

Staff: Cynthia Bray
Date: 2.24.20



Service Recipient: D. Sherritt

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)
Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 Independently request to visit a friend by pointing to picture.		Outcome #2 Twice daily use communication sheet to make wants/needs known.	
Technology Use:			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>contrast dye, ketchup, shrimp, Seroquel, seasonal</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Myo chronic</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bite size pieces. Staff will sit with Du Du when eating. Gluten free and Diabetic Diet.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Anxiety, Autism, Diabetes type 1, MR, OCD, PDD</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Rgt tested daily prior to lunch.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tested daily for Diabetes / insulin given.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Unstable balance. Hard time stepping up/down on curbs.</u> <input type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff Support.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Hypo sensitive to sound + touch.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Re-direct from picking at fingers. Give her a task to re-direct. Staff should remain calm when Debbie is throwing items. once she calms down ask her to pick up & clean up everything she has thrown.</u>	
Important To: <u>Be with friends & go for walks.</u>	Important For: <u>Staff to check her Rgt daily.</u>
Likes: <u>Friends to visit, telling jokes, back rubs, library + Target.</u>	Dislikes: <u>Work for a long period of time. Waiting for long period of time.</u>
Describe Communication Style: <u>Points to symbols + signs. Answer yes or no questions.</u>	

Staff: _____



Service Recipient: M. Tead

Date: _____

Where People with Disabilities Connect with the Community and the World

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Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Play a game with a peer.</u>		Outcome #2 <u>Self regulate when over excited - deep breathing.</u>	
Technology Use: <u>Ipad</u>			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasick</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Tonic Clonic</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will cut his food and prompt him to slow down.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Developmental Delay Seizures Eczema</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will give Mat his medications.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Autism</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Staff will walk with Mat and guide him to slow down.</u> <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff Support</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Balance, may use ear buds to deafen sounds.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Soft voice, verbal prompts to stop picking at fingers, and quiet down when loud.</u>	
Important To: <u>Friends and music</u>	Important For: <u>to have his feet and ear buds on the bus. Staff to guide and walk with him.</u>
Likes: <u>Walking, frogs, music, I-pad watching trains/planes.</u>	Dislikes: <u>Loud noises, participate in sports.</u>
Describe Communication Style: <u>Verbal sounds, facial expressions.</u>	

Staff: Anthony Bry
 Date: 2.24.20



Service Recipient: M. Fontaine

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input type="checkbox"/> Lack of self-preservation/safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Join a group activity for 5mins w/ 3 verbal prompts.</u>		Outcome #2 <u>Accept re-direction from staff using a timer when in the restroom.</u>	
Technology Use: <u>Ipad, Computer</u>			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal, Penicillin sulfai cefzil spectra, Augmentin.</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>may take big bites. Staff will use verbal cues to slow down, take small bites.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Autism, Down Syndrome, Intellectual Developmental Disability.</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Does not take medication at PAI.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Verbal cues to watch for steps + curbs. Staff will tie shoes before he walks.</u> <input type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff will support Matt when in Community.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>slow sensory processing, misaligned optic nerve.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Staff will give matt time to transition from one activity to the next. He does not like change in his routine.</u>	
Important To: <u>Game shows, Routine Clapping, iPad.</u>	Important For: <u>Matt to have time to process transitions.</u>
Likes: <u>IPad, Computer, play games singing.</u>	Dislikes: <u>Stop what I am doing w/out warning. Being rushed. Loud noises, Dr. office.</u>
Describe Communication Style: <u>Clapping of hands. Some Verbal sounds. Facial expressions.</u>	

Staff: _____



Service Recipient: B. Gray

Date: _____

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Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Independently choose community activity.</u>		Outcome #2 <u>Participate in group activity w/ verbal prompts.</u>	
Technology Use:			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa medications, sensitive to milk products</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Partial, General Tonic clonic. Will call 911 if difficult to breathe or unconsciousness.</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>PICA, Verbal prompts to leave items there or spit items out of mouth, Autism, UR.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff support for med.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Staff support to recognize + treat ulcers/injury.</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff support in community + water temp.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Risk of heat exhaustion if temps are above 90° likes to pick at his nails, likes to smell others. Anxiety</u>	
Important To: <u>Sensory items, lotion, play doh, sand.</u>	Important For: <u>Staff support for medications, PICA.</u>
Likes: <u>Puzzles, walks, music, sensory activities.</u>	Dislikes: <u>Waiting for bathroom, Wearing things around his neck.</u>
Describe Communication Style: <u>Verbal communication, and some ASL.</u>	

Staff: _____



Service Recipient: A. Flynn

Date: _____

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: Report if he was abused.	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 Shared paper H a week.		Outcome #2 Use goos motor; Cardio everyday.	
Technology Use: Has a communication device used at home.			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: Gluten Free. Staff will monitor for gluten free items.	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: Celiac	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: NO medication given at PAI.	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes Staff will support Andrew when in community.	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: Spending time w/ family, being active, sticking to a schedule.	Important For: Follow a routine. Provide prompts when I need them.
Likes: Pet therapy, Being active, Snacks.	Dislikes:
Describe Communication Style: Can know some ASL. Facial expressions.	

Staff: Cynthia Bray
 Date: 2-24-20



Service Recipient: R. Favre

Where People with Disabilities Connect with the Community and the World

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Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 Will exchange equal amount of food w/ staff at end of day & verbal prompt.		Outcome #2 will use various communication to participate in group activities w/ 2 verbal cues.	
Technology Use: iPad, cell phone.			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>N/A</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>Does not eat solid food. Staff will watch Ryan & give verbal cues to slow down drinking.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Hypothyroidism, dysrhythmic disorder, GERD</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>medication is not taken at PAI. Staff will monitor for signs of pain & discomfort.</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes . <u>Ryan needs supports when in community.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>may become overstimulated if environment is too loud or visual/tactile stimulation.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Ryan may need support when upset. He may push/pinch others. Staff will redirect Ryan. may bang head when upset.</u>	
Important To: <u>Watching youtube on phone, tries to trade.</u>	Important For: <u>Ryan to have transition objects clearly as to be patient - time to process,</u>
Likes: <u>Disney songs, Youtube, puzzles, iPad</u>	Dislikes: <u>Large groups, Being rushed</u>
Describe Communication Style:	

Staff: _____



Service Recipient: R. Shaffer-Frazier

Date: _____

Where People with Disabilities Connect with the Community and the World

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<input type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 Unbutton her pants w/ 2 hand over hand prompts.		Outcome #2 Pull out chair from table before sitting down w/ unlimited verbal cues.	
Technology Use:			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Seasonal</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>Bite size pieces. Verbal cues to slow down & take smaller offer one item at a time.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Autism MR - Severe Vision</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>Staff will give Britney her medication w/ applesauce & pudding.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Verbal cues to be cautious when walking.</u> <input type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff support.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Over stimulated in loud or busy environments.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Staff will re-direct or offer a few choices to Britney when overstimulated.</u>	
Important To: <u>Nails painted, social interaction Friends, Lip gloss after lunch</u>	Important For: <u>Be with staff in community.</u>
Likes: <u>Dance, music, Nails painted outside walks</u>	Dislikes: <u>Being told "No", watching t.v.</u>
Describe Communication Style: <u>Sign language or gesture.</u>	

Staff: Gentia Brey
 Date: 2.24.20



Service Recipient: L. Rawn

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)
 Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 Independently answer a novel question w/verbal prompts.		Outcome #2 Once a week, Liz will use the exercise bike.	
Technology Use: Keyboard/piano, tape player			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Alphagen eye drops.</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Regular diet, give healthy choices. Food chopped for Liz.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Autism, Blind, MR, PTSD</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>No meds at PAI.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Uses a cane. Staff will offer a hand to help guide Liz around curbs etc.</u> <input type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" type="checkbox"/> Walker / Cane <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Staff will try to assess Liz's environment to see what is upsetting her. Staff will talk to Liz in a soft voice and ask Liz to do the same.</u>	
Important To: <u>Keyboards music, friends.</u>	Important For: <u>Verbal cues for change in routine or what is "next!"</u>
Likes: <u>Piano, shredding, listen to music.</u>	Dislikes: <u>Loud or crowded events, waiting too long</u>
Describe Communication Style: <u>Kerbal - 2 word utterance but can use 5 to 6 words with encouragement.</u>	

Staff: Guthrie Bray



Service Recipient: H. Gustafson

Date: 2.24.20

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Hope will engage w/ groups daily w/ 2 verbal prompts.</u>		Outcome #2 <u>will carry a walking pass when leaving program room.</u>	
Technology Use: <u>IPad, computer</u>			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Towel on lap to wipe hands. staff will monitor food temp. and verbal cues to slow down.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Autism Anxiety</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>No meds at PAI.</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Hold someone's hand when walking for safety + balance as she can get distracted and trip.</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff will be with Hope in community.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Loud noise - may run away or "collapse"</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Verbally, visual cues, Redirect or offer Hope a "break" to calm self.</u>	
Important To: <u>Friends + family. Music,</u>	Important For: <u>Verbal cues for transitions. Staff will look for cues of frustration for a break to calm self.</u>
Likes: <u>Animals, small card games, watching people, music. Walks.</u>	Dislikes: <u>Loud or spontaneous noises, balloons, riding city bus. Restaurants.</u>
Describe Communication Style: <u>Some ASL facial expressions.</u>	

Staff: _____



Service Recipient: N. Haak

Date: _____

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 Respond to Staff prompts in group setting. Increase		Outcome #2 Independently stand up without staff assistance from bean bag.	
Technology Use: activity level.		Increase communication skills.	

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cats</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Food cut into 1" pieces and verbal cues to eat one piece at a time.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>SIB, Severe IBS, Autism</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will assist Nick with meds.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Hold staffs arm when walking to bus. Verbal cues to walk slowly.</u> <input type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff supports.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>May grab hot food. Put items in mouth ie: keys, liquids.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>SIB - Staff will cue Nick to stop. Staff will verbally encourage Nick to participate w/ activities.</u>	
Important To: <u>Projects, Social interaction</u>	Important For: <u>Staff to be with Nick as he may elope from room/building.</u>
Likes: <u>Bean Bag Chair, Country music.</u>	Dislikes:
Describe Communication Style: <u>Facial expression, grabber w/ staff.</u>	

Staff: Cynthia Bray



Service Recipient: Z. Westrum

Date: 2-24-20

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: <u>Biting hand</u>	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Take a break.</u>		Outcome #2 <u>Use an iPad.</u>	
Technology Use: <u>IPad.</u>			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Staff will administer medications.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Autism, T1c, Intellectual Disability</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff Support.</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Ask Zach if we would like to go to his breakroom when loud.</u>	
Important To: <u>Alone time, choices, laughter</u>	Important For: <u>Positive praise, Alone time when needed</u>
Likes: <u>Choices, movie time routine</u>	Dislikes: <u>Loud noises, being rushed, abrupt change in schedule.</u>
Describe Communication Style: <u>Verbal</u>	

Staff: _____



Service Recipient: _____

Date: _____

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

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Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<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/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1		Outcome #2	
Technology Use:			

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	