

Staff: Ann



Service Recipient: DH <sup>Worth</sup> ~~Worth~~

Date: 1/21

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 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 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		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 checked="" type="checkbox"/> Yes - List: <u>mold</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe :	Seizure PRN <input checked="" 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>C.P. Legally Blind Sun Sensitive</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>none 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>walker: legally blind</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 checked="" 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>prompt about obs</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>glass legally blind</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>get frustrated let it Build</u>	
Important To: <u>indep. choices family music</u>	Important For: <u>walk physical support</u>
Likes: <u>tablets family working</u>	Dislikes: <u>NA</u>
Describe Communication Style: <u>verbal</u>	

Staff: Destiny



Service Recipient: Deb Haworth

Date: 11/21/21

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 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 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>N/A</u>		Outcome #2 <u>N/A</u>	
Technology Use: <u>N/A</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>MOLD</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Partial seizures</u>	Seizure PRN <input checked="" 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>Cerebral Palsy, legally blind, sensitive to sun</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>NOT 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>walker</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 checked="" 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>CANT SWIM, CANT WALK ALONE</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>legally blind, glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>ONE ON ONE TIME IF FRUSTRATED AND NEEDS TO TALK</u>	
Important To: <u>INDEPENDENT, MUSIC, MAKING CHOICES</u>	Important For: <u>walker, physical supports</u>
Likes: <u>work, tablet, Ant, community</u>	Dislikes: <u>N/A</u>
Describe Communication Style: <u>verbal</u>	

Staff: Jill Champagne



Service Recipient: Deb Howard  
HAWORTH

Date: 1-21-21

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 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 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:
<b>Outcome #1</b>		<b>Outcome #2</b>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>mold</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>petite mal</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP legally blind sunscreen + hat</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>not PA!</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>uses walker curb etc help</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 checked="" type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ___ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>can't swim can't walk alone</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>legally blind wears glasses</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>talk about what's wrong</u>	
<b>Important To:</b> <u>music independent family</u>	<b>Important For:</b> <u>walker psychical supps</u>
<b>Likes:</b> <u>working family arts crafts</u>	<b>Dislikes:</b> <u>NA</u>
<b>Describe Communication Style:</b> <u>verbal</u>	

Staff: Belle Cooper



Service Recipient: Deb Haworth

Date: 01/21/21

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?

Table with 4 columns: Sexual Abuse, Physical Abuse, Self-Abuse, Financial Exploitation. Includes checkboxes for Yes/No and various abuse categories like 'Lack of understanding of sexuality' and 'Inability to identify dangerous situations'.

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

Does the person require support in this area?

Form with multiple sections: Allergies (Mold), Seizures (frequent seizures), Choking/Specialized Dietary Needs, Chronic Medical Conditions (Cerebral Palsy, legally blind), Medication Administration, Specific Health & Medical Needs, Mobility Supports Fall Risk, Community & Water Safety Skills, Sensory Disabilities, Self-Management of Behaviors, Important To/For, Likes/Dislikes, Describe Communication Style (Verbal).

Staff: Jay



Service Recipient: Deb H

Date: 1-21-21

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?

<b>Sexual Abuse</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Physical Abuse</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Self-Abuse</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<b>Financial Exploitation</b> <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 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:
<b>Outcome #1</b> <u>N/A</u>		<b>Outcome #2</b> <u>N/A</u>	
<b>Technology Use:</b> <u>N/A</u>			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>mold</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>petit mal seizures - follow PAI protocol</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>legally blind, sensitive to sunlight, CP</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>not @ PAI</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed <u>legally blind, needs prompts about obstacles</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>can't swim, can't walk safely alone</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>legally blind, wears glasses</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>sometimes lets frustration build up - may need to talk to</u>	
<b>Important To:</b> <u>Being independent, making choices, family, music</u>	<b>Important For:</b> <u>walker, physical supports</u>
<b>Likes:</b> <u>working, tablet, arts &amp; crafts, family, exploring community</u>	<b>Dislikes:</b> <u>N/A</u>
<b>Describe Communication Style:</b> <u>verbal</u>	

Staff: Kore Plana



Service Recipient: Deb H

Date: 1-21-20

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 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:
<b>Outcome #1</b>		<b>Outcome #2</b>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Mold</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe : <u>Petite mal seizures</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP Legally Blind</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>not pai</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Walker</u>	<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
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind - glasses</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>let frustration build up</u> <u>if time if upset</u>	
<b>Important To:</b> <u>Family music independent choices</u>	<b>Important For:</b> <u>Walker</u>
<b>Likes:</b> <u>Working fabric crafts</u>	<b>Dislikes:</b> <u>N/A</u>
<b>Describe Communication Style:</b> <u>Verbal</u>	

Staff: Nicea Gangl  
 Date: 1/21/21



Service Recipient: Deb. Haworth

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 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 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:
<b>Outcome #1</b>		<b>Outcome #2</b>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Mold</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Petite Mal Seizures</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Legally Blind, Sensitive to Sun</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Not at PAI</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Uses a Walker</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 checked="" type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>needs prompts</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Wears Glasses</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Can let frustrations build up</u>	
<b>Important To:</b> <u>Being Independent, family, music</u>	<b>Important For:</b> <u>Walker, Physical Supports</u>
<b>Likes:</b> <u>Working, Tablet, Crafts, Exploring</u>	<b>Dislikes:</b> <u>N/A</u>
<b>Describe Communication Style:</b> <u>Verbal</u>	

Staff: Dayna Gordon  
 Date: 1/21/2021



Service Recipient: Deb Hamilton

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 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 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>TBA @ 45 Day</u>		Outcome #2 <u>TBA @ 45 Day</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>Mold</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Petite - Mob - call 911</u>	Seizure PRN <input checked="" 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>Cerebral palsy, Sensitive to Sunlight</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Not @ 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>legally blind</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>no swim, no walking alone.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>legally blind</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>She will let another's build - lol to talk</u>	
Important To: <u>Independent, family, music, choices</u>	Important For: <u>Walker, physical supports</u>
Likes: <u>working, tablet, Art, family, community.</u>	Dislikes: <u>N/A</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Courtney Kelly



Service Recipient: Deb H

Date: 1/10/2021

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 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 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 N/A		Outcome #2 N/A	
Technology Use: N/A			

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: mold	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: Petit mal seizures - follow PA's protocol	Seizure PRN <input checked="" 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: legally blind, sensitive to sunlight (hat + sunscreen), + cerebral palsy	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: not @ PAI	
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 legally blind - needs prompts about obstacles <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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 Cannot swim, cannot walk safely alone	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: legally blind, wears glasses	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: Sometimes can let frustration build up - may need to talk 1:1	
Important To: Being independent, making choices, family, music	Important For: walker/physical supports
Likes: working, tablet, arts + crafts, family, exploring community	Dislikes: N/A
Describe Communication Style: Visual	

Staff: Justyn Level



Service Recipient: Deb Haworth

Date: 1/21/21

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 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 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>NA</u>		Outcome #2 <u>NA</u>	
Technology Use: <u>NA</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>Mold</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Petite Mal seizures</u>	Seizure PRN <input checked="" 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>Cerebral Palsy, Legally blind, sensitive to sunlight</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>Not 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>Walker</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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>Cannot swim, cannot safely walk alone</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>wears glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Builds frustration, yells, alone time in hall</u>	
Important To: <u>independent, music, making choices</u>	Important For: <u>walker and physical supports</u>
Likes: <u>working, tablet, arts, crafts, community</u>	Dislikes: <u>NA</u>
Describe Communication Style: <u>verbal</u>	

Staff: Dawn Nelson



Service Recipient: Deb Howard

Date: 1/21/21

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 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 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 <u>N/A</u>		Outcome #2	
Technology Use: <u>N/A</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>Mold</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Petite Mal Seizures - Call 911</u>	Seizure PRN <input checked="" 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>CP, legally blind, sensitive to sun</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>None 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>legally blind, uses walker</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 checked="" 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>can't swim or safely walk alone</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>wears glasses, legally blind</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>lets frustration build, take to hallway to talk about it</u>	
Important To: <u>independent family choices, music making</u>	Important For: <u>walker, physical support</u>
Likes: <u>working, time at family, arts/crafts</u>	Dislikes: <u>N/A</u>
Describe Communication Style: <u>verbal</u>	

Staff: Monti



Service Recipient: DH

Date: 1/22/21

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 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 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>N/A</u>		Outcome #2 <u>N/A</u>	
Technology Use: <u>N/A</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>mold</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>petit mal seizures - follow PAI's protocol</u>	Seizure PRN <input checked="" 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 type="checkbox"/> Yes - List: <u>legally blind, sensitive to sun/ish (not sunscreen,) + cerebral palsy</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>not 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 type="checkbox"/> Yes - Describe primary mobility & supports <u>legally blind - needs prompts about obstacles</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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>cannot swim, cannot wal safely alone</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>legally blind, wears glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Sometimes can let frustration buildup - may need 1 on 1</u>	
Important To: <u>Being independent, making choices, family, music</u>	Important For: <u>walker/physical supports</u>
Likes: <u>working tablet, arts &amp; craft, family, exploring community</u>	Dislikes: <u>N/A</u>
Describe Communication Style: <u>verbal</u>	

Staff: Shelley Stover  
 Date: 1/22/20



Service Recipient: Deb H

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 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 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		Outcome #2	
Technology Use:			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>mold</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>P. major seizure</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP legal blind seizure to the sun</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>None @ PAI</u>	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>walker - legally blind</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 checked="" type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>can't swim can't safely walk alone</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses - wear glasses</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>frustration build up</u>	
<b>Important To:</b> <u>being independent from music</u>	<b>Important For:</b> <u>walker physical support</u>
<b>Likes:</b> <u>women also dogs family</u>	<b>Dislikes:</b> <u>n/a</u>
<b>Describe Communication Style:</b> <u>verbal</u>	

Staff: Anna Which  
 Date: 11/21/2021



Service Recipient: Deb H.

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 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 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:
<b>Outcome #1</b>		<b>Outcome #2</b>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>mold.</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Petite mal - Pai Protocol</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>C.P. legally blind. Sensitive to Sun. Hat! SUNSCREEN</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Not at PAI</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Walker.</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
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Can't swim. Verbal</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>wears glasses. Legally blind.</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>get frustrated. Yells. 1:1 time helps.</u>	
<b>Important To:</b> <u>independence. fam. choices. music.</u>	<b>Important For:</b> <u>Walker. Physical supports.</u>
<b>Likes:</b> <u>tablet. community.</u>	<b>Dislikes:</b> <u>N/A</u>
<b>Describe Communication Style:</b> <u>Verbal.</u>	