

Staff: Anna Pratt

Service Recipient: Henry Hendrickson

Date: 9/10/21



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 checked="" type="checkbox"/> Other: <u>inappropriate self reports</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 indicate which group he would like to participate in		Outcome #2, indicate which activity is next using a schedule	
Technology Use: <u>ipad, TV for making choices, music, videos, & games</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>lactose</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>partially controlled</u>	Seizure PRN <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>NPO G-tube</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Asthma, esophageal dysmotility, scoliosis, cerebral palsy, seizure disorder</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff will administer medication</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>Wheelchair</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 <input type="checkbox"/> # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input checked="" type="checkbox"/> Arjo
<input type="checkbox"/> Support straps/belts needed	
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
Important To: <u>socialization, color in adult colony beds, family</u>	Important For: <u>N/A order, attentive well learned staff</u>
Likes: <u>relaxing in a recliner, listening to music</u>	Dislikes: <u>being left out, not being able to participate</u>
Describe Communication Style: <u>facial expressions, hand & body gestures, vocalizations</u>	

Staff: Anna Preitz



Service Recipient: John Doyle

Date: 9/16/21

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 type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 will <u>Choose a music genre</u>		Outcome #2 <u>Choose an instrument to play while listening to music</u>	
Technology Use: <u>Pad, TV for making choices, music, videos, & games</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Tegretol, Felbamate, Pertussis Vaccine, Immune Globulin, Depakote, mold, dust, & pollen</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>NPO G-tube</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Lenox-Gastaut syndrome, Static Encephalopathy, Chronic Punctate, hypotonia, Klein-Levin Syndrome</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff will administer medication</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>DNR/DNI</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>wheel chair walking sling</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
Important To: <u>Family, fidgets, paper, music, being involved</u>	Important For: <u>NPO order, walking w/ track system, being engaged</u>
Likes: <u>music & therapy, music, fidgets, 1:1 attention</u>	Dislikes: <u>pain, being excluded,</u>
Describe Communication Style: <u>eye pointing, facial expressions, teaching</u>	

Staff: Anna Pratt

Service Recipient: Matt Beal



Date: 9/10/21

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 checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>2x week participate in a group activity</u>		Outcome #2 <u>greet peers/staff w/ blend songs</u>	
Technology Use: <u>ipad, TV for making choices, music, videos, & games</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Absorbable sulfonamides, sulfas, ceflor, Augmentin</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>controlled</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>mechanical soft, thin liquids</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Cerebellar hypoplasia, choreoathetoid cerebral palsy, Hypothyroidism, Thrombocytopenia, constipation</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff will administer medication</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>N/A</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>wheel chair - seat belt + lap tray</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>can army crawl on floor</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>functionally blind</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
Important To: <u>rocker, sitting by the window, walks bus rides</u>	Important For: <u>diet being encouraged to participate seizure protocol</u>
Likes: <u>watching trucks outside, being outside, taking walks</u>	Dislikes: <u>being moved without consent, being pushed to do tasks</u>
Describe Communication Style: <u>facial expressions, switches, & vocalizations</u>	

Staff: Anna Pratt



Service Recipient: Gary Byrne

Date: 9/10/21

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 checked="" type="checkbox"/> Other: <u>inaccurate self reported</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 choose which lunch item he will eat first		Outcome #2 choose an art project to participate in	
Technology Use: <u>ipad, TV, SMARTBOARD</u> for making choices, videos, music, + games			

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>NKA</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>none since 2019</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite sized pieces, honey thickened liquid</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Intermittent explosive disorder, Hep B carrier, B12 deficiency, edema, osteoarthritis, finger atrophy, Diabetes insipidus, migraines, pressure sores, deaf</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff will administer medication</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>spinal fusion, pressure sores</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>wheelchair</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 checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<input type="checkbox"/> Support straps/belts needed	
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>deaf, sensitive to bright lights</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
Important To: <u>participating in group w/ peers, playing games</u>	Important For: <u>responsive & well trained caregivers, body active, propel wheelchair for short distances</u>
Likes: <u>crafts, uno, connect 4, relaxing in a recliner</u>	Dislikes: <u>pain, bright lights, being thirsty</u>
Describe Communication Style: <u>facial expressions, + hand/body gestures</u>	

Staff: Anna Platt

Service Recipient: Nhik Vung



Date: 9/17/21

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 type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>make eye contact during a conversation</u>		Outcome #2 <u>make a music selection</u>	
Technology Use: <u>iPad + TV for making choices, music, videos, & games</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Betadine, Rocephin</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>NPO</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Scoliosis, cerebral palsy w/ spastic quadriplegia, baclofen pump, microcephaly, disc osteopenia, GERD, Hip subluxation, Hip dislocation</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will administer medication</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Bruises easily</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>wheel chair</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 checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>cortical blindness & open angle glaucoma</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
Important To: <u>Friends, culture</u>	Important For: <u>NPO order, seizure protocol</u>
Likes: <u>music, participating in activities</u>	Dislikes: <u>being bored, being excluded</u>
Describe Communication Style: <u>facial expressions & switches</u>	

Staff: Anna Pratt



Service Recipient: Sara Valente

Date: 9/17/21

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 type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:

Outcome #1 independently use a new word of phrase to make a request

Outcome #2 1x week use Yes/No answers to plan a group

Technology Use: ipad, TV for making choices, music, videos, & games

Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)
Does the person require support in this area?

Allergies No Yes - List: NKA Epi Pen/Treatment No Yes Location:

Seizures No Yes - Describe: N/A Seizure PRN No Yes Location:

Choking/Specialized Dietary Needs No Yes - Describe Equipment/Supports: Bite sized pieces

Chronic Medical Conditions No Yes - List: Cerebral Palsy w/ mixed tone quadriplegia, Severe neuromuscular scoliosis, GERD, neurogenic bladder

Medication Administration/Treatment Orders No Yes - Describe Equipment/Supports: staff will administer medication

Specific Health & Medical Needs No Yes - List: N/A

Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>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 checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
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Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List: oculomotor apraxia

Self-Management of Behaviors No Yes - Describe supports: N/A

Important To: <u>Schedule, family</u>	Important For: <u>wearing her chest strap, eating equipment</u>
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Likes: <u>chips, cookies</u>	Dislikes: <u>being touched w/o warning</u>
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Describe Communication Style: vocalizations, verbalizations & facial expressions

Staff: Anna Piatz

Service Recipient: Donald LeVasseur



Date: 9/17/21

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 checked="" type="checkbox"/> Other: <u>inaccurate self-reporter</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 indicate musical instrument of choice		Outcome #2 2x week will engage w/ staff for 230 seconds	
Technology Use: <u>pad, TV, SMART Board</u> for making choices, music, videos, & games			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Codeine, Dilantin, Bactrim, Erythromycin, Augmentin</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>Tonic Clonic & Myoclonic</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>G-tube please tasting</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Cerebral Palsy, Scoliosis, Chronic ear infections, GERD</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will administer medication</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Neurogenic Bladder</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>wheel chair</u> <input checked="" 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 checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>vision impairment</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
Important To: <u>being on outings, hear people sing</u>	Important For: <u>well trained staff, using the verbal in the cares room</u>
Likes: <u>watching movies, bowling, music</u>	Dislikes: <u>being bored, being excluded, sudden loud noise</u>
Describe Communication Style: <u>facial expressions, vocalizations, hand gestures/body language</u>	

Staff: Angie Pratt

Service Recipient: Adam Johnson

Date: 9/17/21



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 checked="" type="checkbox"/> Other: <u>inadequate self reporter</u>	<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 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 type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Choose someone to write a letter to</u>		Outcome #2 <u>Start game group & invite peers to join</u>	
Technology Use: <u>iPad, TV, SMARTBoard for making choices, music, games & videos</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>generalized tonic-clonic</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite sized pieces</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Parkinson's, Moritzbauer syndrome, Scoliosis, Myopia, Asigmatism, ADHD, Asthma</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will administer medication</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>DNR/DNI</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>Wheel chair</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>myopia & astigmatism</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>N/A</u>	
Important To: <u>Family, independence</u>	Important For: <u> caring, well trained staff</u>
Likes: <u>board games, watch TV, sports</u>	Dislikes: <u>being excluded, being bored</u>
Describe Communication Style: <u>verbal, facial expressions, hand gestures / body language</u>	