



# In-service Training Log – Parkway All Staff

Date: 11/3/2021

| Training Time | Trainer Name                      | Content/Description                                                                                                                                                                                                                                                                 |
|---------------|-----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1hr           | Kennedy Norwick<br>Jess Gunderson | Review CSSP & CSSPA responsibilities and where applicable the person's Individ. Abuse Prev. Plan (or any plan approp.) to achieve understanding of the person as a unique individual and how to implement these plans as they relate to the staff's job functions<br>AF, BH, FS, BG |
|               |                                   |                                                                                                                                                                                                                                                                                     |
|               |                                   |                                                                                                                                                                                                                                                                                     |
|               |                                   |                                                                                                                                                                                                                                                                                     |

| Make up Date            | Initial | Last Name         |
|-------------------------|---------|-------------------|
| <b>Lead DSP's/DSP's</b> |         |                   |
|                         | RC      | Ceragioli, Rey    |
|                         | SG      | Gaines, Susan     |
|                         | JG      | Gebhardt, John    |
| 11/4                    |         | Green, Andrea     |
|                         | NK      | Kereluk, Nikki    |
| 11/4                    |         | Moua, Dennis      |
|                         | UP      | Peterson, Chelsie |
|                         | DP      | Popp, Daniel      |
|                         | RS      | Schmidt, Renee    |
|                         | NS      | Snyder, Nancy     |
|                         | KS      | Stein, Kathryn    |
|                         | ZW      | Weinmann, Zach    |
|                         | AW      | Wrich, Anna       |
|                         | DT      | Tuner, Dave       |
|                         |         |                   |
|                         |         |                   |

| Make up Date        | Initial        | Last Name            |
|---------------------|----------------|----------------------|
|                     |                |                      |
|                     |                |                      |
|                     |                |                      |
|                     |                |                      |
|                     |                |                      |
|                     |                |                      |
|                     |                |                      |
| <b>Other (Subs)</b> |                |                      |
|                     |                | Pratt, Anna          |
|                     |                | Snodie, Josh         |
|                     |                | Willis, Megan        |
|                     |                |                      |
| <b>Make up Date</b> | <b>Initial</b> | <b>Manager/Admin</b> |
|                     |                | Kmetz, Kevin         |
|                     |                | Gunderson, Jess      |
|                     | KN             | Norwick, Kennedy     |
|                     |                | Shattuck, Kelli      |



Staff: Drea  
Date: 11/4/21



Service Recipient: Brook 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Brook that he is able to visit and make his own choices throughout the day.</u>                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                              |
| Technology Use:                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                              |

### 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<br>Location:                                                                    |                                                                                                                                                            |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>distress</u>                                                                                       |  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |                                                                                                                                                            |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                           |  |                                                                                                                                                                       |                                                                                                                                                            |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>left arm</u>                                                                         |  |                                                                                                                                                                       |                                                                                                                                                            |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                  |  |                                                                                                                                                                       |                                                                                                                                                            |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                    |  |                                                                                                                                                                       |                                                                                                                                                            |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><input type="checkbox"/> Support straps/belts needed |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><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:                                                                                               |  |                                                                                                                                                                       |                                                                                                                                                            |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                          |  |                                                                                                                                                                       |                                                                                                                                                            |
| Important To:<br><u>love &amp; care</u>                                                                                                                                                        |  | Important For:<br><u>choice needs independent</u>                                                                                                                     |                                                                                                                                                            |
| Likes: <u>soft sensory</u><br><u>observing others, walks at people</u>                                                                                                                         |  | Dislikes:<br><u>he told what to do</u><br><u>not having choices</u>                                                                                                   |                                                                                                                                                            |
| Describe Communication Style:<br><u>nonverbal</u>                                                                                                                                              |  |                                                                                                                                                                       |                                                                                                                                                            |

Staff: DREH  
Date: 11-4-21



Service Recipient: Bryan Gray

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

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

Does the person require support in this area?

|                                                                                                                                                                                                    |                                                                                                                                                                       |                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                              | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |                                                                                                                                                            |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe :                                                                                                          | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |                                                                                                                                                            |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :                                                              |                                                                                                                                                                       |                                                                                                                                                            |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                       |                                                                                                                                                            |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :                                                                |                                                                                                                                                                       |                                                                                                                                                            |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                        |                                                                                                                                                                       |                                                                                                                                                            |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                                                                                |                                                                                                                                                                       |                                                                                                                                                            |
| Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                   |                                                                                                                                                                       |                                                                                                                                                            |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                              |                                                                                                                                                                       |                                                                                                                                                            |
| Important To:<br><u>is engaged &amp; active</u>                                                                                                                                                    | Important For:<br><u>sensory needs met</u>                                                                                                                            |                                                                                                                                                            |
| Likes:<br><u>puzzles, swings, cars</u>                                                                                                                                                             | Dislikes:<br><u>desserts, waiting for someone</u>                                                                                                                     |                                                                                                                                                            |
| Describe Communication Style:<br><u>nonverbal (facial expressions)</u>                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                            |

Staff: Drea  
Date: 11/4/21



Service Recipient: Frank Spiva K

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>engage in group lesson</u>                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2<br><u>limit item going to work headphones only</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:<br><u>suja</u>                                                                                               | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                       |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                           | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>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:<br><u>hyper activity remind to take breaks</u>                                              |                                                                                                                                                                                                                                                                                                                                          |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                      |                                                                                                                                                                                                                                                                                                                                          |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                        |                                                                                                                                                                                                                                                                                                                                          |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                           |                                                                                                                                                                                                                                                                                                                                          |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>sensitive to light</u>                                                                      |                                                                                                                                                                                                                                                                                                                                          |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>physical emotional verbal aggression</u>                               |                                                                                                                                                                                                                                                                                                                                          |
| Important To:                                                                                                                                                                                      | Important For:                                                                                                                                                                                                                                                                                                                           |
| Likes:<br><u>disney, basketball, olympics</u>                                                                                                                                                      | Dislikes:<br><u>not given choices</u>                                                                                                                                                                                                                                                                                                    |
| Describe Communication Style:<br><u>verbal</u>                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                          |

Staff: DREB  
Date: 11/4/21



Service Recipient: Adam Fish

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                        | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                        | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Monitor indirect social behavior</u>                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Outcome #2<br><u>plan schedule for next week</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:<br><u>celaxa, sulsa</u>                                                                                      | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                    |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>loud noises (behavior)</u>                                                                          | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                          |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>bite size, gerd</u>                                     |                                                                                                                                                                                                                                                                                                                                       |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>bipolar, hyper</u>                                                                    |                                                                                                                                                                                                                                                                                                                                       |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                      |                                                                                                                                                                                                                                                                                                                                       |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                        |                                                                                                                                                                                                                                                                                                                                       |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><br><input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><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:                                                                                                   |                                                                                                                                                                                                                                                                                                                                       |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                              |                                                                                                                                                                                                                                                                                                                                       |
| Important To:<br><u>soap operas music family</u>                                                                                                                                                   | Important For:                                                                                                                                                                                                                                                                                                                        |
| Likes:<br><u>games shows</u>                                                                                                                                                                       | Dislikes:<br><u>loud noises</u>                                                                                                                                                                                                                                                                                                       |
| Describe Communication Style:<br><u>verbal</u>                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                       |

Staff: Dennis

Date: 11/4/21



Service Recipient: Adam Fish

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                           | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                        | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b><br><u>redirect social behavior</u>                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Outcome #2</b><br><u>plan schedule for next week</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 checked="" type="checkbox"/> Yes - List:<br><u>Celebra, Sulfa</u>                                                                                     | <b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                             |
| <b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>loud noises (behavior)</u>                                                                          | <b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                   |
| <b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>bite sized, gerd</u>                                    |                                                                                                                                                                       |
| <b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>bipolar</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<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker |
| <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><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><br><u>soap operas, music, family, pets</u>                                                                                                                                           | <b>Important For:</b>                                                                                                                                                 |
| <b>Likes:</b><br><u>game shows, shredding</u>                                                                                                                                                             | <b>Dislikes:</b><br><u>loud noises</u>                                                                                                                                |
| <b>Describe Communication Style:</b><br><u>verbal</u>                                                                                                                                                     |                                                                                                                                                                       |

Staff: DennisDate: 11/4/21Service Recipient: Frank Spvak

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

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

Does the person require support in this area?

|                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sulfur</u>                                                                                                 | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                            | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>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:<br><u>hyper activity remind to take break</u>                                                |                                                                                                                                                                                                                                                                                                                                   |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>He takes PRN, need staff support</u> |                                                                                                                                                                                                                                                                                                                                   |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><del>physical, emotional, verbal aggression</del>                                    |                                                                                                                                                                                                                                                                                                                                   |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                            |                                                                                                                                                                                                                                                                                                                                   |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to light</u>                                                                          |                                                                                                                                                                                                                                                                                                                                   |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>physical, emotional, verbal aggression</u>                              |                                                                                                                                                                                                                                                                                                                                   |
| Important To:<br><del>physical, emotional, verbal aggression</del><br><u>give choices</u>                                                                                                           | Important For:                                                                                                                                                                                                                                                                                                                    |
| Likes:<br><u>disney, basketball, olympics, ipod, movies</u>                                                                                                                                         | Dislikes:<br><u>not given choices</u>                                                                                                                                                                                                                                                                                             |
| Describe Communication Style:<br><u>verbal.</u>                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                   |

Staff: Dennis  
Date: 11/4/21



Service Recipient: Brock 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                           | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>visit other peers</u>                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2<br><u>milk his own choices</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><del>seasonal</del> seasonal</u>                                                                          | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                       |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                           | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                             |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>bite sized pieces</u>                        |                                                                                                                                                                                                                                                                                                                                          |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                                                                                                                                                                                          |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>takes with milk, staff support</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<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                                                                                |                                                                                                                                                                                                                                                                                                                                          |
| Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                   |                                                                                                                                                                                                                                                                                                                                          |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                              |                                                                                                                                                                                                                                                                                                                                          |
| Important To:<br><u>Dave + Chris friends</u>                                                                                                                                                       | Important For:<br><u>choice cards</u>                                                                                                                                                                                                                                                                                                    |
| Likes:<br><u>soft sensory</u><br><u>observing others</u>                                                                                                                                           | Dislikes:<br><u>being told what to do,</u><br><u>no choices</u>                                                                                                                                                                                                                                                                          |
| Describe Communication Style:<br><u>nonverbal</u>                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                          |

Staff: Dennis

Date: 11/4/21



Service Recipient: Bryan Gray

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

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

Does the person require support in this area?

|                                                                                                                                                                                                    |                                                                                                                                                                       |                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                              | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |                                                                                                                                                             |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe :                                                                                                          | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |                                                                                                                                                             |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :                                                   |                                                                                                                                                                       |                                                                                                                                                             |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :                                                     |                                                                                                                                                                       |                                                                                                                                                             |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                        |                                                                                                                                                                       |                                                                                                                                                             |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                                                                                |                                                                                                                                                                       |                                                                                                                                                             |
| Sensory Disabilities <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seeking deep pressure sensory</u>                                                   |                                                                                                                                                                       |                                                                                                                                                             |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                              |                                                                                                                                                                       |                                                                                                                                                             |
| Important To:<br><u>engaged &amp; active</u>                                                                                                                                                       | Important For:<br><u>sensory, needs</u>                                                                                                                               |                                                                                                                                                             |
| Likes:<br><u>puzzles, swings, car</u>                                                                                                                                                              | Dislikes:<br><u>dessert; waiting for bathroom</u>                                                                                                                     |                                                                                                                                                             |
| Describe Communication Style:<br><u>vocalization, facial expressions, gestures</u>                                                                                                                 |                                                                                                                                                                       |                                                                                                                                                             |

Staff: Rey Ceemagiori  
Date: 11/21/21



Service Recipient: Brock H.

Reviewed by: \_\_\_\_\_

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                        | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>Brock will visit another program area</u>                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2 <u>using his choice cards</u>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                              |
| Technology Use: <u>computer with touch screen, Kindle</u>                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                              |

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

|                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>seasonal</u>                                                                                                                                                                          | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                                                            |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe: <u>history and controlled by medications</u>                                                                                                                                          | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                                                                  |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe Equipment/Supports: <u>bite sized pieces, verbal reminders to eat and chew slowly</u>                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                               |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – List:                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                               |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe Equipment/Supports: <u>meds with chocolate milk</u>                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                               |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>partial paralysis on the left side</u>                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                               |
| Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe primary mobility & supports<br><u>staff will walk be him, give prompts, offer hand or arm to hold on to</u><br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker <input type="checkbox"/> Arjo<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Manual Lift # staff _____ |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>help with safety rules, remain close if crowded, redirect him if staring too long at someone, deaf</u>                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                               |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>deaf</u>                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                               |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                               |
| Important To: <u>peers, observe others, invite to join in activities, soft, squishy toys,</u>                                                                                                                                                                                  | Important For: <u>make his own decisions, staff take the time to learn about him</u>                                                                                                                                                                                                                                                                                                                          |
| Likes: <u>being around people, chocolate milk, iPad, ripping paper.</u>                                                                                                                                                                                                        | Dislikes: <u>being told what to do, taking his meds.</u>                                                                                                                                                                                                                                                                                                                                                      |
| Describe Communication Style: <u>Sign language, facial expression and gestures</u>                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                               |

Staff: Rey Ceragioni  
Date: 11/3/21



Service Recipient: Bryan G.

Reviewed by: \_\_\_\_\_

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b><br><u>participating in group activity</u>                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Outcome #2</b><br><u>using a choice board to pick an activity after lunch</u>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              |
| <b>Technology Use:</b> <u>ipad</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>salt medications</u>                                                                                                           |  | <b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                           |                                                                                                                                                                                |
| <b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe: <u>seizure protocol call 911 after 3 minutes</u>                                                                               |  | <b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe Equipment/Supports: <u>meds at home, but if given meds at PAI, staff would need to assist</u> |  |                                                                                                                                                                                                     |                                                                                                                                                                                |
| <b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>90° ↑ out door outing, is not allowed to go.</u>                                                     |  |                                                                                                                                                                                                     |                                                                                                                                                                                |
| <b>Fall Risk/Mobility Supports</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed                      |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker <input type="checkbox"/> Arjo | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Manual Lift # staff ____ |
| <b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff will help Bryan follow rules and safety</u>                                                            |  |                                                                                                                                                                                                     |                                                                                                                                                                                |
| <b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>seeking deep sensory input</u>                                                                                      |  |                                                                                                                                                                                                     |                                                                                                                                                                                |
| <b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe supports: <u>might eat things that aren't meant to be eaten. might lick.</u>                                |  |                                                                                                                                                                                                     |                                                                                                                                                                                |
| <b>Important To:</b> <u>engage in sensory activities, engaged and active.</u>                                                                                                                                                  |  | <b>Important For:</b> <u>able to engage in sensory activities having choices, encourage to be engaged and active.</u>                                                                               |                                                                                                                                                                                |
| <b>Likes:</b> <u>puzzles, swings, car rides, swimming, sensory activities and music</u>                                                                                                                                        |  | <b>Dislikes:</b> <u>deserts, going on walks when windy, tank tops, transitions, waiting</u>                                                                                                         |                                                                                                                                                                                |
| <b>Describe Communication Style:</b> <u>non-verbal, vocalizations, body language.</u>                                                                                                                                          |  |                                                                                                                                                                                                     |                                                                                                                                                                                |

Staff: Rey Crago  
 Date: 11/3/21



Service Recipient: Frank S. IV

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b><br><u>engage in activity at lessons</u>                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Outcome #2</b> <u>going to work, Frank will limit his personal items, to ipod and headphones and one other item</u>                                                                                                                                                                                                                                                                                                       |                                                                                                   |
| <b>Technology Use:</b> <u>computer, ipad, CD player, laptop</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>certain medications</u>                                                                                                                                                                                                       |  | <b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>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<br>Location:                                                                   |                                                                                                                                                            |
| <b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>surge and sweets intake redirecting to salty foods</u>                                                                                                                         |  |                                                                                                                                                                       |                                                                                                                                                            |
| <b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tight chest muscles, hyperactivity, queing him to take a break, modelling instead of verbal when he's overwhelmed</u>                                                                                        |  |                                                                                                                                                                       |                                                                                                                                                            |
| <b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>all</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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed                                                                                                                     |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff support in the community / able to swim</u>                                                                                                                                                           |  |                                                                                                                                                                       |                                                                                                                                                            |
| <b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>motor impairment, Dyspraxia, dilated pupils, shallow breathing</u>                                                                                                                                                 |  |                                                                                                                                                                       |                                                                                                                                                            |
| <b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Shoved others when overwhelmed, yelling, modelling instead of verbal. leave him alone. One step directives when overwhelmed, checking up on him. running into the street when overwhelmed</u> |  |                                                                                                                                                                       |                                                                                                                                                            |
| <b>Important To:</b> <u>family, internet, watching movies, reading, his devices</u>                                                                                                                                                                                                                                           |  | <b>Important For:</b> <u>participates and is engaged in activities, ipod, buying things, being out in the community</u>                                               |                                                                                                                                                            |
| <b>Likes:</b> <u>movies, ipad, quiet places</u>                                                                                                                                                                                                                                                                               |  | <b>Dislikes:</b> <u>loud environments</u>                                                                                                                             |                                                                                                                                                            |
| <b>Describe Communication Style:</b> <u>Verbal, short sentences.</u>                                                                                                                                                                                                                                                          |  |                                                                                                                                                                       |                                                                                                                                                            |

Staff: Rey CeragioliService Recipient: Adam F.Date: 11/3/21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b><br><u>Will follow staff redirection when talking about inappropriate comments.</u>                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Outcome #2</b> <u>on Fridays, will sit with staff and plan for his week</u>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                              |
| <b>Technology Use:</b> <u>Smart T.V., iPad</u>                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

## Self-Management Assessment (SMA) &amp; 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>tegretol and calexsa</u>                                                                                                                                                                                          |  | <b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                        |                                                                                                                                                                        |
| <b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Seizure like symptoms triggered by loud noises - Blank stare</u>                                                                                                                                               |  | <b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                              |                                                                                                                                                                        |
| <b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite sized pieces, reminding to eat slowly, no milk, no sedicrom, cereal</u>                                                                                       |  |                                                                                                                                                                       |                                                                                                                                                                        |
| <b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>ADHD, Bipolar, anxiety, sleep disorder</u><br><u>sweats easily - hyper hydro</u> <u>APOs</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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>APOs</u>                                                                                                                                                                                |  |                                                                                                                                                                       |                                                                                                                                                                        |
| <b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Straps for his wheelchair, staff helps move his wheelchair</u><br><input type="checkbox"/> Support straps/belts needed                                       |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input checked="" type="checkbox"/> Arjo |
| <b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staying with Adam and helping</u><br><u>can't swim</u>                                                                                                                                          |  |                                                                                                                                                                       |                                                                                                                                                                        |
| <b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>startle reflex to loud noises, vision impairment, headaches and eye phatque</u>                                                                                                                        |  |                                                                                                                                                                       |                                                                                                                                                                        |
| <b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>thrashing in his chair, getting him on a mat if he won't calm down. call parents if he can't calm down. Quiet place to help, might start laughing in inappropriate situations</u> |  |                                                                                                                                                                       |                                                                                                                                                                        |
| <b>Important To:</b> <u>soap operas, pet therapy, animals, being included.</u>                                                                                                                                                                                                                                    |  | <b>Important For:</b> <u>calm, quiet environments, staff knowing his mental health, straps are</u>                                                                    |                                                                                                                                                                        |
| <b>Likes:</b> <u>music, sea operas, magazines, family, friends</u>                                                                                                                                                                                                                                                |  | <b>Dislikes:</b> <u>Not being included, not loud noises, not being able to participate</u>                                                                            |                                                                                                                                                                        |
| <b>Describe Communication Style:</b> <u>Verbal, prefers verbal ques</u>                                                                                                                                                                                                                                           |  |                                                                                                                                                                       |                                                                                                                                                                        |

Staff: Renee Se



Service Recipient: Brock Hamilton

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<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                        | Physical Abuse<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                    | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: <u>none</u> | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>visit peer in other program room</u>                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Outcome #2<br><u>using choice cards</u>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |
| Technology Use: <u>Computer w/ touch screen Kindal Horn</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<br>Location:                                                                                                                                                                                                                                              |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>History controlled by meds 1994</u>                                                                                                                | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                    |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Bite size pieces Nickel size slow down Chew thoroughly</u>                                                    |                                                                                                                                                                                                                                                                                                                                                 |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                 |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>with chocolate milk will refuse keep offering</u>                                         |                                                                                                                                                                                                                                                                                                                                                 |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Partial Paralysis - Support w/ left side</u>                                                                                 |                                                                                                                                                                                                                                                                                                                                                 |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports<br><u>Staff will walk by him offer hand/arm</u><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Personal space help w/ safety rules reduce staring remain close in crowds</u>                                                                      |                                                                                                                                                                                                                                                                                                                                                 |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>Deaf</u>                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                 |
| Important To: <u>invite to join play date peers observe others soft sex</u>                                                                                                                                                                    | Important For: <u>staff to understand him / his communication make choice and decision</u>                                                                                                                                                                                                                                                      |
| Likes: <u>chocolate milk ripping paper around people iPad</u>                                                                                                                                                                                  | Dislikes: <u>pushing him to do something taking meds</u>                                                                                                                                                                                                                                                                                        |
| Describe Communication Style:<br><u>Deaf picture cards Signing lip read</u>                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                 |

Staff: Renee Schmitt  
Date: 11/3/2021



Service Recipient: Frank Speza 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>engage in group activities</u>                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2 <u>When going to work limit personal life to 1 pad one other item</u>                                                                                                                                                                                                                                                                                                                                             |                                                                                                   |
| Technology Use: <u>IPod Computer IPad CD Player</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:<br><u>Sulfa medications</u>                                                                                                                                                                 | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                                                                                                          | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                      |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Sugar Restriction</u>                                                                                                                  |                                                                                                                                                                                                                                                                                                                                   |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Verbal ques when over whelmed</u><br><u>Tight Chest muscles</u> <u>Hyperactivity - walking fast + turning</u>                                                        |                                                                                                                                                                                                                                                                                                                                   |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>None at PAH</u> <u>Staff help if needed</u>                                                                                   |                                                                                                                                                                                                                                                                                                                                   |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                   |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><input type="checkbox"/> Support straps/belts needed                                                                                               | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Can swim staff in community trusting</u>                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                   |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>dilated pupils</u> <u>sensitive to light</u><br><u>fine motor impairment</u> <u>dyspraxia - shallow breathing</u>                                                                     |                                                                                                                                                                                                                                                                                                                                   |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>yelling</u> <u>one step directions</u> <u>may run into street</u><br><u>pushed over</u> <u>stimulated noise making</u> <u>redirect to parking lot</u> |                                                                                                                                                                                                                                                                                                                                   |
| Important To: <u>IPod HIS devices</u><br><u>family internet reading movies</u>                                                                                                                                                                                                    | Important For:<br><u>participate and engaged inactive</u>                                                                                                                                                                                                                                                                         |
| Likes:<br><u>movies IPod community buying things</u>                                                                                                                                                                                                                              | Dislikes:<br><u>waiting loud environment</u>                                                                                                                                                                                                                                                                                      |
| Describe Communication Style:<br><u>Verbal</u> <u>Short Sentence</u> <u>yes/no questions</u>                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                   |

Staff: Renee Schmidt  
Date: 1/13/2021



Service Recipient: Brian Gray

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                           | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  | Financial Exploitation<br><input type="checkbox"/> Yes <input type="checkbox"/> No                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other:<br><u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>part group activities</u>                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2 <u>using a choice board to choose activities</u>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              |
| Technology Use: <u>Home - iPad - Apps</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:<br><u>Sulfa meds.</u>                                                                               | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>longer than 3min call 911</u>                                                              | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                      |                                                                                                                                                                       |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                    |                                                                                                                                                                       |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Not at PAI Would need assistance.</u> |                                                                                                                                                                       |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>NO outdoor outing 90°+</u>                                              |                                                                                                                                                                       |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                    | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                      | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo           |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Staff help out in community</u>                                                               |                                                                                                                                                                       |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>History of deep sensory input</u>                                                  |                                                                                                                                                                       |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:<br><u>Pica like behaviors redirect when</u>                                    |                                                                                                                                                                       |
| Important To: <u>engaged and active engage in sensory activities</u>                                                                                                                      | Important For: <u>having choices encourage to be active able to engage in sensory activities</u>                                                                      |
| Likes: <u>car rides swimming music puzzles, swings, sensory activities</u>                                                                                                                | Dislikes: <u>tank tops transitions desserts, walk on windy, waiting</u>                                                                                               |
| Describe Communication Style: <u>non verbal body language</u>                                                                                                                             |                                                                                                                                                                       |

Staff: Renee Schmitt  
Date: 11/3/2021



Service Recipient: Adam fish

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                    | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input checked="" type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>will follow staff redirection w/ talking in appropriate</u>                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Outcome #2<br><u>fridays sit with staff plan next week schedule</u>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                              |
| Technology Use: <u>Smart TV, iPad</u>                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Tegretol, Celexa</u>                                                                                                                                                                  | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                         |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>History of seizures 2 decades ago</u><br><u>Load Repetitive noises</u>                                                                                                             | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                               |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Ger d - Relax - diet no milk High sodium</u><br><u>need bite size pieces eat slowly</u><br><u>No food from PAH unless ok from Hor.</u> |                                                                                                                                                                                                                                                                                                                                                 |
| Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>Hypohidrosis</u><br><u>Bipolar, anxiety Sleep disorder</u><br><u>Sweating profusely</u>                                                                                         |                                                                                                                                                                                                                                                                                                                                                 |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                 |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>AFO</u>                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                 |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>cerebral palsy</u><br><u>wheelchair</u><br><input checked="" type="checkbox"/> Support straps/belts needed                                     | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input checked="" type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Stay with him Straps fastened Can not swim</u>                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                 |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>stardal Relax to loud noise visual impairment</u>                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                 |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>quiet place to calm down/Relax</u><br><u>thrashing throw self out of chair if not satisfied</u>                                                       |                                                                                                                                                                                                                                                                                                                                                 |
| Important To:<br><u>Soap's music Pet therapy included</u>                                                                                                                                                                                                                         | Important For:<br><u>Staff knowing hi/low's</u><br><u>calm quiet environment, strap</u>                                                                                                                                                                                                                                                         |
| Likes:<br><u>Family friend</u><br><u>Music game shows</u>                                                                                                                                                                                                                         | Dislikes:<br><u>not being included</u>                                                                                                                                                                                                                                                                                                          |
| Describe Communication Style: <u>gentle reminders</u><br><u>Verbal communication verbal cues</u>                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                 |

Staff: Leahy Snyder  
Date: 11-2-21



Service Recipient: Brian Grey

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

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

Does the person require support in this area?

|                                                                                                                                                                                       |                                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Sulfa medications</u>                                                                     | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>call 911 after 3 minutes</u>                                                           | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                  |                                                                                                                                                                       |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                |                                                                                                                                                                       |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>None at PAI</u>                   |                                                                                                                                                                       |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Not to go on outings if above 90 - can do indoor outings</u>        |                                                                                                                                                                       |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                  | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo           |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff helps in community</u>                                                   |                                                                                                                                                                       |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>History seeking Deep sensory - offer different things</u>                      |                                                                                                                                                                       |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>Pica like behavior - spit out things that were edible</u> |                                                                                                                                                                       |
| Important To: <u>engage in sensory activities</u><br><u>engaged &amp; active</u>                                                                                                      | Important For: <u>choices / encourage to be active</u><br><u>able to engage in sensory activities</u>                                                                 |
| Likes: <u>puzzles / swings / car rides / music</u><br><u>swimming / sensory activities</u>                                                                                            | Dislikes: <u>Tak Dots / transitions / waiting</u><br><u>NO deserts / going on windy walks</u>                                                                         |
| Describe Communication Style:<br><u>Nonverbal / Gestures / Body Language</u>                                                                                                          |                                                                                                                                                                       |

Staff: Adrienne SnyderDate: 11-3-21Service Recipient: Ashley Fish

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Follow redirection on inappropriate</u>                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2<br><u>Fridays - sit w/ staff and plan</u>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                              |
| Technology Use: <u>smart TV/ipld - subjects</u>                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <u>Schedule for next wk</u>                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Tegretol &amp; Celebra</u>                                                                                              | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                              |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>NOT happened in long time / seizure like / Blank</u>                                                                 | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                    |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>cut food in bite size pcs / remind to eat slowly</u>                     |                                                                                                                                                                                                                                                                                                                                      |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Bipolar / Anxiety / Sleep Disturbance</u><br><u>Gerd (reflux) No milk - NO food unless OK'd by Mom</u> |                                                                                                                                                                                                                                                                                                                                      |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                  |                                                                                                                                                                                                                                                                                                                                      |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>AFO's</u><br><u>Bipolar / Anxiety / Sleep Disturbance / Hyper-sweating</u>                                   |                                                                                                                                                                                                                                                                                                                                      |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Cerebral palsy / straps on chair</u>                                  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>stay w/ him, straps correctly fastened, swim</u>                                                             |                                                                                                                                                                                                                                                                                                                                      |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Startle reflex, vision impairment, eye fatigue</u>                                                           |                                                                                                                                                                                                                                                                                                                                      |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>trashing = relax on floor mat, Quiet place to calm down.</u>                            |                                                                                                                                                                                                                                                                                                                                      |
| Important To: <u>Game shows / magazines</u><br><u>soap operas / music / pet's / being included</u>                                                                                                                  | Important For: <u>straps are secure</u><br><u>calm quiet / staff knowing high &amp; lows</u>                                                                                                                                                                                                                                         |
| Likes:<br><u>Game shows / soap operas</u>                                                                                                                                                                           | Dislikes:<br><u>loud noises / being included</u>                                                                                                                                                                                                                                                                                     |
| Describe Communication Style:<br><u>Verbal - Gentle reminders</u>                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                      |

Staff:

Date:



Service Recipient:

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

Outcome #1

Engage in group activities

Outcome #2

Work = limit items to iPod w/ headphones

Technology Use:

Computer, iPad, iPod, CD Player / 1 other item

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

Does the person require support in this area?

|                                                                                                     |                                                                                                    |
|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br>Sulfamides | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location: |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:            | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:       |

Choking/Specialized Dietary Needs ☒ No ☐ Yes - Describe Equipment/Supports:

Diet = sweets restrictions

Chronic Medical Conditions ☐ No ☐ Yes - List:

tight chest muscles, Hyperactivity = take breaks

Medication Administration/Treatment Orders ☐ No ☒ Yes - Describe Equipment/Supports:

staff help if needed

Specific Health & Medical Needs ☐ No ☐ Yes - List:Mobility Supports Fall Risk ☒ No ☐ Yes - Describe primary mobility & supports☐ Support straps/belts needed
☐ Verbal Cues  
☐ Physical Assistance  
☐ Posey / Gait Belt  
☐ Walker

☐ 2 Person Hoyer  
 # staff in cares room: \_\_\_\_  
☐ 1 Person Hoyer / Track  
☐ Arjo
Community & Water Safety Skills ☐ No ☐ Yes

very trusting can swim / Needs staff in community

Sensory Disabilities ☐ No ☒ Yes - List:

dyspraxia = affects coordination, sensitive to light shallow

Self-Management of Behaviors ☐ No ☒ Yes - Describe supports:
 ~ may run into street = "no street" (Has done this before)  
 Shoved others if upset / yelling / Don't ask questions

Important To:

Devices family / internet / movies / reading

Important For:

engaged / quiet spot / movies

Likes:

Movies / iPod / community

Dislikes:

Writing / loud environment

Describe Communication Style:

Verbal / short sentences

Staff:

Date:



Service Recipient:

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                    | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other:<br>unable to report | <input type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br>visit his peers                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2<br>using choice cards for decision                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                              |
| Technology Use: Home - computer / - Kindle                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br>seasonal                                                                                                                                        | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                        |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br>controlled by meds                                                                                                                           | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                              |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br>Nickle sized bites - verbal slowdown; Chew                                                       |                                                                                                                                                                                                                                                                                                                                                           |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                           |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br>meds w/ choc. Milk - spits out meds - cont. to offer                                    |                                                                                                                                                                                                                                                                                                                                                           |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br>partial paralysis - left side (Needs support)                                                                             |                                                                                                                                                                                                                                                                                                                                                           |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br>staff walk by him - offer hand or arm<br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes help follow safety rules / stay close                                                                                                |                                                                                                                                                                                                                                                                                                                                                           |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br>Deaf / Knows some signs                                                                                                              |                                                                                                                                                                                                                                                                                                                                                           |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                           |
| Important To: Peers, observe others, invite him to join, play dough                                                                                                                                                                      | Important For: make his own choices, decisions / staff understand him                                                                                                                                                                                                                                                                                     |
| Likes: choc milk, iPad - observing                                                                                                                                                                                                       | Dislikes: taking meds                                                                                                                                                                                                                                                                                                                                     |
| Describe Communication Style:<br>some sign language / gestures / facial expressions                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                           |

Staff: Garner, Jorie

Date: 11/1/2011



Service Recipient: Gray, Brian

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                       | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                             | Self-Abuse<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Lack of understanding of sexuality<br><input type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: <u>unable to report</u> | <input type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>group activities, using a</u>                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Outcome #2 <u>using a choice. Usually after lunch</u>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                              |
| Technology Use: <u>no - home - iPad w/apps</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:                                                                                                                                    |  | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                            |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:                                                                                                                                 |  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                  |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                               |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                               |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:                                                                            |  |                                                                                                                                                                                                                                                                                                                                                               |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>not outdoor or outdoor using if above 90°</u>                                                             |  |                                                                                                                                                                                                                                                                                                                                                               |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                                                   |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br><input type="checkbox"/> # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                               |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>staff will help when needed.</u>                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                               |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>sensory deep. hand/arm rubs</u>                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                               |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>eat things he shouldn't eat. if he puts "play dough" then him spit out. then explain why he can't eat.</u> |  |                                                                                                                                                                                                                                                                                                                                                               |
| Important To: <u>Engag. sensory - paint, play dough</u><br><u>stay active</u>                                                                                                                                            |  | Important For: <u>Engag. and active.</u><br><u>keep hands busy. handling choices</u>                                                                                                                                                                                                                                                                          |
| Likes: <u>puzzles, swings, car rides, swimming,</u><br><u>Sensory activities, music.</u>                                                                                                                                 |  | Dislikes: <u>desserts, going on walks - windy,</u><br><u>park trips. transmons. waiting for anything.</u>                                                                                                                                                                                                                                                     |
| Describe Communication Style: <u>Non Verbal - body language</u>                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                               |

Staff: Gaines, Suzie  
 Date: 11/11/2020



Service Recipient: Fish, Adam

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>Adam will listen to redirection by staff</u>                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Outcome #2 <u>Friday Adam will sit w/ staff about plans for next week</u>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |
| Technology Use: <u>Smart t.v. / iPad</u>                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tegretol, Celebra</u>                                                                                                                                              |                                                                                                                                                                       | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                     |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>has not had one in 20 years / blank</u>                                                                                                                         |                                                                                                                                                                       | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                           |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Cut up to bite size pieces eat slowly</u><br><u>Food - No milk, drinks out of sports bottle w/ straw (water)</u> |                                                                                                                                                                       |                                                                                                                                                             |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Mood Swings</u> - <u>Bipolar</u> - <u>anxiety</u><br><u>Sleep</u>                                                                              |                                                                                                                                                                       |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                                               |                                                                                                                                                                       |                                                                                                                                                             |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>apo's risk of falling</u><br><u>Strips on Wheel Chair</u>                                                                                            |                                                                                                                                                                       |                                                                                                                                                             |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                                                                                                 | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <input checked="" type="checkbox"/> Support straps/belts needed                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Strips - on Wheel chair / Needs support</u>                                                                                                          |                                                                                                                                                                       |                                                                                                                                                             |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>loud noises, vision, headaches</u>                                                                                                                      |                                                                                                                                                                       |                                                                                                                                                             |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>throwing himself. Place on mat on floor. Sometimes stays at home. Quite place to calm down.</u>                                               |                                                                                                                                                                       |                                                                                                                                                             |
| Important To: <u>Soap operas, music, loves animals</u>                                                                                                                                                                                                      | Important For: <u>Clam, quite, Staff knowing high/low</u>                                                                                                             |                                                                                                                                                             |
| Likes: <u>game shows, friends, family</u>                                                                                                                                                                                                                   | Dislikes: <u>loud noises, not being involved</u>                                                                                                                      |                                                                                                                                                             |
| Describe Communication Style:<br><u>Verbal -</u>                                                                                                                                                                                                            |                                                                                                                                                                       |                                                                                                                                                             |

Staff: Gaines, Stie



Service Recipient: Frank Spivak

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                          | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                  | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to identify dangerous situations<br><input type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b> <u>Frank will engage in group activities.</u>                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Outcome #2</b> <u>When going to work Frank will use iPod w/ headphones, 1 other item of choice to</u>                                                                                                                                                                                                                                                                                                                     |                                                                                                   |
| <b>Technology Use:</b> <u>uses, Computer, iPad, iPod - uses CD player. Laptop</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>Slatta meds</u>                                                                                                                                                                |                                                                                                                                                                       | <b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>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<br>Location:                                                         |
| <b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Sugar - sweets mood - salty - over sugar</u>                                                                                 |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>right chest muscles.</u><br><u>loud noise, walking fast.</u>                                                                                               |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Staff would help if needed</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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed                                                                      | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <b>Community &amp; Water Safety Skills</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Strong swimmer / Staff to stay safe / Very trusting of others</u>                                                                                            |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor</u> , <u>sensitive light</u> , <u>de spraxia (physical)</u> , <u>Shallow breathing</u>                                                                   |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>Checking on him</u> , <u>pushed some one. trying to get some where</u> , <u>yelling + redirection</u> , <u>quite place 1 step direction</u> |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Important To:</b> <u>family. being able to watch movies, reading, having his things.</u>                                                                                                                                                                                    | <b>Important For:</b> <u>engage. quite place to go.</u>                                                                                                               |                                                                                                                                                             |
| <b>Likes:</b> <u>being out in community</u>                                                                                                                                                                                                                                    | <b>Dislikes:</b> <u>having to wait / loud noises</u>                                                                                                                  |                                                                                                                                                             |
| <b>Describe Communication Style:</b> <u>Label. Short sen. yes / no questions</u><br><u>doesn't like alot of questions</u>                                                                                                                                                      |                                                                                                                                                                       |                                                                                                                                                             |

Staff: Games, Suzie

Date: 11/4/2021



Service Recipient: Brock 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                          | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                             | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Lack of understanding of sexuality<br><input type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to identify dangerous situations<br><input type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>Visit his peers</u>                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Outcome #2 <u>Using choice graphics</u>                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   |
| Technology Use: <u>home - Computer touch screen / Kindle /</u>                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |

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

Does the person require support in this area?

|                                                                                                                                                                                                    |                                                                                                                                                                                             |                                                                                                                                                             |
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| Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Seared</u>                                                                                                |                                                                                                                                                                                             | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                          |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Controlled by meds - last one 10/24</u>                                                                |                                                                                                                                                                                             | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>bite size - and everything slow down</u>                |                                                                                                                                                                                             |                                                                                                                                                             |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                                             |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>meds w/ Chocolate milk</u>                     |                                                                                                                                                                                             |                                                                                                                                                             |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>Paralysis on left side</u>                                                                  |                                                                                                                                                                                             |                                                                                                                                                             |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Staff will walk by him prompt by rock, curb, etc</u> | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Follow Safety rules, Remm Close if abt</u>                                                             |                                                                                                                                                                                             |                                                                                                                                                             |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>deaf, does understand some signs</u>                                                           |                                                                                                                                                                                             |                                                                                                                                                             |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                              |                                                                                                                                                                                             |                                                                                                                                                             |
| Important To: <u>around peers, Watch people invite him to do things, play days</u>                                                                                                                 | Important For: <u>make own choices, staff understands him.</u>                                                                                                                              |                                                                                                                                                             |
| Likes: <u>around peers, Choc. milk, iPad</u>                                                                                                                                                       | Dislikes: <u>if he doesn't want he won't doesn't like being told what to do</u>                                                                                                             |                                                                                                                                                             |
| Describe Communication Style: <u>Some Sign language.</u>                                                                                                                                           |                                                                                                                                                                                             |                                                                                                                                                             |

Staff: John GebhardtService Recipient: Adam FishDate: 11-3-21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b><br><u>Adam will follow staff re-direction</u>                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Outcome #2</b> <u>Adam on Fridays will plan his schedule with staff for the next week.</u>                                                                                                                                                                                                                                                                                                                                           |                                                                                                              |
| <b>Technology Use:</b> <u>I Pad, TV,</u>                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

## Self-Management Assessment (SMA) &amp; 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>Tegretol and celexa medication</u><br><u>Allergies</u>                                                                                                                                  | <b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                            |
| <b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Hx of seizures/triggered by loud repetitive noises</u>                                                                                                                               | <b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                  |
| <b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Has difficulty swallowing food, Has GERD - Special Diet - no Milk, no salts, Must have access to water.</u>                              |                                                                                                                                                                                                                                                                                                                                      |
| <b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>GERD - Special Diet of no Milk, no salt</u><br><u>BI Polar Disorder, Mood Swings, Anxiety, Drinks with straw, Sleep Disorder.</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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Wears AFO's</u>                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                      |
| <b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>uses wheel chair, strapped down.</u><br><input checked="" type="checkbox"/> Support straps/belts needed <u>correctly fastened.</u> | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Does not swim</u>                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                      |
| <b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to startling noises.</u>                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                      |
| <b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Re-direct, Reminders/verbal cues</u><br><u>Have a quiet place to relax and calm down.</u>                                                               |                                                                                                                                                                                                                                                                                                                                      |
| <b>Important To:</b><br><u>Music, Soap Operas, Animals/dogs</u>                                                                                                                                                                                                                         | <b>Important For:</b><br><u>A calm &amp; quiet environment</u>                                                                                                                                                                                                                                                                       |
| <b>Likes:</b> <u>Music, Animal-Pet Therapy</u><br><u>Game Shows, magazines</u>                                                                                                                                                                                                          | <b>Dislikes:</b> <u>not being included</u><br><u>loud noises.</u>                                                                                                                                                                                                                                                                    |
| <b>Describe Communication Style:</b><br><u>Verbal communication</u>                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                      |

Staff: John GebhardtDate: 11-3-21Service Recipient: Brian Gray

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>Unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>He participate in Group Down Time Activity</u>                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2 <u>Will use a choice Board</u>                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                              |
| Technology Use: <u>I pad with Apps used at home</u>                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Self Meds,</u>                                                                                            | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                   |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Hx of Seizures,</u>                                                                                    | Seizure PRN: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                        |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                               |                                                                                                                                                                                                                                                                                                                                      |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                                                                                                                                                                                      |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>If needed will take with assistance</u>           |                                                                                                                                                                                                                                                                                                                                      |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>No out door outing or activity when Temps are over 90°F</u>                         |                                                                                                                                                                                                                                                                                                                                      |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Follow General Pedestrian Rules with Staff</u>                                              |                                                                                                                                                                                                                                                                                                                                      |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seekr deep sensory input. offer to use hand and arm squeezers gently.</u>                      |                                                                                                                                                                                                                                                                                                                                      |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>History of eating in edibles,</u>                                         |                                                                                                                                                                                                                                                                                                                                      |
| Important To: <u>Engage in sensory activities, Have choices.</u>                                                                                                                                   | Important For: <u>Staying Engaged in Sensory Activities.</u>                                                                                                                                                                                                                                                                         |
| Likes: <u>Puzzles, Swings, car rides, Swimming, music, sensory stuff.</u>                                                                                                                          | Dislikes: <u>Desserts, Windy places, Wearing Tank Tops, wieghting.</u>                                                                                                                                                                                                                                                               |
| Describe Communication Style: <u>Non-verbal. Vocal sounds, body language</u>                                                                                                                       |                                                                                                                                                                                                                                                                                                                                      |

Staff: John GebhardtDate: 11-3-21Service Recipient: Brock 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                           | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                              | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> <del>Verbally/physically abusive to others</del><br><input checked="" type="checkbox"/> <del>"Victim" history exists.</del><br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> <del>Engages in self-injurious behaviors</del><br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Will visit peers in Program Area.</u>                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Outcome #2 <u>Use his choice Cards</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |
| Technology Use: <u>Has Touch Screen Computer &amp; Kindle at home</u>                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u>                                                                                                                                 | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                        |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Hx of seizures. Med. controlled</u>                                                                                                       | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                              |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Cut up food to small bite sizes. slow eat, chew thorough</u>                              |                                                                                                                                                                                                                                                                                                                                                           |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                           |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Needs assistance with Meds and drinks chocolate milk.</u>                        |                                                                                                                                                                                                                                                                                                                                                           |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Partial paralysis on Left side. Needs support on Left side</u>                                                      |                                                                                                                                                                                                                                                                                                                                                           |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports<br><u>Walk with him, offer a hand.</u><br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Follow all safety Rules. Be close to him</u>                                                                                              |                                                                                                                                                                                                                                                                                                                                                           |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Deaf; can hear and sense vibrations. use body language and sign language</u>                                                      |                                                                                                                                                                                                                                                                                                                                                           |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                           |
| Important To: <u>Being around his peers. Invite him to participate.</u>                                                                                                                                                               | Important For: <u>To help him make his own choices.</u>                                                                                                                                                                                                                                                                                                   |
| Likes: <u>Room staff, being around people. iPad. Tearing Paper</u>                                                                                                                                                                    | Dislikes: <u>Telling him what to do taking medications</u>                                                                                                                                                                                                                                                                                                |
| Describe Communication Style:<br><u>sign language, facial expressions, body language.</u>                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                           |

Staff: John Gebhardt



Service Recipient: Frank Spevak

Date: 11-3-21

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

#### Outcome #1

Will engage in lessons & activities

#### Outcome #2

When going to work, he will limit his personal items to

Technology Use: Computer, iPad, iPod, his iPod and headphones and 1 item.

Has own laptop

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

Does the person require support in this area?

|                                                                                                                                                                                                                                        |                                                                                                                                                                       |                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa meds</u>                                                                                                                                |                                                                                                                                                                       | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                          |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                                                               |                                                                                                                                                                       | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Must have alternative to sugars and sweets foods</u>                            |                                                                                                                                                                       |                                                                                                                                                             |
| Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Limit physical activity. (Deep Breaths)</u><br><u>Hyperactivity history. Allow a space to calm down</u>                                 |                                                                                                                                                                       |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :                                                                                         |                                                                                                                                                                       |                                                                                                                                                             |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>Needs help with advocating his feelings/symptoms.</u>                                                                           |                                                                                                                                                                       |                                                                                                                                                             |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>If he runs. Tell him "No Street."</u>                                                    | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                                                                   |                                                                                                                                                                       |                                                                                                                                                             |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>He can swim. and get around places</u>                                                                                          |                                                                                                                                                                       |                                                                                                                                                             |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List:<br><u>Dyspraxia Disorder. Has light sensitivity</u>                                                                                              |                                                                                                                                                                       |                                                                                                                                                             |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>Ax of yelling and pushing people out of his way. Running. Redirect him to a quiet space. Check on him.</u> |                                                                                                                                                                       |                                                                                                                                                             |
| Important To: <u>Family. Internet. Movies, reading. His devices</u>                                                                                                                                                                    | Important For: <u>Participation and Engagement.</u>                                                                                                                   |                                                                                                                                                             |
| Likes: <u>Movies, iPad. Buying Things</u>                                                                                                                                                                                              | Dislikes: <u>loud environments.</u>                                                                                                                                   |                                                                                                                                                             |
| Describe Communication Style: <u>Too many questions can overwhelm him. Verbal. has short sentences and phrases.</u>                                                                                                                    |                                                                                                                                                                       |                                                                                                                                                             |

Staff: Dave Tice



Service Recipient: Bryan G.

Date: 11/3/21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                       | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>Unable to self-Regul</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Participate in group activity</u>                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2<br><u>Using a choice Board to choose activity</u>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                              |
| Technology Use: <u>At home he uses IPAD NOT AT PAI.</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:<br><u>SULFA</u>                                                                                                        |  | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>HAS A PROTOCOL BUT NO PRN med.</u>                                                                            |  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                         |  |                                                                                                                                                                       |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                       |  |                                                                                                                                                                       |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Would need assistance if he were to take meds at PAI</u> |  |                                                                                                                                                                       |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Not to go on outings if Above 90°F.</u>                                                    |  |                                                                                                                                                                       |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                                       |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                                         |  | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo           |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff will help him follow rules</u>                                                                  |  |                                                                                                                                                                       |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Used to throw self on floor. Hx of waiting deep input.</u>                                            |  |                                                                                                                                                                       |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>Will eat things that are not food. Tell him to not eat objects</u>               |  |                                                                                                                                                                       |
| Important To: <u>Painting, Playdoh</u>                                                                                                                                                                       |  | Important For: <u>Engaged &amp; active</u>                                                                                                                            |
| Engage in sensory activity                                                                                                                                                                                   |  | Dislikes: <u>Desserts, Going on walks</u>                                                                                                                             |
| Likes: <u>Car rides, swimming, sensory activity, Playdoh, painting, Puzzles, swings</u>                                                                                                                      |  | <u>Tank tops, Transitions, waiting</u>                                                                                                                                |
| Describe Communication Style:<br><u>NON-VERBAL, Vocalizations</u>                                                                                                                                            |  |                                                                                                                                                                       |

Staff: Arue JonesDate: 11.3.21Service Recipient: Adam 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Adam will follow staff redirection when inappropriate</u>                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2<br><u>2. Fridays - Adam will sit with staff and</u>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                              |
| Technology Use: <u>IPAD, TV, IPOD</u>                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <u>schedule following week</u>                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tegretol, Celebra</u>                                                                                                                                                                                        | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                   |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Triggered from bad repetitive noises</u><br><u>Adam</u><br><u>No seizures in twenty years</u>                                                                                                             | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                    |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                      |
| <u>Difficulty swallowing. Remind Adam to eat slower, GERD</u>                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                      |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Mood swings - excessive talking to &amp; talking.</u>                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                      |
| <u>BIPOLAR Anxiety, Sleep Disturbances, Hyperhydrosis</u>                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                      |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                      |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>AFO's</u>                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                      |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports<br><u>Straps in chair - throw himself from chair.</u><br><u>- suspension, check straps,</u><br><input checked="" type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>(NOT SAFE IN WATER)</u>                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                      |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Startled by loud noises. Visual impairment, Eye Fatigue, Headaches</u>                                                                                                                         |                                                                                                                                                                                                                                                                                                                                      |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>calm self in chair. Quiet place to calm.</u><br><u>THROW SELF out of chair, Redirection.</u>                                                                              |                                                                                                                                                                                                                                                                                                                                      |
| Important To: <u>Music Soap, Operas</u><br><u>Magazines</u>                                                                                                                                                                                                                                           | Important For: <u>calm quiet environment,</u><br><u>staff knows highs + lows, Straps secured</u>                                                                                                                                                                                                                                     |
| Likes: <u>Music, soap operas, Magazines</u><br><u>Being included, Game Shows, Family</u>                                                                                                                                                                                                              | Dislikes: <u>Not Being included,</u><br><u>stalling loud noises</u>                                                                                                                                                                                                                                                                  |
| Describe Communication Style:<br><u>Verbal communication, Gentle Reminders, verbal cues</u>                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                      |

Staff: DaveDate: 11/3/21Service Recipient: Block 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>Unable to Report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/><br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/><br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Block will visit peers</u>                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Outcome #2<br><u>Using Choice cards to make decision</u>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                              |
| Technology Use: <u>Computer with touch screen, Kindle</u>                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>SEASONAL</u>                                                                                                                   | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                                  |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>Controlled by meds. (Lost seizure 2012 1994)</u>                                                                            | Seizure PRN: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                                       |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Food needs to be cut into nickel size pieces. Reminders to chew slowly.</u>     |                                                                                                                                                                                                                                                                                                                                                                                     |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                     |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>(Gives Meds with chocolate milk)</u>                                   |                                                                                                                                                                                                                                                                                                                                                                                     |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Partial paralysis on left side.</u>                                                                      |                                                                                                                                                                                                                                                                                                                                                                                     |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Staff will walk near him, prompts when approaching difficult situations.</u> | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br><input type="checkbox"/> # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes<br><u>(Redirect if starting to long.) (Personal space.) Help Block follow safety rules, close supervision</u>          |                                                                                                                                                                                                                                                                                                                                                                                     |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Yes. Deaf some signs</u>                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                     |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                     |
| Important To: <u>Peers, observe others, invite him, sort manipulative.</u>                                                                                                                                                 | Important For: <u>MAKE choices + Decisions, understand him,</u>                                                                                                                                                                                                                                                                                                                     |
| Likes: <u>Ice, chocolate milk, IPAD</u>                                                                                                                                                                                    | Dislikes: <u>Doesn't want to do something he will quit.</u>                                                                                                                                                                                                                                                                                                                         |
| Describe Communication Style:<br><u>Facial expression, Ring of communication cards.</u>                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                     |

Staff: Dave Ture



Service Recipient: Frank Spivak IV

Date: 11/3/21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Frank will engage in group lessons/activities</u>                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2<br><u>When going to work Frank will limit items to IPAD + one other</u>                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |
| Technology Use: <u>Computer, IPAD, IPOD, DVD player, Laptop.</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>SO LFA</u>                                                                                    | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                               | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                   |                                                                                                                                                                       |
| <u>Sugar Restrictions</u> Redirect to SALT vs. Sugary.                                                                                                                                 |                                                                                                                                                                       |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>- Model vs verbalizing instructions</u>                                      |                                                                                                                                                                       |
| <u>Tight chest muscles - limit certain physical activities hyperactivity</u>                                                                                                           |                                                                                                                                                                       |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:                                          |                                                                                                                                                                       |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                            |                                                                                                                                                                       |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                 | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                   | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo           |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>strong swimmer, staff needs to be with him.</u>                                            |                                                                                                                                                                       |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Some fine motor disability, dyspraxia (physical), Dilated Pupils.</u>              |                                                                                                                                                                       |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>- model redirection - letting him be - one step direction</u> |                                                                                                                                                                       |
| Important To: <u>Family, movies, internet, Reading, devices</u>                                                                                                                        | Important For: <u>Participate + engages in activities.</u>                                                                                                            |
| Likes: <u>Movies, IPOD, Shopping, Community</u>                                                                                                                                        | Dislikes: <u>having to wait, loud environments</u>                                                                                                                    |
| Describe Communication Style: <u>Verbal - short sentences, one word questions</u>                                                                                                      |                                                                                                                                                                       |

Staff: Kathryn Stern

Date: 1/13/21



Service Recipient: Bryan Gray

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                           | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>participate in group activity</u>                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Outcome #2 <u>using a choice board to choose down-time activity after lunch</u>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                              |
| Technology Use: <u>IPAD at home</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>Sulfa meds</u>                                                                                         | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                   |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>seizure for 3 mins call 911 has protocol</u>                                                        | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                         |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                            |                                                                                                                                                                                                                                                                                                                                      |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                          |                                                                                                                                                                                                                                                                                                                                      |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>NO current meds at PAI</u>                     |                                                                                                                                                                                                                                                                                                                                      |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>No outings or outdoors if weather about 90 degrees</u>                           |                                                                                                                                                                                                                                                                                                                                      |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports:<br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                                                                             |                                                                                                                                                                                                                                                                                                                                      |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seeks deep sensory input</u>                                                                |                                                                                                                                                                                                                                                                                                                                      |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Pica like behaviors, puts objects in his mouth</u>                     |                                                                                                                                                                                                                                                                                                                                      |
| Important To: <u>engage in sensory activities, engaged and active</u>                                                                                                                           | Important For: <u>Sensory activities, choices, encouraged to be engaged and active</u>                                                                                                                                                                                                                                               |
| Likes: <u>puzzles, swings, car rides, swimming, sensory activities, music</u>                                                                                                                   | Dislikes: <u>desserts, going on walks when it's windy, tank tops, transitions, waiting</u>                                                                                                                                                                                                                                           |
| Describe Communication Style: <u>Vocalizations, Nonverbal, gestures, body language</u>                                                                                                          |                                                                                                                                                                                                                                                                                                                                      |

Staff: Kathryn SteinDate: 11/3/21Service Recipient: Adam Fish

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 will follow staff redirection when talking about inappropriate subjects                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Outcome #2 on Friday's, will plan schedule for the next week                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                              |
| Technology Use: <u>IPAD</u>                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                       |                                                                                                                                                                       |                                                                                                                                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>ER</u><br><u>8 celexa, Tegretol</u>                                                                                                          |                                                                                                                                                                       | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                     |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:<br><u>triggered by loud repetitive noises, Absent seizures</u>                                                                               |                                                                                                                                                                       | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                           |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>difficulty swallowing, bite sized pieces, no milk</u><br><u>uses sports cup long straw</u> |                                                                                                                                                                       |                                                                                                                                                                        |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>GERD, Bipolar, Sleep deprived disturbance, Anxiety, Hyperhydrosious</u>                                                  |                                                                                                                                                                       |                                                                                                                                                                        |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                         |                                                                                                                                                                       |                                                                                                                                                                        |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Wears AFO's</u>                                                                                                     |                                                                                                                                                                       |                                                                                                                                                                        |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>uses straps</u><br><input type="checkbox"/> Support straps/belts needed                 | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input checked="" type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                                                                                                                   |                                                                                                                                                                       |                                                                                                                                                                        |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Startle reflex, visual impairment, Eye Fatigue</u>                                                                                |                                                                                                                                                                       |                                                                                                                                                                        |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>thrashing in chair, quiet place to calm down</u>                                                          |                                                                                                                                                                       |                                                                                                                                                                        |
| Important To: <u>Soap operas, pet therapy, animals, being included</u>                                                                                                                                                                | Important For: <u>calm quiet environment, trained staff, straps secured</u>                                                                                           |                                                                                                                                                                        |
| Likes: <u>music, game shows, magazines, friends</u>                                                                                                                                                                                   | Dislikes: <u>not being included, loud noises</u>                                                                                                                      |                                                                                                                                                                        |
| Describe Communication Style:<br><u>Verbal, verbal cues, gentle reminders</u>                                                                                                                                                         |                                                                                                                                                                       |                                                                                                                                                                        |

Staff: Kathryn Stern  
Date: 11/3/21



Service Recipient: ~~IR~~ Brock Hamelton  
Brock Hamelton

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                          | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                      | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Lack of understanding of sexuality<br><input type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other:<br><u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>visit peers or other program</u><br><u>area</u>                                                                                                                                                                                                | Outcome #2 <u>using choice cards to make a decision</u>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              |
| Technology Use: <u>Computer with touch screen, kindle</u>                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u>                                                                                                                                        | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                        |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Controlled by meds</u>                                                                                                                           | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                              |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite sized/nickel sized pieces, verbal reminders "slow down"</u>                                     |                                                                                                                                                                                                                                                                                                                                                           |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                           |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Meds with chocolate milk, will spit out med sometimes</u>                                   |                                                                                                                                                                                                                                                                                                                                                           |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>partial <del>paralysis</del> <sup>ER</sup> party'sis</u>                                                                                 |                                                                                                                                                                                                                                                                                                                                                           |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Verbal prompts, will walk with him</u><br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Safety rules, staff stay close in crowds, remind him of personal space</u>                                                            |                                                                                                                                                                                                                                                                                                                                                           |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>deaf</u>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                           |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                           |
| Important To: <u>be around peers, observing others, being included</u>                                                                                                                                                                       | Important For: <u>Choices/descriptions, staff take time to understand him</u>                                                                                                                                                                                                                                                                             |
| Likes: <u>playdoh, being around people, chocolate milk, IPAD</u>                                                                                                                                                                             | Dislikes: <u>being told what to do</u>                                                                                                                                                                                                                                                                                                                    |
| Describe Communication Style: <u>nonverbal, vocalizations, body gestures, understands some sign</u>                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                           |

Staff: Kathryn Stern

Date: 11/3/21



Service Recipient: Frank Spevak

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 will engage in group lesson or activities                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2 When going to work, will limit personal items to IPOD w/ headphones and one other item of his choice                                                                                                                                                                                                                                                                                                              |                                                                                                   |
| Technology Use: <u>Computer, IPAD, IPOD, CD Player</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>Sulfa meds</u>                                                                                                                                             |                                                        | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                                                                            |                                                        | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Sugar sweets restriction</u>                                                                             |                                                        |                                                                                                                                                                       |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>tight chest muscles, hyperactivity</u>                                                                                                 |                                                        |                                                                                                                                                                       |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                                                  |                                                        |                                                                                                                                                                       |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                                    |                                                        |                                                                                                                                                                       |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                                                                              |                                                        | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                                                                                |                                                        | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo           |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                                                                                                                                 |                                                        |                                                                                                                                                                       |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Some fine motor impairment; Dyspraxia, dilated pupils, shallow breathing</u>                                                                 |                                                        |                                                                                                                                                                       |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>History of being physical with others</u><br><u>Modeling to help regulate</u> <u>history of running into the street</u> |                                                        |                                                                                                                                                                       |
| Important To: <u>family, internet, movies, reading</u>                                                                                                                                                                                              | Important For: <u>participates, quiet place to go,</u> |                                                                                                                                                                       |
| Likes: <u>Disney, movies, IPOD, being out in community</u>                                                                                                                                                                                          | Dislikes: <u>waiting, loud environment</u>             |                                                                                                                                                                       |
| Describe Communication Style:<br><u>verbal</u>                                                                                                                                                                                                      |                                                        |                                                                                                                                                                       |

Staff: Chelsie  
Date: 11/3/21



Service Recipient: Brock 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                          | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                        | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input checked="" type="checkbox"/> Other: _____ | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input checked="" type="checkbox"/> Other: _____ | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: _____ |
| Outcome #1<br><u>Visit peers another room</u>                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Outcome #2<br><u>using choice cards to make decision</u>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                    |
| Technology Use: <u>Computer with touch screen / Kindle</u>                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                    |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u>                                                                                                                                                         | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location: _____                                                                                                                                                                                                                                                   |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Controlled by meds Not one (94')</u>                                                                                                                              | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location: _____                                                                                                                                                                                                                                                         |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Bite size food</u><br><u>Verbal reminders to slow down and chew</u>                                                |                                                                                                                                                                                                                                                                                                                                                            |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: _____                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                            |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>meds with chocolate milk / might spit it out</u>                                                          |                                                                                                                                                                                                                                                                                                                                                            |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Paralysis on left side</u>                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                            |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Staff walk by him / Prompted curb / rock offer hand</u><br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff assistance / remain close / personal space</u>                                                                                                   |                                                                                                                                                                                                                                                                                                                                                            |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Deaf, understands some signs</u>                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                            |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>No</u>                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                            |
| Important To: <u>Around peers, observe others</u><br><u>Invite him to join in, soft squishy</u>                                                                                                                                                               | Important For: <u>make own decisions,</u><br><u>staff take time to understand him / communicates.</u>                                                                                                                                                                                                                                                      |
| Likes: <u>Being around people / chocolate milk</u><br><u>Ipad / ripping up paper</u>                                                                                                                                                                          | Dislikes: <u>Don't want to do what he don't want to.</u>                                                                                                                                                                                                                                                                                                   |
| Describe Communication Style:<br><u>Sign Language, facial expression</u>                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                            |

Staff: Chelsie  
 Date: 11/3/21



Service Recipient: Frank Spavak

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                           | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b><br><u>engage group lesson/activities</u><br><b>Technology Use:</b><br><u>co plays Ipad / computer / Ipad</u>                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Outcome #2</b> <u>When going to work Frank will limit his bag to Ipad/Headphones</u><br><u>one other item of his choice</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>Sulfa medications</u>                                                                                                                                          |  | <b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>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<br>Location:                                                                   |                                                                                                                                                             |
| <b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Sugar &amp; Sweets</u><br><u>redirect to salt not sugar</u>                                      |  |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tight chest muscles</u><br><u>Hyper activity -</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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>ASK</u>                                                                                                                              |  |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><input type="checkbox"/> Support straps/belts needed                                                          |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Strong swim / needs staff</u>                                                                                                                |  |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Fine motor impairments / dyspraxia</u><br><u>Shallow breathing</u>                                                                                  |  |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>He has shoved others. Yelling. (Running to street) outside</u><br><u>Written or modeling assistances. 1 step directions</u> |  |                                                                                                                                                                       |                                                                                                                                                             |
| <b>Important To:</b> <u>Family / internet</u><br><u>Watch movies / reading / devices</u>                                                                                                                                                                       |  | <b>Important For:</b> <u>Participates / engaged.</u><br><u>Ipad / movie / buying things</u><br><u>Quiet place to go</u>                                               |                                                                                                                                                             |
| <b>Likes:</b><br><u>Ipad / movie / buying things</u>                                                                                                                                                                                                           |  | <b>Dislikes:</b><br><u>Waiting / loud noises</u>                                                                                                                      |                                                                                                                                                             |
| <b>Describe Communication Style:</b><br><u>- NO Street -</u><br><u>Verbal / no several questions</u>                                                                                                                                                           |  |                                                                                                                                                                       |                                                                                                                                                             |

Staff: ChelsieDate: 11/3/21Service Recipient: Adam Fish

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Follow Staffs redirection when talking</u>                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Outcome #2<br><u>Friends sit with Staff plan his next week</u>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                              |
| Technology Use: <u>About inappropriate Subjects</u><br><u>IPad / TV</u>                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tegretol / <del>Solera</del> Celexa</u>                                                                                                                                                                      | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                         |
| Seizures <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Triggered by loud repeating noises. Absents Seizures</u>                                                                                                                                       | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                               |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Drinks out Sports cup</u><br><u>Difficulty swallowing / Bite size pieces</u><br><u>Slow down when eating / He has gura / no milk / <sup>high</sup> sodium</u> |                                                                                                                                                                                                                                                                                                                                                 |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Bi polar / Anxiety and sleep disturbance</u><br><u>Hydrohydroses (Sweating)</u>                                                                                                             |                                                                                                                                                                                                                                                                                                                                                 |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                 |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>AFOS</u>                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                 |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Straps in Chair</u><br><u>Try to throw himself out of Chair</u><br><input checked="" type="checkbox"/> Support straps/belts needed                      | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input checked="" type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Stay with him / help him move / NO swim</u>                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                 |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Startle reflex, vision impairment</u><br><u>eye fatigue</u>                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                 |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Thrashing - Safely get him to</u><br><u>Laugh at serious situation / remove him to calm down mat on the floor.</u><br><u>Quiet Place to calm down</u>                        |                                                                                                                                                                                                                                                                                                                                                 |
| Important To:<br><u>Soap operas / pet therapy</u><br><u>Being included</u>                                                                                                                                                                                                                            | Important For: <u>Calm, quiet place</u><br><u>staff knowing about highs/lows</u><br><u>Straps are Secured</u>                                                                                                                                                                                                                                   |
| Likes: <u>MUSIC / Game shows / Magazines</u><br><u>Family &amp; friends</u>                                                                                                                                                                                                                           | Dislikes: <u>Not being included</u><br><u>startling noises</u><br><u>Food he can't have</u>                                                                                                                                                                                                                                                     |
| Describe Communication Style:<br><u>Verbal ques / Gentle reminder</u>                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                 |

Staff: Chelsie

Date: 11/3/21



Service Recipient: Bryan Gray

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| <b>Outcome #1</b><br><u>Participate in Group activity</u>                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Outcome #2</b><br><u>Using A Choice board</u>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              |
| <b>Technology Use:</b> <u>Ipod At Home</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>Sulfate medications</u>                                                                                   | <b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                         |
| <b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe: <u>Protocol - call 911 after 10m</u>                                                                      | <b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes<br>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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe Equipment/Supports: <u>Antibiotic is needed</u>                          |                                                                                                                                                                                                                                                                                                                                   |
| <b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>no outings on 90° days unless its inside</u>                                    |                                                                                                                                                                                                                                                                                                                                   |
| <b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff assist</u>                                                                        |                                                                                                                                                                                                                                                                                                                                   |
| <b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>Seeking deep sensory - throw himself against wall.</u>                                         |                                                                                                                                                                                                                                                                                                                                   |
| <b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe supports: <u>Eat stuff not suppose too.</u>                                            |                                                                                                                                                                                                                                                                                                                                   |
| <b>Important To:</b><br><u>Engage in Sensory activities</u><br><u>engaged and active</u>                                                                                                                  | <b>Important For:</b> <u>Able to engage in activities/choices/encourage.</u><br><u>engaged and active</u>                                                                                                                                                                                                                         |
| <b>Likes:</b> <u>Puzzles/Swings/Car rides/</u><br><u>Swimming/Sensory/Music</u>                                                                                                                           | <b>Dislikes:</b> <u>Desserts, going windy walks</u><br><u>Tank tops/transistions/waiting</u>                                                                                                                                                                                                                                      |
| <b>Describe Communication Style:</b><br><u>Non-Verbal / Body Language</u>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                   |

Staff: Anna wrichDate: 11/3/21Service Recipient: Adam fish

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>will follow staffs redirection when being inappropriate</u>                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Outcome #2 <u>on fridays Adam will sit w/ staff and plan schedule for the next week</u>                                                                                                                                                                                                                                                                                                                                                 |                                                                                                              |
| Technology Use: <u>ipad, smart TV.</u>                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                      |  |                                                                                                                                                                       |                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tegretol, celexa</u>                                                                                                                                        |  | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |                                                                                                                                                             |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>triggered by loud repetitive noise. could have seizures.</u>                                                                                             |  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |                                                                                                                                                             |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>difficulty swallowing food that isn't cut up into bite size pieces. GERD. no milk. NO high sodium foods.</u> |  |                                                                                                                                                                       |                                                                                                                                                             |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bipolar, anxiety, sleep disturbance. Hyperhydrosis. AFO's</u>                                                                              |  |                                                                                                                                                                       |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>needs full supports.</u>                                                                            |  |                                                                                                                                                                       |                                                                                                                                                             |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>AFO's</u>                                                                                                                             |  |                                                                                                                                                                       |                                                                                                                                                             |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>CP. use straps. Staff propels chair.</u>                                                                  |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <input checked="" type="checkbox"/> Support straps/belts needed                                                                                                                                                                                      |  |                                                                                                                                                                       |                                                                                                                                                             |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>needs full assistance. cannot swim</u>                                                                                                        |  |                                                                                                                                                                       |                                                                                                                                                             |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>startle reflex to loud noise. visual impairments</u>                                                                                             |  |                                                                                                                                                                       |                                                                                                                                                             |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>thrashing in chair. move him to a mat. call parents quiet place to calm down. remove him from situation</u>                 |  |                                                                                                                                                                       |                                                                                                                                                             |
| Important To: <u>soap operas. music. Pet therapy. being included.</u>                                                                                                                                                                                |  | Important For: <u>calm environment. knowing mental health needs. secured straps.</u>                                                                                  |                                                                                                                                                             |
| Likes: <u>music, game shows, magazines. family</u>                                                                                                                                                                                                   |  | Dislikes: <u>not being included. loud noise.</u>                                                                                                                      |                                                                                                                                                             |
| Describe Communication Style: <u>Verbal</u>                                                                                                                                                                                                          |  |                                                                                                                                                                       |                                                                                                                                                             |

Staff: Anna WrichDate: 11/3/21Service Recipient: Bryan Gray

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

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

Does the person require support in this area?

|                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa medications</u>                                                                                     | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>PAI protocol - over 3 mins call all</u>                                                                | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                      |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                               |                                                                                                                                                                                                                                                                                                                                   |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                                                                                                                                                                                   |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>none at PAI. would need assistance.</u>           |                                                                                                                                                                                                                                                                                                                                   |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>not to go outdoors above 90°</u>                                                    |                                                                                                                                                                                                                                                                                                                                   |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff will help follow pedestrian safety</u>                                                |                                                                                                                                                                                                                                                                                                                                   |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>deep sensory input. &amp; history.</u>                                                         |                                                                                                                                                                                                                                                                                                                                   |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Sometimes eats inedible things Pica like behaviors.</u>                   |                                                                                                                                                                                                                                                                                                                                   |
| Important To: <u>sensory activities, staying active.</u>                                                                                                                                           | Important For: <u>sensory activities, choices encouraged to be active</u>                                                                                                                                                                                                                                                         |
| Likes: <u>Puzzles, swings, car rides swimming, sensory, music.</u>                                                                                                                                 | Dislikes: <u>desserts, walks when its windy, tank tops, transitions waiting</u>                                                                                                                                                                                                                                                   |
| Describe Communication Style: <u>non-verbal. Vocalizations. Body lang, gestures.</u>                                                                                                               |                                                                                                                                                                                                                                                                                                                                   |

Staff: Anna Wrich



Service Recipient: Brock Hamilton

Date: 11/3/21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                   | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                          | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                              | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>unable to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> <del>Inappropriate interactions with others</del><br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> <del>Verbally/physically abusive to others</del><br><input type="checkbox"/> "Victim" history exists<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> <del>Engages in self-injurious behaviors</del><br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input checked="" type="checkbox"/> Other: |
| Outcome #1 <u>will visit peers in another program area.</u>                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Outcome #2 <u>use choice cards to make a decision.</u>                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                         |
| Technology Use: <u>Computer w/ touch screen. Kindle</u>                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                         |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                          |                                                                                                                                                                                             |                                                                                                                                                             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seasonal</u>                                                                                                                                                    |                                                                                                                                                                                             | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                          |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>History. controlled by meds</u>                                                                                                                              |                                                                                                                                                                                             | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>cut into nickel size pieces. verbal reminders to slow down.</u>                                                  |                                                                                                                                                                                             |                                                                                                                                                             |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                                   |                                                                                                                                                                                             |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>use take meds w/ chocolate milk.</u>                                                                    |                                                                                                                                                                                             |                                                                                                                                                             |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Partial Paralysis on @ side</u>                                                                                                           |                                                                                                                                                                                             |                                                                                                                                                             |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Staff will walk by him. Prompts lend hand/ Arm</u><br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>needs assistance in community.</u> <span style="float: right;">reminders of Personal space</span>                                                 |                                                                                                                                                                                             |                                                                                                                                                             |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>deaf</u>                                                                                                                                             |                                                                                                                                                                                             |                                                                                                                                                             |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                                                    |                                                                                                                                                                                             |                                                                                                                                                             |
| Important To: <u>Peers, observing.</u>                                                                                                                                                                                                                   | Important For: <u>choices, taking the time to understand him</u>                                                                                                                            |                                                                                                                                                             |
| Likes: <u>play-doh. being around people. chocolate milk. iPad. ripping paper.</u>                                                                                                                                                                        | Dislikes: <u>being told what to do.</u>                                                                                                                                                     |                                                                                                                                                             |
| Describe Communication Style: <u>some signs. gestures, body language vocalizations</u>                                                                                                                                                                   |                                                                                                                                                                                             |                                                                                                                                                             |

Staff: Anna WrichService Recipient: Frank SpevakDate: 11/3/21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                           | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                    | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input checked="" type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>will engage in group activity</u>                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Outcome #2 <u>when going to work Frank will limit items to ipod, headphones and one other item of choice.</u>                                                                                                                                                                                                                                                                                                                |                                                                                                   |
| Technology Use: <u>Computer iPad iPod</u>                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>sulfa meds.</u>                                                                                                                                                          | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe:                                                                                                                                                                          | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                      |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports: <u>Sugar/sweet restrictions sugar free or salty instead.</u>                                                                 |                                                                                                                                                                                                                                                                                                                                   |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>tight chest muscles hyperactivity rapid body movements, walking quickly.</u>                                                                            |                                                                                                                                                                                                                                                                                                                                   |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe Equipment/Supports: <u>none at PAI would need assistance.</u>                                                                           |                                                                                                                                                                                                                                                                                                                                   |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – List:                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                   |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes – Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed                                                                | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>needs staff in community. overly trusting</u>                                                                                                              |                                                                                                                                                                                                                                                                                                                                   |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – List: <u>fine motor impairments, dyspraxia shallow breathing.</u>                                                                                                      |                                                                                                                                                                                                                                                                                                                                   |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes – Describe supports: <u>has shoved others, yelling modeling redirection. not asking to many questions. calm area. short one step directions, ran into street</u> |                                                                                                                                                                                                                                                                                                                                   |
| Important To: <u>family. internet. movies reading devices</u>                                                                                                                                                                                                     | Important For: <u>Participation, having a quiet place to relax</u>                                                                                                                                                                                                                                                                |
| Likes: <u>ipod. community. movies.</u>                                                                                                                                                                                                                            | Dislikes: <u>waiting. loud noise</u>                                                                                                                                                                                                                                                                                              |
| Describe Communication Style: <u>verbal</u>                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                   |

Staff: Nikki KerehukDate: 11/3/21Service Recipient: Bryan G.

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                               | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                 | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>can't report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>participate in group activity</u>                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2 <u>using choice board for sensory activity</u>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |
| Technology Use: <u>ipad @ home</u>                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sulfa meds</u>                                                                                            | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                   |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>history and protocol</u>                                                                               | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                         |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                               |                                                                                                                                                                                                                                                                                                                                      |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                                                                                                                                                                                      |
| 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>not to go outdoors in above 90°F.</u>                                               |                                                                                                                                                                                                                                                                                                                                      |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>supervision, <del>extra</del> safety skills</u>                                             |                                                                                                                                                                                                                                                                                                                                      |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seeking deep sensory input (history)</u>                                                       |                                                                                                                                                                                                                                                                                                                                      |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>tendency to eat items not edible — pika behaviors</u>                                |                                                                                                                                                                                                                                                                                                                                      |
| Important To: <u>Sensory <del>and</del> activities engaged/active</u>                                                                                                                              | Important For: <u>sensory, choices, encouraged to engage</u>                                                                                                                                                                                                                                                                         |
| Likes: <u>puzzles, swings, car rides, swimming, sensory, music</u>                                                                                                                                 | Dislikes: <u>deserts, walks in wind, tank tops, transitions, waiting</u>                                                                                                                                                                                                                                                             |
| Describe Communication Style: <u>nonverbal, vocalizations</u>                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                      |

Staff: Nikki KerelukDate: 11/3/21Service Recipient: Adam F.

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 will follow staff's redirection when talking inappropriately                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Outcome #2 Fridays - sit w/ staff                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                              |
| Technology Use: <u>leisure ipad/tv/computer</u>                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tegretol, celexa</u>                                                                                                                                            | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                         |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>history of seizures - no disorder from loud, repetitive noises "Absent seizures"</u>                                                                         | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                          |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite size pieces, eat slowly GERD, sports cup w/ straw</u>                                                       |                                                                                                                                                                                                                                                                                                                                                            |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Bipolar disorder, anxiety, sleep hyperhydrosis → dehydration, wears AFOs disturbances</u>                                                      |                                                                                                                                                                                                                                                                                                                                                            |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>not @ PAI</u>                                                                                           |                                                                                                                                                                                                                                                                                                                                                            |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>wears AFOs</u>                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                            |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><u>Cerebral Palsy (may throw himself out of chair)</u><br><input checked="" type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input checked="" type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input checked="" type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>supervision, straps on</u>                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                            |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>startle reflex to loud noises vision impairment, eye fatigue, headaches</u>                                                                          |                                                                                                                                                                                                                                                                                                                                                            |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>SIB - thrashing ... get him safely to a mat on floor and call parents quiet place to calm down</u>                              |                                                                                                                                                                                                                                                                                                                                                            |
| Important To: <u>soap operas, music, pet therapy, animals, being included.</u>                                                                                                                                                                           | Important For: <u>calm environment, staff knowing mental health, strap on</u>                                                                                                                                                                                                                                                                              |
| Likes: <u>music, game shows, soaps, magazines family, friends.</u>                                                                                                                                                                                       | Dislikes: <u>not being included, loud noises, can't eat certain foods</u>                                                                                                                                                                                                                                                                                  |
| Describe Communication Style: <u>verbal</u>                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                            |

Staff: Nikki Kereluk



Service Recipient: ~~Brock H~~  
Brock H

Date: 11/3/21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                               | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>can't report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>visit peers in another room</u>                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2 <u>choice cards</u>                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                              |
| Technology Use: <u>computer @ home, Kindle</u>                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seasonal</u>                                                                                           |  | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location: <u>          </u>                                                                             |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>history (1994) - controlled by meds</u>                                                             |  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location: <u>          </u>                                                                                   |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite/nickle size pieces, "slow down"</u>                |  |                                                                                                                                                                                                  |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>          </u>                                                                        |  |                                                                                                                                                                                                  |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>w/ chocolate milk - may spit out or pocket</u> |  |                                                                                                                                                                                                  |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>partial paralysis on left side</u>                                               |  |                                                                                                                                                                                                  |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>walk next to him - prompts offer hand</u>            |  | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker      |
|                                                                                                                                                                                                 |  | <input type="checkbox"/> 2 Person Hoyer<br><input type="checkbox"/> # staff in cares room: <u>          </u><br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>supervision, remain close, personal space</u>                                            |  |                                                                                                                                                                                                  |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>deaf</u>                                                                                    |  |                                                                                                                                                                                                  |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>          </u>                                                         |  |                                                                                                                                                                                                  |
| Important To: <u>be around peers, observe others, included, soft sensory</u>                                                                                                                    |  | Important For: <u>choices, independence, staff understand him</u>                                                                                                                                |
| Likes: <u>Dave, being w/ ppl, chocolate milk, ipad,</u>                                                                                                                                         |  | Dislikes: <u>tell him to do something, taking meds sometimes</u>                                                                                                                                 |
| Describe Communication Style: <u>some ASL, non verbal</u>                                                                                                                                       |  |                                                                                                                                                                                                  |

Staff: Nikki KerelukDate: 11/3/21Service Recipient: Frank S.

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>engage in lesson/activity</u>                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2 <u>going to work, Frank limits personal items - ipod/headphones &amp; 1 item</u>                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |
| Technology Use: <u>computer, ipad, ipod, CD player</u>                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |

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

Does the person require support in this area?

|                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sulfa meds</u>                                                                                                                   | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                   |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                                                  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                         |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>sugar/sweets restrictions - mood</u>                                           |                                                                                                                                                                                                                                                                                                                                      |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tight chest muscles, hyperactivity.</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 type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                          |                                                                                                                                                                                                                                                                                                                                      |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed                        | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>supervision / safety skills</u>                                                                                    |                                                                                                                                                                                                                                                                                                                                      |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor impairments, dyspraxia, dilated pupils, shallow breathing</u>                                              |                                                                                                                                                                                                                                                                                                                                      |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>spc history of shoving peers, yelling, time to process, one step directions, elope to street</u> |                                                                                                                                                                                                                                                                                                                                      |
| Important To: <u>family, internet, movies, readings, devices</u>                                                                                                                                                          | Important For: <u>participates/engaged</u>                                                                                                                                                                                                                                                                                           |
| Likes: <u>movies, ipod, buying things, community.</u>                                                                                                                                                                     | Dislikes: <u>waiting, loud environments</u>                                                                                                                                                                                                                                                                                          |
| Describe Communication Style: <u>verbal, short phrases, yes/no</u>                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                      |

Staff: Brock  
Date: 11-3-21



Service Recipient: Zach

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

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

Does the person require support in this area?

|                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u>                                                                                                                    | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                        |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:                                                                                                                                 | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                              |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bite size,</u>                                                                   |                                                                                                                                                                                                                                                                                                                                                           |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                           |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Chocolate milk</u>                                                      |                                                                                                                                                                                                                                                                                                                                                           |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Partial Paralysis</u>                                                                                     |                                                                                                                                                                                                                                                                                                                                                           |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>staff with him</u><br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>not close</u>                                                                                                     |                                                                                                                                                                                                                                                                                                                                                           |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Deaf</u>                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                           |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                    |                                                                                                                                                                                                                                                                                                                                                           |
| Important To: <u>Peers, observe others</u><br><u>Invite to join</u>                                                                                                                                                      | Important For: <u>Make own choices.</u><br><u>Take time to understand him.</u>                                                                                                                                                                                                                                                                            |
| Likes: <u>Soft Manipulatives</u><br><u>Being around people</u><br><u>Dave</u>                                                                                                                                            | Dislikes: <u>Being made to do stuff</u>                                                                                                                                                                                                                                                                                                                   |
| Describe Communication Style: <u>Non Verbal, Some ASL</u>                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                           |

Staff: Frank S

Date: 11-3-21



Service Recipient: Zach Weinmann

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                    | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>Engage in Group</u>                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2 <u>Going to work limit personal Items to Ipod &amp; 1 other item</u>                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |
| Technology Use: <u>CPU, Ipad, Ipad CD Players, lap top</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>Sulfa</u>                                                                               |  | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                    |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe :                                                                                        |  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                          |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>Sugar/Sweets restriction</u> |  |                                                                                                                                                                       |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tight chest muscles, Hyperactive</u>                                   |  |                                                                                                                                                                       |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :                                   |  |                                                                                                                                                                       |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                      |  |                                                                                                                                                                       |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                           |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                             |  | <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo              |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>can swim, staff with him Runs into Street.</u>                            |  |                                                                                                                                                                       |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Some fine motor impairment dysphagia, Dilated Pupils Shallow breathing.</u>  |  |                                                                                                                                                                       |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Has shoved others, yelling,</u>                         |  |                                                                                                                                                                       |
| Important To: <u>Family, Internet, reading, Having his devices</u>                                                                                                               |  | Important For: <u>Participates &amp; is engaged. Buying stuff</u>                                                                                                     |
| Likes: <u>Going out, Buying stuff</u>                                                                                                                                            |  | Dislikes: <u>loud environs</u>                                                                                                                                        |
| Describe Communication Style: <u>Verbal</u>                                                                                                                                      |  |                                                                                                                                                                       |

Staff: Zach W.

Service Recipient: Adam Fish

Date: 11-3-21



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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>Follow staff redirection</u>                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Outcome #2 <u>Fridays sit w/ staff &amp; Plan schedule 4 weeks</u>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                              |
| Technology Use: <u>Smart TV Ipad</u>                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tegretol, Gelexa</u>                                                                          |  | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                       |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Triggered by loud repetitive noises</u>                                                    |  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                             |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>GERD Sport Cup Difficult Bite-sized Pieces</u> |  |                                                                                                                                                                                                                                                                                                                                                          |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Bipolar, Anxiety &amp; sleep disturbance Hyper Hydrosis</u>                  |  |                                                                                                                                                                                                                                                                                                                                                          |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                          |  |                                                                                                                                                                                                                                                                                                                                                          |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>AFO's</u>                                                                          |  |                                                                                                                                                                                                                                                                                                                                                          |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports<br><u>Straps in chair</u>                       |  | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input checked="" type="checkbox"/> Arjo 4 change |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff with him Can't swim</u>                                                   |  |                                                                                                                                                                                                                                                                                                                                                          |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>startle reflex Visual impairment</u>                                               |  |                                                                                                                                                                                                                                                                                                                                                          |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Thrashing, Stays home when too Manic</u>                      |  |                                                                                                                                                                                                                                                                                                                                                          |
| Important To: <u>Soap operas, music, Pet therapy Being included</u>                                                                                                                    |  | Important For: <u>Calm, quiet environment, staff who know</u>                                                                                                                                                                                                                                                                                            |
| Likes: <u>Music, soaps, Game shows</u>                                                                                                                                                 |  | Dislikes: <u>Loud noises, Not being included.</u>                                                                                                                                                                                                                                                                                                        |
| Describe Communication Style: <u>Verbal</u>                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                          |

Staff: Zach W  
Date: 11-3-21



Service Recipient: Bryan G

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                               | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: <u>can't report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1 <u>Group Activity</u>                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2 <u>Using a Choice Board.</u>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                              |
| Technology Use: <u>I pad</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>Sulfa</u>                                                                                                 | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                                          |                                                                                                                                                                       |                                                                                                                                                             |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:                                                                                                           | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                                                                |                                                                                                                                                                       |                                                                                                                                                             |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                               |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:                                                      |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>No outings or outdoors over 90'</u>                                                 |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports<br><br><input type="checkbox"/> Support straps/belts needed | <table border="1"><tr><td><input type="checkbox"/> Verbal Cues<br/><input type="checkbox"/> Physical Assistance<br/><input type="checkbox"/> Posey / Gait Belt<br/><input type="checkbox"/> Walker</td><td><input type="checkbox"/> 2 Person Hoyer<br/># staff in cares room: _____<br/><input type="checkbox"/> 1 Person Hoyer / Track<br/><input type="checkbox"/> Arjo</td></tr></table> | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker                              | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo                                                                                                                                                                                                                                 |                                                                                                                                                                       |                                                                                                                                                             |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff w/ him</u>                                                                            |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seeks deep sensory input</u>                                                                   |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>PICA like behaviors</u>                                                   |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |
| Important To: <u>Engage in sensory &amp; Active</u>                                                                                                                                                | Important For: <u>Able to engage in sensory activities, choices, engaged &amp; Active</u>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                       |                                                                                                                                                             |
| Likes: <u>Puzzles, Swings, car rides, swimming sensory, Music</u>                                                                                                                                  | Dislikes: <u>Desserts, Going on walks when it's windy, Tank Tops, Transitions</u>                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                       |                                                                                                                                                             |
| Describe Communication Style: <u>Non Verbal.</u>                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                       |                                                                                                                                                             |

Staff: Dan P.  
Date: 11/3/21



Service Recipient: Brook 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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                     | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                         | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input checked="" type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input checked="" type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Visit peers in another program area</u>                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Outcome #2<br><u>Using Choice Card</u>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |
| Technology Use: <u>Computer with touch screen and Kindle</u>                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u>                                                                                                                                              | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                        |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Controlled by Meds * Not since 1994 *</u>                                                                                                              | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                                                                                                                                                                                              |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Bite Size Pieces, reminders to chew and slow down</u>                                                  |                                                                                                                                                                                                                                                                                                                                                           |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                           |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Meds with Chocolate Milk</u>                                                                  |                                                                                                                                                                                                                                                                                                                                                           |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Partial Paralysis on Left side (arm)</u>                                                                                         |                                                                                                                                                                                                                                                                                                                                                           |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Stiff walk by him, prompt when obstacles</u><br><input type="checkbox"/> Support straps/belts needed | <input checked="" type="checkbox"/> Verbal Cues<br><input checked="" type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker<br><input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>remain close if in crowd. Redirect if staring</u>                                                                                           |                                                                                                                                                                                                                                                                                                                                                           |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Deaf but responds to gestures and signs</u>                                                                                                 |                                                                                                                                                                                                                                                                                                                                                           |
| Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                           |
| Important To:<br><u>observes others, being included</u>                                                                                                                                                                                            | Important For:<br><u>Makes own choices</u>                                                                                                                                                                                                                                                                                                                |
| Likes:<br><u>playdough, being involved, ipad, observing</u>                                                                                                                                                                                        | Dislikes:<br><u>not being included, taking meds</u>                                                                                                                                                                                                                                                                                                       |
| Describe Communication Style:<br><u>Some Signs and gestures</u>                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                           |

Staff: Dan P.



Service Recipient: Frank S.

Date: 11/3/21

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                   | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                            | Financial Exploitation<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No     |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input type="checkbox"/> Inability to be assertive<br><input checked="" type="checkbox"/> Other: | <input type="checkbox"/> Inability to identify dangerous situations<br><input type="checkbox"/> Lack of community orientation skills<br><input checked="" type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>engage in group lessons and activities</u>                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Outcome #2<br><u>when going to work, limits personal items</u>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| Technology Use: <u>computer, ipad, CD player, owns laptop</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>Sulfa</u>                                                                                                                                                         |                                                                                                                                                                                  | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                          |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:                                                                                                                                                                   |                                                                                                                                                                                  | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Sugar and Sweets reduced</u>                                                                                    |                                                                                                                                                                                  |                                                                                                                                                             |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>hyperactivity</u><br><u>Tight Chest muscles, limit some physical activities.</u>                                                                 |                                                                                                                                                                                  |                                                                                                                                                             |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>Doesn't have scheduled meds at day program</u>                                                         |                                                                                                                                                                                  |                                                                                                                                                             |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Doesn't always report</u>                                                                                                                |                                                                                                                                                                                  |                                                                                                                                                             |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports                                                                                                                     | <input checked="" type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: _____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| <input type="checkbox"/> Support straps/belts needed                                                                                                                                                                                                       |                                                                                                                                                                                  |                                                                                                                                                             |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Very trusting, Once ran in Street</u>                                                                                                               |                                                                                                                                                                                  |                                                                                                                                                             |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>shallow breathing</u> <u>Dispraxia (affects coordination)</u> <u>Sensitive to light</u>                                                             |                                                                                                                                                                                  |                                                                                                                                                             |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>- redirect with written directions</u><br><u>- one step directions</u><br><u>has shoved others, yelling if over stimulated</u> |                                                                                                                                                                                  |                                                                                                                                                             |
| Important To:<br><u>Family, internet, reading, having devices</u>                                                                                                                                                                                          | Important For:<br><u>Participates in activities, having quiet spot</u>                                                                                                           |                                                                                                                                                             |
| Likes:<br><u>ipod, buying things in community</u>                                                                                                                                                                                                          | Dislikes:<br><u>loud environment</u>                                                                                                                                             |                                                                                                                                                             |
| Describe Communication Style:<br><u>Verbal</u> <u>short, stilted phrases,</u> <u>Does not like multiple questions in a row</u>                                                                                                                             |                                                                                                                                                                                  |                                                                                                                                                             |

Staff: Don P

Date: 11/3/21



Service Recipient: Brian G.

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

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

Does the person require support in this area?

|                                                                                                                                                                                                                               |                                                                                                                                                                       |                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa</u>                                                                                                                            |                                                                                                                                                                       | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                         |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe:                                                                                                                                      |                                                                                                                                                                       | Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                               |
| Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:                                                                                          |                                                                                                                                                                       |                                                                                                                                                            |
| Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:                                                                                                                        |                                                                                                                                                                       |                                                                                                                                                            |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:<br><u>if needed med here like antibiotic we could be no scheduled meds here</u> |                                                                                                                                                                       |                                                                                                                                                            |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>if above 90° avoid outdoor activities</u>                                                                   |                                                                                                                                                                       |                                                                                                                                                            |
| Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports:<br><u>Monitor Pedestrian skills when in community</u>                                 | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes                                                                                                                           |                                                                                                                                                                       |                                                                                                                                                            |
| Sensory Disabilities <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>History of wanting deep sensory input</u>                                                                   |                                                                                                                                                                       |                                                                                                                                                            |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:<br><u>Sometimes eats unedible things</u>                                                                |                                                                                                                                                                       |                                                                                                                                                            |
| Important To: <u>engaged and active</u><br><u>Sensory activities (Paint, Playdough, clay)</u>                                                                                                                                 | Important For: <u>having choices, encourage active choice</u><br><u>able to engage in sensory activities</u>                                                          |                                                                                                                                                            |
| Likes: <u>Music,</u><br><u>Puzzles, Swings, Car rides, swimming, sensory</u>                                                                                                                                                  | Dislikes: <u>Transitions, Waiting</u><br><u>Desserts, walking in wind, Tank Tops</u>                                                                                  |                                                                                                                                                            |
| Describe Communication Style:<br><u>Non Verbal, gestures body language</u>                                                                                                                                                    |                                                                                                                                                                       |                                                                                                                                                            |

Staff: Dan P.



Service Recipient: Adam F

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<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                | Physical Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                              | Self-Abuse<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                       | Financial Exploitation<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality<br><input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation<br><input checked="" type="checkbox"/> Inability to be assertive<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to identify dangerous situations<br><input checked="" type="checkbox"/> Lack of community orientation skills<br><input type="checkbox"/> Inappropriate interactions with others<br><input checked="" type="checkbox"/> Inability to deal with aggressive persons<br><input checked="" type="checkbox"/> Verbally/physically abusive to others<br><input type="checkbox"/> "Victim" history exists<br><input type="checkbox"/> Other: | <input type="checkbox"/> Dresses inappropriately<br><input type="checkbox"/> Refuses to eat<br><input checked="" type="checkbox"/> Inability to care for self-help needs<br><input checked="" type="checkbox"/> Lack of self-preservation/ safety skills<br><input checked="" type="checkbox"/> Engages in self-injurious behaviors<br><input type="checkbox"/> Neglects/refuses to take medications<br><input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters<br><input type="checkbox"/> Other: |
| Outcome #1<br><u>Follow redirection when inappropriate</u>                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Outcome #2<br><u>Fridays will plan next week schedule</u>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                              |
| Technology Use: <u>ipad, computer</u>                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                              |

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

Does the person require support in this area?

|                                                                                                                                                                                                                                        |                                                                                                                                                                       |                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tegretol and Celexa</u>                                                                                                                       | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                               |                                                                                                                                                            |
| Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Seizure like symptoms with loud noises</u>                                                                                                 | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes<br>Location:                                                                                     |                                                                                                                                                            |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>Bite size pieces and remind to chew slowly, Drinks from Straws</u>                         |                                                                                                                                                                       |                                                                                                                                                            |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u><del>Gout</del> Bipolar, anxiety, and sleep disturbance</u>                                                               |                                                                                                                                                                       |                                                                                                                                                            |
| Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :<br><u>A</u>                                                                                        |                                                                                                                                                                       |                                                                                                                                                            |
| Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>A.F.D.S., Straps on Chair</u>                                                                                        |                                                                                                                                                                       |                                                                                                                                                            |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports<br><u>Chest and lap belt</u><br><input checked="" type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues<br><input type="checkbox"/> Physical Assistance<br><input type="checkbox"/> Posey / Gait Belt<br><input type="checkbox"/> Walker | <input type="checkbox"/> 2 Person Hoyer<br># staff in cares room: ____<br><input type="checkbox"/> 1 Person Hoyer / Track<br><input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes                                                                                                                                    |                                                                                                                                                                       |                                                                                                                                                            |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:<br><u>Startle reflex, eye fatigue</u>                                                                                                 |                                                                                                                                                                       |                                                                                                                                                            |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:<br><u>Can move around and rock in chair when manic. Have a quiet place</u>                                                  |                                                                                                                                                                       |                                                                                                                                                            |
| Important To:<br><u>Soap operas, music, Pet therapy</u>                                                                                                                                                                                | Important For: <u>make sure straps are secure</u><br><u>calm quiet environment, staff understanding highs and lows</u>                                                |                                                                                                                                                            |
| Likes:<br><u>being included, magazines, family</u>                                                                                                                                                                                     | Dislikes:<br><u>Being uninvited</u>                                                                                                                                   |                                                                                                                                                            |
| Describe Communication Style:<br><u>Verbal communication, gentle reminders</u>                                                                                                                                                         |                                                                                                                                                                       |                                                                                                                                                            |