

Staff: Erica W



Service Recipient: Katie L

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 type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Financial Exploitation <input 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 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 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 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 checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> Will review her schedule with staff each morning		<b>Outcome #2</b> Will stretch or do yoga daily each day	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Sulfa drugs, wine</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>N/A</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>Ataxia, Short term memory loss</u>	
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>Ataxia</u> <u>Wheelerchair</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
<b>Community &amp; Water Safety Skills</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
<b>Important To:</b> <u>opportunity to work, to be social with peer's</u>	<b>Important For:</b> <u>have opportunity to socialize with friends, being included</u>
<b>Likes:</b>	<b>Dislikes:</b>
<b>Describe Communication Style:</b>	

Staff: Erica W



Service Recipient: Deb H

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 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 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 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> <del>Work on</del> <u>work on technology skills</u>		<b>Outcome #2</b> <del>become more independent</del> <u>become more independent with her own money</u>	
<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 type="checkbox"/> Yes - List: <u>Mold</u>	<b>Epi Pen/Treatment</b> <input 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</u>	<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input 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>Cerebral Palsy Sunlight Sensitivity, legally blind,</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<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>legally blind, cerebral palsy, wears AFO's</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	
<b>Community &amp; Water Safety Skills</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
<b>Important To:</b> <u>Visiting family, Exploring her community</u>	<b>Important For:</b>
<b>Likes:</b> <u>Arts, Craft</u>	<b>Dislikes:</b>
<b>Describe Communication Style:</b> <u>Verbal</u>	

Staff: Erica W



Service Recipient: Alvaro

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 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:
<b>Outcome #1</b> <u>Work on communication skills with others</u>		<b>Outcome #2</b> <u>Choosing his outing</u>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:	<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	<b>Seizure PRN</b> <input 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:	
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:	
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed <u>Cataracts</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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
<b>Important To:</b> <u>family, music, dancing</u>	<b>Important For:</b> <u>have opportunities to work, engage in his community</u>
<b>Likes:</b>	<b>Dislikes:</b>
<b>Describe Communication Style:</b> <u>verbal</u>	

Staff: Erica Wubban



Service Recipient: brooke

Date: 7/9/21

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 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 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>Sort a variety of familiar items into correct categories</u>		<b>Outcome #2</b> <u>Practice her money skills in the community</u>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>N/A</u>	<b>Seizure PRN</b> <input 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: <u>N/A</u>	
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>hypertthyroidism</u>	
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
<b>Mobility Supports Fall Risk</b> <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
<b>Community &amp; Water Safety Skills</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
<b>Important To:</b> <u>family, being independent traveling</u>	<b>Important For:</b> <u>have staff support, to eat healthy and safe</u>
<b>Likes:</b>	<b>Dislikes:</b>
<b>Describe Communication Style:</b> <u>Verbal</u>	

Staff: Erica Wubban



Service Recipient: bill, Dobihal

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 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 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 checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" 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>Practice copying his phone daily</u>		Outcome #2	
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 type="checkbox"/> Yes - List: <u>N/A</u>	Epi Pen/Treatment <input 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 type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>N/A</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>N/A</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>Unstable</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
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: <u>have positive attitude, to do the right things,</u>	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Erica Wubben



Service Recipient: Amy McVary

Date: 7/7/21

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 type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Financial Exploitation <input checked="" 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 checked="" 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 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 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>Check in with staff each afternoon to talk about any problems</u>		<b>Outcome #2</b> <u>Will participate in at least one community activity</u>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:		<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe:		<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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports:			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed <u>Balance issues</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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:			
<b>Important To:</b> <u>Opportunity to participate in outings, work at PAI, positive attitude</u>		<b>Important For:</b> <u>Staff support to eat healthy and safe</u>	
<b>Likes:</b> <u>Country music, the Twins, puzzles, spending time w/ Sam</u>		<b>Dislikes:</b>	
<b>Describe Communication Style:</b>  <u>Verbal</u>			

Staff: Erica W  
 Date: 7/7/21



Service Recipient: Alex R

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 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 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 checked="" 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 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:
<b>Outcome #1</b> Sign himself into PAI every morning he attends		<b>Outcome #2</b> Daily check his blood sugar during break	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:		<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe :		<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe Equipment/Supports : <u>Diabetic diet</u>			
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Mobility Supports Fall Risk</b> <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
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:			
<b>Important To:</b> <u>technology, helping others, volunteering, being happy</u>		<b>Important For:</b> <u>having opportunity to participate in the community</u>	
<b>Likes:</b> <u>Riding his bike, video games, cooking</u>		<b>Dislikes:</b>	
<b>Describe Communication Style:</b> <u>Verbal</u>			

Staff: Erica Wubbon



Service Recipient: Hung Vo

Date: 07/18/21

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 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 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 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 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>be more independent with making purchases</u>		<b>Outcome #2</b> <u>work on being more confident</u>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List: <u>Seasonal Allergies</u>	<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe: <u>History of Seizures</u>	<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – List: <u>Cerebral Palsy</u>	
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports:	
<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>Can not bear weight</u> <input type="checkbox"/> Support straps/belts needed <u>uses wheel chair</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>Wear's glasses</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
<b>Important To:</b> <u>having strong friendships, working and making money,</u>	<b>Important For:</b> <u>having physical support to continue living a healthy and safe manner</u>
<b>Likes:</b> <u>listen to music, watch tv, cooking, viking</u>	<b>Dislikes:</b>
<b>Describe Communication Style:</b> <u>Verbal</u>	

Staff: Erica Wubben  
 Date: 7/8/21



Service Recipient: Linda Scherrer

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 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 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 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>to stay on track during her morning and get to her homeroom &amp; start setting in</u>		<b>Outcome #2</b> <u>Participating in community outings and try new places</u>	
<b>Technology Use:</b>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:		<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe :		<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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Mobility Supports Fall Risk</b> <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
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:			
<b>Important To:</b> <u>her parents and brother, going shopping, working and making a paycheck</u>		<b>Important For:</b> <u>having job opportunities, staying active, incorporating into her community</u>	
<b>Likes:</b>		<b>Dislikes:</b>	
<b>Describe Communication Style:</b>  <u>Verbal</u>			

Staff: Erica Wubben



Service Recipient: Blair Mercer

Date: 7/8/21

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 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 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 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:
<b>Outcome #1</b> Will Practice money skills Daily in her morning moneyman		<b>Outcome #2</b> Will work on an educational college of her choosing once a week with a staff	
<b>Technology Use:</b> iPad			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		<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>Grand Mal</u>		<b>Seizure PRN</b> <input 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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Mobility Supports Fall Risk</b> <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
<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:			
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> her iPad, her family working parents		<b>Important For:</b> having patient staff that are receptive to Blair's feelings	
<b>Likes:</b> puzzles, iPad, pasta, pancakes, going on walks animals		<b>Dislikes:</b> Spicy food	
<b>Describe Communication Style:</b>  Verbal			

Staff: Erica Wabben



Service Recipient: Tiffany

Date: 7/8/21

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 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 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>Spend 10 mins reading during down time</u>		<b>Outcome #2</b> <u>Will ask question to an individual of her choice</u>	
<b>Technology Use:</b> <u>I Pad</u>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:		<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>avoid milk</u>			
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Mobility Supports Fall Risk</b> <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
<b>Community &amp; Water Safety Skills</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <u>working at PAI, spending time with family living at home</u>		<b>Important For:</b> <u>have staff support to stay healthy</u>	
<b>Likes:</b>		<b>Dislikes:</b>	
<b>Describe Communication Style:</b> <u>Verbal</u>			

Staff: Erica Wubben



Service Recipient: Sean

Date: 7/8/21

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 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 checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" 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>Maintain appropriate conversation with co-workers</u>		<b>Outcome #2</b> <u>will sign out when leaving PAI for community employment</u>	
<b>Technology Use:</b> <u>Radio, TV, Phone</u>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Citrus fruit, tomatoes</u>	<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>N/A</u>	<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>low-fat / low calorie diet, limit soda consumption</u>	
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <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	
<b>Community &amp; Water Safety Skills</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
<b>Important To:</b> <u>family, friends, scrapbooking, people be nice</u>	<b>Important For:</b> <u>Spending time with his friends, Art projects, alone time</u>
<b>Likes:</b>	<b>Dislikes:</b>
<b>Describe Communication Style:</b> <u>Verbal</u>	