imminent risk of harm.  
 Yes  No If yes, explain how it will be used:
8. Is a restraint needed as an intervention procedure to position this person due to physical disabilities?  
 Yes  No If yes, explain how it will be used:
9. Is positive verbal correction specifically focused on the behavior being addressed?  
 Yes  No If yes, explain how it will be used:
10. Is temporary withholding or removal of objects being used to hurt self or others being addressed?  
 Yes  No If yes, explain how it will be used:
11. Are adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition being used?  
 Yes  No If yes, explain how it will be used:

#### Staff information

Are any additional requirements requested for staff to have or obtain in order to meet the needs of the person?  
 Yes  No

If yes, please specify what these requirements are: Not applicable

Does a staff person who is trained in cardiopulmonary resuscitation (CPR) need to be available when this person is present and staff are required to be at the site to provide direct service?  Yes  No

Staff ratio: For facility-based day services only  
 NA for residential services



*For facility-based day services only* – please indicate the staff ratio required for this person. Additional information on how this ratio was determined is maintained in the person’s service recipient record:

- 1:4     1:8     1:6     Other (please specify):

**Frequency of reports and notifications**

1. Frequency of *Progress Reports and Recommendations*, at a minimum of annually:  
 Quarterly     Semi-annually     Annually
2. Frequency of service plan review meetings, at a minimum of annually:  
 Quarterly     Semi-annually     Annually
3. Request to receive the *Progress Report and Recommendation*:  
 At the support team meeting; or  At least five working days in advance of the support team meeting.
4. Frequency of receipt of *Psychotropic Medication Monitoring Data Reports*, this will be done quarterly unless otherwise requested:  
 Quarterly     Other (specify):     NA

### SELF-MANAGEMENT ASSESSMENT

Name: Lorinda (Lori) Boer

Date of *Self-Management Assessment* development: 11/19/21

For the annual period from: Nov. 2021-Nov. 2022

Name and title of person completing the review: Leah Ference, Designated Coordinator

Within the scope of services to this person, the license holder must assess, at a minimum, the areas included on this document. Additional information on self-management may be included per request of the person served and/or legal representative and case manager. The *Self-Management Assessment* will be completed by the company's designated staff person and will be done in consultation with the person and members of the support team.

The license holder will complete this assessment before the 45-day planning meeting and review it at the meeting. Within 20 working days of the 45-day meeting, dated signatures will be obtained from the person and/or legal representative and case manager to document the completion and approval of the *Self-Management Assessment*. At a minimum of annually, or within 30 days of a written request from the person and/or legal representative or case manager. This *Self-Management Assessment* will be reviewed by the support team or expanded support team as part of a service plan review and dated signatures obtained.

Assessments must be based on the person's status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified.

The general and health-specific supports and outcomes necessary or desired to support the person based upon this assessment and the requirements of person centered planning and service delivery will be documented in the *CSSP Addendum*.

#### Health and medical needs to maintain or improve physical, mental, and emotional well-being

Assessment area	Is the person able to self-manage in this area?	Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms
Allergies (state specific allergies): adhesive tape and talc	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA – there are no allergies	<i>Lori is aware of this and could report it to medical professionals.</i>
Seizures (state specific seizure types): controlled, staring spells (last seizure: 2010)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA – no seizures	SYMPTOMS: Lori has had seizures in the past that involved staring. STRENGTHS: Lori is aware of her diagnosis and cooperative with her treatment. SKILLS: Lori takes daily seizure medication. Lori reports seizures to staff. Lori's parents take her to medical appointments/labs to monitor this condition.
Choking	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<i>Lori chews and swallows without difficulty.</i>
Special dietary needs (state specific need): angiomyolipoma (kidney tumors)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA – there are no special dietary needs	<i>Lori has made some changes in her diet to improve her kidney health.</i>
Chronic medical conditions (state condition): Tuberous sclerosis with	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA – there are no chronic medical conditions	SYMPTOMS: Lori has a complex disorder that results in tumors and related complications. STRENGTHS: Lori has some understanding of her

lymphangioliomyomatosis (LAM)		diagnosis and participates in her care. SKILLS: Lori is able to take her medications, as well as any oxygen therapy ordered.
Self-administration of medication or treatment orders	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	BEHAVIORS: Lori would need assistance with medication changes, as well as short-term or comfort medications. STRENGTHS: Lori has a good general understanding of her routine medications and schedule. SKILLS: Lori prepares a weekly pill caddy that she keeps locked in her room.
Preventative screening	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	BEHAVIORS: Lori does not schedule or attend appointments on her own. STRENGTHS: Lori understands the need for routine medical care. She attends most appointments with her family, or occasionally staff (dental). SKILLS: Lori is an active participant in her medical care.
Medical and dental appointments	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	BEHAVIORS: Lori does not schedule or attend appointments on her own. STRENGTHS: Lori understands the need for routine medical care. She attends most appointments with her family, or occasionally staff (dental). SKILLS: Lori is an active participant in her medical care.
Other health and medical needs (state specific need):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Other health and medical needs (state specific need):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	

**Personal safety to avoid injury or accident in the service setting**

Assessment area	Is the person able to self-manage in this area?	Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms
Risk of falling (include the specific risk):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA – not at risk for falling	
Mobility issues (include the specific issue):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA – there are no mobility issues	
Regulating water temperature	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<i>Lori is able to check and adjust the water temperature for washing or bathing.</i>
Community survival skills	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	BEHAVIOR: While Lori does access her home community independently, Lori would need transportation and staff present in a larger community (for example, shopping trip out-of-town.) STRENGTHS: Lori is familiar with and comfortable in her community of Edgerton. She often rides her

		bicycle during good weather. SKILLS: Lori knows many people and has the communication skills to ask for assistance. Lori has and uses a cell phone.
Water safety skills	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<i>Lori has adequate skills to safely access a pool for exercise.</i>
Sensory disabilities	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	SYMPTOM: Lori has glasses to correct her vision. STRENGTHS: She independently puts them on when she feels she needs them (before going to work), but does not wear them at home. SKILLS: Lori attends vision exams scheduled and taken by her parents.
Other personal safety needs (state specific need):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Other personal safety needs (state specific need):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Other personal safety needs (state specific need):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
<b>Symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subd. 11 clauses (4) to (7) or suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others.</b>		
<b>Assessment area</b>	<b>Is the person able to self-manage in this area?</b>	<b>Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms</b>
Self-injurious behaviors (state behavior):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Physical aggression/conduct (state behavior):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Verbal/emotional aggression (state behavior):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Property destruction (state behavior):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Suicidal ideations, thoughts, or attempts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Criminal or unlawful behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Mental or emotional health symptoms and crises (state diagnosis): depression/ anxiety	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> NA	SYMPTOMS: Lori has had some mild depression/anxiety. STRENGTHS: Lori takes an anti-depressant medication as prescribed by her physician. SKILLS: Lori talks to staff or family members when she is feeling anxious. Lori often prefers to be alone in her bedroom to relax.



# HOPE HAVEN

Unauthorized or unexplained absence from a program	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
An act or situation involving a person that requires the program to call 911, law enforcement or fire department	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	
Other symptom or behavior (be specific):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> NA	



**Individual Abuse Prevention Plan (IAPP)**

Person's Name: Lorinda (Lori) Boer

Date of Review: November 2021

**Instructions:** For each area, assess whether the person is susceptible to abuse by others and the person's risk of abusing other vulnerable people. If susceptible, indicate why by checking the appropriate reason or by adding a reason. Identify specific measures to be taken to minimize the risk within the scope of licensed services and identify referrals needed when the person is susceptible outside the scope or control of the licensed services. If the person does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, document this determination and identify the area of the program prevention plan that addresses the area of susceptibility.

**A. Sexual Abuse**

Is the person susceptible to abuse in this area?       Yes (if any area below is checked)       No

	<i>Specific measures to minimize risk of abuse for each area checked:</i>
<input type="checkbox"/> Lack of understanding of sexuality	
<input type="checkbox"/> Likely to seek or cooperate in an abusive situation	
<input type="checkbox"/> Inability to be assertive	
<input type="checkbox"/> Other:	

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred). Not applicable

**B. Physical Abuse**

Is the person susceptible to abuse in this area?       Yes (if any area below is checked)       No

	<i>Specific measures to minimize risk of abuse for each area checked:</i>
<input type="checkbox"/> Inability to identify potentially dangerous situations	
<input type="checkbox"/> Lack of community orientation skills	
<input type="checkbox"/> Inappropriate interactions with others	
<input checked="" type="checkbox"/> Inability to deal with verbally/physically aggressive persons	Staff will place themselves between Lori and an aggressive person. Staff will verbally prompt Lori to move to a safe area.
<input type="checkbox"/> Verbally/physically abusive to others	



<input type="checkbox"/> "Victim" history exists	
<input type="checkbox"/> Other:	

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred). Not applicable

**C. Self Abuse**

Is the person susceptible to abuse in this area?  Yes (if any area below is checked)  No

	<i>Specific measures to minimize risk of abuse for each area checked:</i>
<input type="checkbox"/> Dresses inappropriately	
<input type="checkbox"/> Refuses to eat	
<input type="checkbox"/> Inability to care for self-help needs	
<input type="checkbox"/> Lack of self-preservation skills (ignores personal safety)	
<input type="checkbox"/> Engages in self-injurious behaviors	
<input type="checkbox"/> Neglects or refuses to take medications	
<input type="checkbox"/> Other:	

Referrals made when the person is susceptible to abuse outside the scope or control of this program. (Identify the referral and the date it occurred). Not applicable

**D. Financial Exploitation**

Is the person susceptible in this area?  Yes (if any area below is checked)  No

	<i>Specific measures to minimize risk of abuse for each area checked:</i>
<input checked="" type="checkbox"/> Inability to handle financial matters	Lori can make small purchases, but needs assistance from her parents for more complex financial matters. Hope Haven staff maintain a petty cash account for Lori per her Financial Authorization.
<input type="checkbox"/> Other:	

Referrals made when the person is susceptible to abuse outside the scope or control of this program



(Identify the referral and the date it occurred).

Lori's parents, Pete and Bev Boer, were appointed as her Conservators/Guardians in 1992.

- E. Is the program aware of this person committing a violent crime or act of physical aggression toward others?**     Yes     No

Specific measures to be taken to minimize the risk this person might reasonably be expected to pose to visitors to the program and persons outside the program, if unsupervised: Not applicable

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred). Not applicable

**SINGLE DATED SIGNATURE PAGE**

Name: Lorinda Boer

Date: 11/19/21

Today's support team meeting was a/an:

<input type="checkbox"/> Intake meeting	<input type="checkbox"/> 30-day meeting (for ICFs/DD)	<input type="checkbox"/> 45-day service or 60-day calendar meeting (for 245D Intensive support)
<input type="checkbox"/> 60-day meeting (for 245D Basic support)	<input type="checkbox"/> Quarterly progress report review meeting	<input type="checkbox"/> Semi-annual progress report review meeting
<input checked="" type="checkbox"/> Annual meeting	<input type="checkbox"/> Special support team meeting	<input type="checkbox"/> Other:

Today, as support team members, we reviewed the following documents:

<input checked="" type="checkbox"/> Self-Management Assessment (SMA)	<input checked="" type="checkbox"/> Individual Abuse Prevention Plan (IAPP)	<input checked="" type="checkbox"/> CSSP Addendum
<input checked="" type="checkbox"/> Service Outcomes and Behavior Outcome (if applicable)	<input checked="" type="checkbox"/> Progress Report with Recommendations	<input checked="" type="checkbox"/> Meeting Minutes with Attendance Notes
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

**Acknowledgement:**

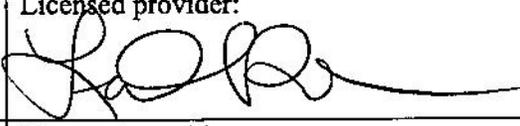
By having my dated signature on this form, I am indicating that I have reviewed and approved the documents listed above that have a checkmark in the box. With my dated signature, I am also acknowledging and agreeing to the changes that are contained within these documents with my approval for implementation.

**Please note:**

Per MN Statutes, section 245D.071, subdivision 4, (c), within 20 working days of the 45-day planning meeting (and within 10 working days of the service plan review meeting), the assessment and the addendum must be submitted to and dated signatures obtained dated by the person served and/or legal representative and case manager to document completion and approval.

Per MN Statutes, section 245D.071, subdivision 4, (c); and subdivision 5, (c); if within 10 working days of this submission, the person served and/or legal representative or case manager has not signed and returned to the license holder the assessment and *Coordinated Service and Support Plan Addendum* or has not proposed written modification to its submission, the submission is deemed approved and in effect. It will remain in effect until the next annual month or until the person served and/or legal representative or case manager submits a written request to revise them.

**SIGNATURE PAGE**

<b>PRINTED NAME</b>	<b>SIGNATURES</b>	<b>DATE</b>
Person served:	Person served:	Date:
Legal representative:	Legal representative:	Date:
Case manager: Sarah Maurice	Case manager: <i>Sarah Maurice</i>	Date: 11/19/2021
Licensed provider: <i>Leah Ference</i>	Licensed provider: 	Date: 11-19-21
Licensed provider:	Licensed provider:	Date:
Other support team member:	Other support team member:	Date:
Other support team member:	Other support team member:	Date:

## SINGLE DATED SIGNATURE PAGE

Name: Lorinda Boer

Date: 11/19/21

Today's support team meeting was a/an:

<input type="checkbox"/> Intake meeting	<input type="checkbox"/> 30-day meeting (for ICFs/DD)	<input type="checkbox"/> 45-day service or 60-day calendar meeting (for 245D Intensive support)
<input type="checkbox"/> 60-day meeting (for 245D Basic support)	<input type="checkbox"/> Quarterly progress report review meeting	<input type="checkbox"/> Semi-annual progress report review meeting
<input checked="" type="checkbox"/> Annual meeting	<input type="checkbox"/> Special support team meeting	<input type="checkbox"/> Other:

Today, as support team members, we reviewed the following documents:

<input checked="" type="checkbox"/> Self-Management Assessment (SMA)	<input checked="" type="checkbox"/> Individual Abuse Prevention Plan (IAPP)	<input checked="" type="checkbox"/> CSSP Addendum
<input checked="" type="checkbox"/> Service Outcomes and Behavior Outcome (if applicable)	<input checked="" type="checkbox"/> Progress Report with Recommendations	<input checked="" type="checkbox"/> Meeting Minutes with Attendance Notes
<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

**Acknowledgement:**

By having my dated signature on this form, I am indicating that I have reviewed and approved the documents listed above that have a checkmark in the box. With my dated signature, I am also acknowledging and agreeing to the changes that are contained within these documents with my approval for implementation.

**Please note:**

Per MN Statutes, section 245D.071, subdivision 4, (c), within 20 working days of the 45-day planning meeting (and within 10 working days of the service plan review meeting), the assessment and the addendum must be submitted to and dated signatures obtained dated by the person served and/or legal representative and case manager to document completion and approval.

Per MN Statutes, section 245D.071, subdivision 4, (c); and subdivision 5, (c); if within 10 working days of this submission, the person served and/or legal representative or case manager has not signed and returned to the license holder the assessment and *Coordinated Service and Support Plan Addendum* or has not proposed written modification to its submission, the submission is deemed approved and in effect. It will remain in effect until the next annual month or until the person served and/or legal representative or case manager submits a written request to revise them.