

Staff: Ray Ceragishi  
 Date: 11/23/21



Service Recipient: Cassey Haft

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>physical activity with the help of staff</u>		Outcome #2 <u>will decide what to purchase in the community</u>	
Technology Use: <u>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>perfume, cigarette smoke, straw + hay, mold, dust, pollen, after shave, reschedule outings if high of allergens.</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>no seeded fruits + veggies dairy products, raisins, grapes and blueberries, no wheat. liver + pancreas malfunction, food cut in pickle size, drink slowly</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>scoliosis, DD, trisomy 13 disorder, hearing impairment, asthma, diverticulitis</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>would need help with staff assistance to pass any meds needed</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>diverticulitis, scoliosis, trisomy 13</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>scoliosis, likes to wear slippers + socks</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<input checked="" type="checkbox"/> Support straps/belts needed <u>"1,2,3 stand" giving her time and come back</u>	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff model community safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>certain food textures, noises or too close busy room.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>bites hands, slaps surfaces, throws herself on the floor. Int, scratch, bite, grab hair or throw items. redirection and finding out what's wrong or bothering her</u>	
Important To: <u>relaxing, magazines, being included, mom</u>	Important For: <u>exercise, encouraging participating, active movement and choices, time for transitions, clear walk way</u>
Likes: <u>to laugh, magazines, participation music, walking, time</u>	Dislikes: <u>not given time, transitions, being told no</u>

Describe Communication Style: understands vocal, some signs, vocalizations gentle reminders, short verbal requests

Staff: Rey Ceragioli



Service Recipient: Melissa Coffey

Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>will 3x a week take a 5 minute walk</u>		Outcome #2 <u>independently put away items before during another activity</u>	
Technology Use: <u>Ipad, T.V. sensors</u>			

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

Does the person require support in this area?

Allergies  No  Yes - List:

Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe: history of seizures in the past last one in the 80s  
Seizure PRN  No  Yes  
Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: staff will cut her food and keep an eye on her and remind her to slow down.  
Ileostomy: avoid raw veggies, popcorn or nuts

Chronic Medical Conditions  No  Yes - List: No

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: no meds at PAI but staff would help if needed.

Specific Health & Medical Needs  No  Yes - List: heat sensitivity/shade + water, wheelchair, ~~skin~~ eat lotion, deodorant, flat hand on her hand and use a firm voice

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
unsteady, staff assistance, cautious on steps, reminding to use handrails  
 Support straps/belts needed "mom doesn't like that"

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 help with safety in the community.

Sensory Disabilities  No  Yes - List: fine motor tasks, encourage her to do things that she can accomplish on her own.

Self-Management of Behaviors  No  Yes - Describe supports: biting herself, digging her nails into her skin. Be firm and direct. Yes or No questions if visible in distress

Important To: music, shredding, going for walks, sensory activities

Important For: dietary needs, walking, prompting her to communicate.

Likes: joking around, messing with people, helping

Dislikes: Being rushed, physical touch, being told what to do when she doesn't want to do.

Describe Communication Style: Some Verbal / single words, vocalizations, sign language, give her time to respond.

Staff: Suzie Games

Service Recipient: Cassie H.

Date: 11/23/21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

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Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily, Cassie will engage in a physical activity with staff.</u>		Outcome #2 <u>Cassie will choose what items she would to purchase when in the Community.</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 checked="" type="checkbox"/> Yes - List: <u>peanuts, cigarette smoke, straw, hay, mold, dust, pollen, &amp; after shave.</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>to take small bites, to eat slowly. does not chew well.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Scoliosis, asthma, hearing impairment, diverticulitis.</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 <u>Cassie will have staff support by walking next her. offering to hold her hand or upper arm near stairs.</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff needs to watch Cassie, risk of drowning.</u>	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Cassie doesn't like certain food like apple sauce. redirection away from busy/loud environments</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>walking, choice laughing, pop</u>	Important For:
Likes:	Dislikes: <u>being rushed, loud noise</u>
Describe Communication Style:	

Staff: Suzie Gaines



Service Recipient: Melissa

Date: 11/23/2021

Where People with Disabilities Connect with the Community and the World

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

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

Does the person require support in this area?

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

Staff: John Gebhardt

Service Recipient: Cassie Hunt

Date: 11-23-21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Perfume, smoke, straw/hay mold, dust, pollen, after shave</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Food cut to Nickel sizes, no seeds in fruits and veggies, no dairy, no raisins, no grapes, no blueberries, no wheat products.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Has scoliosis, D.D., Trisomy 13, Hearing Impairment, Asthma, Diabetic/diabetes</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>would need help if medication is needed.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Must drink in small amounts. Has unsteady gait, uses wheelchair.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Staff to walk close to her use the wheelchair &amp; strap belt</u> <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Needs to be with staff always</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Certain textures, sensitive to noises</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>can bang head, slap surfaces, can hit, grab hair can throw items when upset, note any SIBs</u>	
Important To: <u>walking, Relax time, Magazines, Being included</u>	Important For: <u>Exercise, participating Active movement, choices</u>
Likes: <u>Mom, having choices, Magazines, laughing, Waking</u>	Dislikes: <u>Being forced/rushed, Transitions.</u>
Describe Communication Style: <u>some signs, gentle reminders, vocals.</u>	

Staff: John Gebhardt  
 Date: 11-23-21



Service Recipient: Melissa Coffey  
~~\_\_\_\_\_~~

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Will 3x a week take a 5 minute walk.</u>		Outcome #2 <u>Will choose an activity</u>	
Technology Use: <u>The TV, iPad - Music and Pictures.</u>			

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

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>History, None since '80s</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Food gets cut up and reminder to slow down when eating food. Has Ileostomy Bag. No nuts, no popcorn.</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:	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Has heat sensitivity. Provide shade. Verbal reminders.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Unsteady Gait, Tell her to stand and offer a hand to walk.</u>	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Stay close to her, watch closely</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Fine Motor skills + abilities.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>A history of biting herself and digging fingernails into skin</u>	
Important To: <u>Music, songs, walks, Paper shredding, sensories</u>	Important For: <u>Prompting to communicate</u>
Likes: <u>walking, songs, smiles, joking around.</u>	Dislikes: <u>Being rushed, and physical touch.</u>
Describe Communication Style: <u>Verbal and vocalizations, signs. Do Practice and Repititions.</u>	

Staff: ANDREA G.

Service Recipient: CASSIE H.

Date: 11/23



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<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>engage in physical activity</u>		Outcome #2 <u>choose item to buy in community</u>	
Technology Use: <u>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>mold, dust, pollen, pecan, cigar smoke, straw, they hate shave</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>no seeded fruits/vegie wheat: cut into small size</u> <u>daily bananas grapes blueberry drink in small amounts</u> <u>after a few bites</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>scoliosis, DD, trisomy 13, hearing impair, Ascaris diverticulitis</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff help</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>scoliosis &amp; trisomy 13</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>walk next to her</u>	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<input checked="" type="checkbox"/> Support straps/belts needed	
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>Be w/ staff</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>food texture or loud noises</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>hang head throws self to floor, not grab rail</u> <u>throw items</u>	
Important To: <u>Rest &amp; relaxed: included time for transition</u>	Important For: <u>encourage to participate offer choices</u>
Likes: <u>laugh, joke magazines</u> <u>clean walk way</u>	Dislikes: <u>Regard</u>
Describe Communication Style:	

Staff: ANDREA GREEN

Service Recipient: MELISSA C.



Date: 11/23

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1: 3 times a week take 5 min walk

Outcome #2: independently put her things away

Technology Use: IPAD / TV sensory music discs

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 Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>history - none since 80's</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>popcorn, nuts</u>	<u>(1) ostomy bag</u> <u>raw veggies</u>
<u>cut food. reminders to slow down / put spoon 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>staff help</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Heat sensitivity, wheelchair for long distance (exercise)</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>unsteady, slow walker reminders to stand straight up.</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>walk on her</u>	<input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: <u>---</u> <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor test</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>history of biting &amp; digging nails in skin</u>	
Important To: <u>music, shepherding walks</u>	Important For: <u>dietary needs, walking, prompting to talk</u>
Likes: <u>helping, joking around</u>	Dislikes: <u>rushed, physical touch</u>
Describe Communication Style: <u>some verbal, sign, give time to respond</u>	

Staff: Nikki Kereluk



Service Recipient: Cassie Hanft

Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input checked="" type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input checked="" type="checkbox"/> Other:
Outcome #1 <u>daily, will engage in physical activity w/ staff</u>		Outcome #2 <u>will choose an item to purchase in community</u>	
Technology Use: <u>ipad / TV in room</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>perfume, cigarette smoke, straw, hay, mold, dust, pollen, after shave,</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: _____
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: _____	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: _____
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>no seeded fruits/veggies * avoid dairy, raisins, grapes, blueberries, wheat. → liver/pancreas</u> <u>- food cut into nickle size pieces</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>scoliosis, dd. Trisomy 13, malfunction</u> <u>hearing impairment, diverticulitis, asthma</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>No @ PAI</u> <u>would need help</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: _____	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>unsteady gait → scoliosis, Trisomy 13</u> <u>indoors w/ no shoes → at risk of slipping</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>strap on wheelchair</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>dietary restrictions, supervision at all times</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>doesn't like certain food textures</u> <u>loud/chatic environments can overstimulate</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>sometimes bang head, bite hand, slap surfaces, throw herself</u> <u>* redirection → walk, quiet space, activity</u> <u>* others: hit, bite, scratch, grab hair, throw items</u>	
Important To: <u>resting/relaxing, magazines, being included, mom,</u> <u>periods</u>	Important For: <u>exercise, encouraging participation, support movement, choices</u> <u>time for transitions</u>
Likes: <u>laughter, magazines, inclusion, walking</u>	Dislikes: <u>not given enough time, transitions,</u>
Describe Communication Style: <u>non-verbal, understands verbal, vocalizations, body language, gentle reminders</u>	

Staff: Nikki Kereluk

Service Recipient: Melissa C.



Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1 will 3x/week take 5 min walk.

Outcome #2 independently put away activity before new one

Technology Use: ipad, TV, (sensory, music, pictures)

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

Does the person require support in this area?

Allergies  No  Yes - List: \_\_\_\_\_ Epi Pen/Treatment  No  Yes Location: \_\_\_\_\_

Seizures  No  Yes - Describe: history (in past since 80's)

Seizure PRN:  No  Yes Location: \_\_\_\_\_

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: eats quickly, cut food, visually observe her, "slow down" \*ileostomy bag -> raw veggies, popcorn, nuts to avoid\*

Chronic Medical Conditions  No  Yes - List: ~~no chronic conditions~~

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: no @ PAI would need help

Specific Health & Medical Needs  No  Yes - List: heat sensitivity -> water, wheelchair, shade PICA -> reminders to not eat inedible food

Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>unsteady gait, slow, hand-in-hand</u> <u>reminders to stand up straight</u> <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
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Community & Water Safety Skills  No  Yes supervision, safety skills, friendly to strangers

Sensory Disabilities  No  Yes - List: fine motor tasks -> support in those areas  
encourage independence

Self-Management of Behaviors  No  Yes - Describe supports: history of SIB -> biting and digging nails into skin... be direct and let mom know.

Important To: music, shredding, walks, sensory

Important For: dietary needs, walking, encourage to communicate.

Likes: joking around, being helpful

Dislikes: being rushed, physical touch

Describe Communication Style: mostly non-verbal, ASL, vocalizations (time to respond)

Staff: Dennis Mauer



Service Recipient: Cassie ~~Hamft~~ Hamft

Date: 01/23/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily engage physical activity with staff</u>		Outcome #2 <u>Indicate item to purchase</u>	
Technology Use: <u>tivi and 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>perfume, cigarettes smoke, steam, hay, mold, dust, pollen, after shave,</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>no seeded fruits &amp; veggies, dairy products, raisins, grapes &amp; blueberries, wheat, cut wickled size <del>pieces</del> encourage to feed with every other fork,</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>liver &amp; pancreas malfunction, scoliosis, developmental delay, trisomy 13 disorder, hearing impairment, asthma, diverticulitis, unstable gut</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>need help with any needs</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>unsteady gait, trisomy 13 &amp; scoliosis wears slippers &amp; socks, wheelchair <del>use area rest</del></u>	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>needs to be with staff whole time</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>certain food textures, sensitive to certain noises</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>will sometimes bang her head, slap her hand, throw herself to floor, will hit, grab, bite, throw items, when frustrated / upset.</u>	
Important To: <u>rest &amp; relax, magazines, hang out with mom, clear walking area</u>	Important For: <u>exercise, encourage participation, <del>active movement</del> fine motor transitions</u>
Likes: <u>Lab, <del>magazine</del> magazine, included in group, walking</u>	Dislikes: <u>swimming, transitions</u>
Describe Communication Style: <u>understands verbal, vocalization, some signs, refers gentle reminders</u>	

Staff: Dennis Mone

Service Recipient: Melissa Kaufe



Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1: 8x a week take 5 min walk

Outcome #2: Put away activity before putting away vacuum

Technology Use: Use of iPad, TV, sensory, music, pictures

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

Does the person require support in this area?

Allergies  No  Yes - List:

Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe: has in the past, 1980's

Seizure PRN  No  Yes  
Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports:  
eats quickly, staff cut her food, seemed to slow down, ask to put her spoon down, ileostomy bag (soft food can cause blockage) Raw veggies,

no popcorn, nuts,

Chronic Medical Conditions  No  Yes - List:

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: needs help with any meds

Specific Health & Medical Needs  No  Yes - List: heat sensitivity, bring wheelchair for long distances, pica

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports:  
unsteady on her feet, no rushing her, hands at waist, cautious on slopes  
 Support straps/belts needed use hand rails,

Verbal Cues  
 Physical Assistance  
 Posey / Gait Belt  
 Walker

2 Person Hoyer  
 # staff in care room: \_\_\_\_\_  
 1 Person Hoyer / Track  
 Arjo

Community & Water Safety Skills  No  Yes be next to her help with safety issues

Sensory Disabilities  No  Yes - List: fine motor task; she pretends to not be able to do things.

Self-Management of Behaviors  No  Yes - Describe supports:  
biting ~~her~~ herself, digging into her skin

Important To: music, shredding, walking, sensory activity

Important For: even dietary, walking to store mobile, prompting her to communicate

Likes: going around with ppl, likes being walked,

Dislikes: rusted, physical touch

Describe Communication Style: sign, vocalizations, learns through practice/repetition

Staff: Chelsie  
 Date: 11/23



Service Recipient: Cassie Hurft

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> <u>Daily physical activity</u>		<b>Outcome #2</b> <u>Cassie will chose item to purchase</u>	
<b>Technology Use:</b> <u>TV, iPad</u>		<u>On outings</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>Perfume, cigarette smoke, straw, Hay, mold, dust, pollen, aftershave.</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>No seeded fruit or veggies</u> <u>Drink with every few bites</u> <u>Cut in nickel size peices</u> <u>wheat, dairy products, raisins</u> <u>Wheat, grapes, blueberries</u>	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Scoliosis, DD, Trisomy 13</u> <u>Hearing impairment, asthma, diverticulitis</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff Assist</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Wheelchair, staff assist</u> <u>IF saying no</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>No shoes indoors</u> <u>Give her back</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input checked="" type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff assist, wheelchair,</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Food texture, Noises Chaos</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Sometimes banging head,</u> <u>Bite her hand, throw self on the floor.</u> <u>For others: Hit, scratch, bite, throw items</u>	
<b>Important To:</b> <u>Time to rest, relax,</u> <u>Magazines, Being included, MOM</u>	<b>Important For:</b> <u>Exercise, encourage participate</u> <u>Active moment, choices, clear walk away</u>
<b>Likes:</b> <u>Laugh and joke, magazines</u> <u>Walking, music,</u>	<b>Dislikes:</b> <u>Time to make decisions</u> <u>Transitions</u>
<b>Describe Communication Style:</b> <u>Staff verbal requests.</u> <u>Non-verbal, vocalizations</u>	

Staff: Chelsie  
 Date: 11/23



Service Recipient: Melissa Coffee

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>3x a week 5 minute walk</u>		Outcome #2 <u>independently put away activity before choosing a new.</u>	
Technology Use: <u>Ipod, TV, Music, Pictures</u>			

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

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>History in the past not since the 80's</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Melissa eats quickly, staff will cut her food, slow down ILEO stromy bag - NO RAW veggies, nuts.</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>Staff assist</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Heat Sensitivity, Wheelchair, Pika, verbal reminders of "Don't eat that"</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>unsteady - (Hand? HAND)</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed <u>cautious on slopes</u>	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff assist</u> <u>upneelation</u> <u>Mom doesn't like that</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor tasks -</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Biting herself, Scratching and Digging nails into skin.</u> <u>Straight forward Yes or No(?)</u>	
Important To: <u>Music, Shredding, Walks, Sensory Activities.</u>	Important For: <u>Dietary Needs, Walks, Sign, Communication</u>
Likes: <u>Joking, Helpful.</u>	Dislikes: <u>Being rushed, Physical touch</u>
Describe Communication Style: <u>Some verbal, sign language.</u>	

Staff: Daniel P.

Service Recipient: Cassie H.

Date: 11/23/21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1 <u>Engage in physical activity with staff</u>	Outcome #2 <u>Choose items to purchase in community</u>
Technology Use: <u>TV and 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>Purfume, cigarettes, straw, hay, mold, dust, pollen, and aftershave</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports :  
No blueberries, wheat, cut into small (nickel pieces) No dairy

Chronic Medical Conditions  No  Yes - List: Scoliosis, D.P, Trisomy 13, Hearing and Asthma difficulties

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

Specific Health & Medical Needs  No  Yes - List:  
Diberculitis, uneasy gait when walking

Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>uneasy gait</u> <u>has strap for wheelchair in addition to seatbelt</u> <input type="checkbox"/> Support straps/belts needed <u>if says "No" give break</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
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Community & Water Safety Skills  No  Yes

Sensory Disabilities  No  Yes - List:  
Doesn't like certain textures and noises

Self-Management of Behaviors  No  Yes - Describe supports:  
Sometimes bangs head, bites hand, or throw self on floor

Important To: <u>time for transitions</u> <u>time to rest, magazines, being included, mom</u>	Important For: <u>time for transitions</u> <u>exercise, encouraging participation, support active movement</u>
Likes: <u>laughing, magazines, being involved</u>	Dislikes: <u>Being rushed, transitions</u>

Describe Communication Style:  
Understands Verbal, Vocalizes wants, some signs, short verbal requests

Staff: Dan P.



Service Recipient: Melissa C.

Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Take 5 minute walk 3x week</u>		Outcome #2 <u>independently put away activity before new one</u>	
Technology Use: <u>ipad, TV, pictures</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>in past. Not had one since 1980's</u>	Seizure PRN: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff cut her food, observe, and remind to slow down</u>	<u>avoid raw veggies, popcorn and nuts</u> <u>has ileostomy bag</u>
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>has it</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: <u>Heat sensitivity. stay in shade on hot days. has PICA</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>unsteady, slow walking, walk hand in hand, be aware of slopes, bring wheelchair on</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: ___ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>fine motor tasks</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>dig into her skin. Be firm and direct</u>	
Important To: <u>Gaffi, music, shredding</u>	Important For: <u>Dietary needs are met, walking, Prompt to Communicate</u>
Likes: <u>joking around, being helpful</u>	Dislikes: <u>being rushed</u>
Describe Communication Style: <u>Signs, vocalizes emotions, Give time to respond</u>	

Staff: Renee Schmolt  
 Date: 11/24/21



Service Recipient: Cassie H.

Where People with Disabilities Connect with the Community and the World

**Individual Abuse Prevention Plan (IAPP)**

Is the person susceptible to abuse in this area?

Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>unable to report</u>	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input checked="" type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily will engage in physical activity w/staff</u>		Outcome #2 <u>will choose an item to purchase in the community</u>	
Technology Use: <u>IPad / TV in Room</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>perfume, cigarette smoke, straw hay dust pollen after shave</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>No seeded fruit/veggies avoid dairy raisins, grapes, blueberries food cut up into nickle size wheat</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>sciosis, dd trisomy 13 hearing impairment, diverticulitis, asthma.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>none at PAT would need help</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>unsteady gait sciosis, trisomy 13 at risk for slipping indoors w/ no shoes</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>on wheelchair</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>dietary restrictions supervision at all times</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>some food textures loud/chaotic environment can overstimulate</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>Slaps surfaces throw herself when upset grabs hair, throws items bangs head bites hands scratch redirect quiet space</u>	
Important To: <u>Resting/relaxing mom being included magazines</u>	Important For: <u>exercise, encourage support movement time for transition</u>
Likes: <u>laughter walks being included magazines</u>	Dislikes: <u>Transitions &amp; not given enough time</u>
Describe Communication Style: <u>gentle reminders non-verbal, understande verbal vocalizations body language</u>	

Staff: Renee Schmitt  
 Date: 11/24/21



Service Recipient: Melissa C.

Where People with Disabilities Connect with the Community and the World

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

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

Outcome #1: will exercise 3x a week for 5 mins  
 Outcome #2: independently put away activity before new one  
 Technology Use: 1 Pad, TV (music pictures)

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

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>History of Seizures in 80's</u>	Seizure PRN: <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>eats quickly, cut food (no raw veggies, popcorn, nuts has ileostomy bag) remainder 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>would need help not @ PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>heat sensitivity food water</u> <u>PICA - reminders not to eat inedible</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports: <u>unsteady gait slow hand in hand Reminders to stand up straight</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Supervision safety skills friendly to strangers</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor skills - support in those areas encourage independence</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>History of SIB - Biting digging nails into skin bedirect and let mom know</u>	
Important To: <u>music, shredding walks Sensory</u>	Important For: <u>dietary needs walking encourage communication</u>
Likes: <u>Joking around being helpful music</u>	Dislikes: <u>Being rushed Physical touch</u>
Describe Communication Style: <u>mostly non verbal ASL vocalizations - time to respond</u>	

Wendy Snyder

Staff: ~~Wendy Snyder~~



Service Recipient: Cassie Hanft

Date: 11-23-21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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: perfume, cig smoke, straw, hay, mold, dust, pollen, aftershave	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: no seeded fruits/veggies, dairy, raisins, grapes, blueberries, no wheat Food cut in nickel size pcs, drink in small amounts	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: scoliosis, dev. delay (DD), trisomy 13; hearing impairment asthma, diverticulitis (food w/ seeds) = unsteady gait	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: would need staff help w/ meds	
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: scoliosis, trisomy 13 & unsteady gait Support straps/belts needed: straps in wheel chair	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes be w/ staff in community	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: noises, food textures	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: bang her head, bite hands, slap surfaces, throw self to floor - hits others, bites, grab hair	
Important To: rest & relax time, magazines, being involved mom	Important For: exercise, participation, choices encourage
Likes: laughing, humor, magazines music, walking	Dislikes: being rushed, transitions
Describe Communication Style: understands verbal - vocalization, some signs	

Staff: Mary Snyder  
 Date: 11-23-21



Service Recipient: Melissa Coffey

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>3 times a week - take 5 min. walk</u>		Outcome #2 <u>independently put away activity before getting new one</u>	
Technology Use: <u>iPAD - TV - music - Pictures</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>History in past - NO seizures since 1980's</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Eats quickly - Staff cut up food - reminder to slow down Ileostomy bag - some foods to avoid - raw veggies, but have popcorn or nuts</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NA</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff needs to help</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Heat sensitivity - shade, water outside, PICA = toothpaste, paper, lotion</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>unsteady, slow walking hand &amp; hand, careful on slopes, wheelchair in community</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>watch &amp; be near her</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor tasks / struggles with</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>History of biting herself, digging nails into skin,</u>	
Important To: <u>music, shredding, walks sensory activities</u>	Important For: <u>Diet needs, walking, communication support</u>
Likes: <u>joking around, being helpful,</u>	Dislikes: <u>rushed, touching</u>
Describe Communication Style: <u>Some words, sign, vocalizations, give time to respond</u>	

Staff: Kathryn Stein



Service Recipient: Cassie Hampt ER

Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>daily will engage in physical activity with staff</u>		Outcome #2 <u>Choose item to purchase in community</u>	
Technology Use: <u>TU, 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>perfume, cigarette smoke, straw, hay, mold, dust, pollen, aftershave</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>no seeded fruits or vegetables, avoid dairy, raisins, grapes, blueberries, wheat drink in small amounts</u> <u>liver and pancreas malfunction Bitesized pieces, small bites, nickel sized pieces</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Scoliosis, DD, Trisomy 13 disorder, hearing impairment, asthma, diverticulitis</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>None at PAI</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>likes shoes off, staff need to walk with her if she says NO give break try again</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>needs to staff with staff</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>dislikes certain food tasks, sensitive to sound</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Will bang her head, slap surfaces, throw self to floor.</u> <u>HAS hit, bite, scratch others</u>	
Important To: <u>time to rest and relax, magesines, being included</u>	Important For: <u>clear walkway</u> <u>exercise, encouraging participation, offer choices, being away of her menses, time for transitions</u>
Likes: <u>laugh/joke around, magesines, being included, music, walking</u>	Dislikes: <u>not being given time, transitions</u>
Describe Communication Style: <u>vocalizations, understands verbal, some sign, prefers gentle reminders</u>	

Staff: Kathryn Stein



Service Recipient: Melissa Coffee

Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 3 times a week take a 5 minute walk		Outcome #2 independently put away activity before choosing a new one	
Technology Use: <u>IPAD, TV, Pictures</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>no seizure since 1980's</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will cut her food, visually observe her, remind her to slow down ask her to put spoon down, Ileostomy bag-avoid raw vegetables, popcorn, nuts</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>1 ER</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>None at PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>heat sensitivity - shade, water, wheelchair for long distances PICA</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Unsteady, slow walking, offer hand, cautious on slopes use hand rails</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>history of sitting in the middle of the road</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor task difficulty</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>history of biting her self, scratching her self, digging nails into her own skin</u>	
Important To: <u>Shredding, going for walks, sensory activity</u>	Important For: <u>dietary needs, walking, helping her communicate</u>
Likes: <u>music, joking, Raffi, helping</u>	Dislikes: <u>being rushed, being touched</u>
Describe Communication Style: <u>Some verbal, sign language, vocalizations</u>	

Staff: Dave Tolmo

Service Recipient: Cassie Hanft

Date: 11/23/21



Where People with Disabilities Connect with the Community and the World

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

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

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

Allergies  No  Yes - List:  
perfume, cigarette smoke, straw, hay, mold, dust, pollen, alcohol

Seizures  No  Yes - Describe:

Epi Pen/Treatment  No  Yes  
Location:

Seizure PRN  No  Yes  
Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports:  
No seeded vegetables, dairy products, blueberries, wheat

Chronic Medical Conditions  No  Yes - List:  
Scoliosis, CP, trisomy 13 - heart impaired, Diak with every few blades, liver + pancreas malfunction - cut food into nickel size pieces

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports:  
Would need help if taken at PAI

Specific Health & Medical Needs  No  Yes - List:

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports:  
Staff need to be with her, stops clear walkway, IC strategy

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

Sensory Disabilities  No  Yes - List:  
Noises - too loud

Self-Management of Behaviors  No  Yes - Describe supports:  
Bite hand throw wrist to floor grab hair, ~~throw~~

Important To: Time for Included: Time for transitions - supporting monkey.  
Increase participation

Likes: To laugh, magazines, walking, Dislikes: Being rushed,

Describe Communication Style: Physical cues.  
Understands verbal, Vocalizations, Gentle reminders, Short verbal requests

Div  
ice  
Lit

Staff: Dave Turner



Service Recipient: Melissa C.

Date: 11.23.21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Melissa will take a five min walk x 3 weekly.</u>		Outcome #2 <u>Melissa will independently put away activity before a new one is added</u>	
Technology Use: <u>(IPAD, TV, music, pictures)</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>HAS NOT HAD a seizure since 1980's.</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>(Put your spoon down...)</u>	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>(D)</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>No meds at PAI - she would need assistance.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Heat sensitivity - She needs shade, water, + wheel chair</u>	<u>When in community.</u>
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Unsteady - slow walking, bends at waist</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed <u>Use handrails - remind Melissa</u>	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Supervise when in community.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Fine Motor Tasks</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>self injurious behavior biting, scratching - digging nails in.</u>	
Important to: <u>Music, Shredding, walks,</u>	Important For: <u>Prompting to communicate with signs</u>
Likes: <u>joking around, messing with people</u> <u>being helpful</u>	Dislikes: <u>being rushed</u>
Describe Communication Style: <u>Some words are verbalized, Vocalizations, Slow processing.</u>	<u>learns best with repetitive</u>

Staff: Zach Weinmann

Service Recipient: Cassie Hanft

Date: 11-23-21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1 Engage in physical activity w/ staff

Outcome #2 Choose items to purchase

Technology Use: TV, I pads,

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>Perfume, cigarette smoke, straw, hay, Mold, dust, Pollen, Aftershave,</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
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Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
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Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: No seeded Fruit veg, Nickel-sized pieces Dairy, raisins grapes, Blueberries wheat Drink every few bites small amounts.

Chronic Medical Conditions  No  Yes - List: Scoliosis, D.D., Trisomy 13, Hearing Aids, diverticulitis

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

Specific Health & Medical Needs  No  Yes - List:

Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>unsteady Gait, Strap in chair, 1..2..3.. Stand Clear surface to stand</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
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Community & Water Safety Skills  No  Yes Staff with her

Sensory Disabilities  No  Yes - List: Food textures, noises & chaos

Self-Management of Behaviors  No  Yes - Describe supports: Hit scratch bite, grab hair, Throw items when upset, Bang head, bite hands, Slap surfaces, Fall down

Important To: Time to R&R, magazines, Being included, Mom

Important For: exercise, encourage clear walking, Participation, Choices, Being aware of Menses

Likes: Laugh, Joke, Mags, Recognition of things, walking

Dislikes: Being in a loud place, transitions, Being rushed.

Describe Communication Style: Nonverbal, understands verbal, some sign,

Staff: Zach Weinmann  
 Date: 11-23-21



Service Recipient: Melissa C.

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1: 3x weekly take 5 min walk

Outcome #2: Ind put away activity by choosing new one

Technology Use: Ipad, TV

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

Does the person require support in this area?

Allergies  No  Yes - List:

Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe: Not had one since 1980s

Seizure PRN  No  Yes  
Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: cats quickly, cut food; observe  
No Raw Vegies, Nuts, Popcorn, Ileostomy Bag

Chronic Medical Conditions  No  Yes - List: Ileostomy bag

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

Specific Health & Medical Needs  No  Yes - List: Heat Sensitive, Shade/water/w/c, PCA

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports

- Verbal Cues
- Physical Assistance
- Posey / Gait Belt
- Walker

- 2 Person Hoyer
- # staff in cares room:
- 1 Person Hoyer / Track
- Arjo

Support straps/belts needed

Community & Water Safety Skills  No  Yes Model, etc.

Sensory Disabilities  No  Yes - List: Fine motor struggles

Self-Management of Behaviors  No  Yes - Describe supports: History of biting self, digging nails

Important To: Mom, Music, Sensory stuff, Shredding, walks,

Important For: Dietary stuff, walking, Having her ask for what she needs

Likes: Raffi, The elephant show, Being helpful, Joking

Dislikes: Being rushed, Physical

Describe Communication Style: Signs, some words, vocalizations, Time to process

Staff: Anna which



Service Recipient: Cassie Hanft

Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>daily, will engage in physical activity w/ staff.</u>		Outcome #2 <u>will choose item to purchase in community.</u>	
Technology Use: <u>T.V. iPad in room.</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>perfume, cigarette smoke, Hay, straw, mold, dust, pollen, aftershave.</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>NO Seeded fruits &amp; veg, no dairy, raisins, grapes, blueberries. No wheat. cut into nickle size. Liver and pancreas malfunction. drink in small amounts every few bites.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Scoliosis, D.P. trisomy 13 hearing impairment, Asthma, Diverticulitis</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>would need support. no meds at PAI.</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>unsteady gait, scoliosis, trisomy 13 wears socks, walk w/ her @ all times.</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>"1, 2, 3 stand" allow breaks.</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>model community safety. stay w/ staff.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>doesn't like certain food textures. certain noise. Loud areas.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>may bang head, slap, bite hand. may grab hair. slap, throw items. offer new/calm area. redirect to preferred activity. walks. "safe hands."</u>	
Important To: <u>time to relax, magazines, being involved / included, mom.</u>	Important For: <u>exercise, encouraging clear participation, choices, aware of <sup>walkway</sup> clear menses.</u>
Likes: <u>Laugh, jokes, magazines, music, walking around.</u>	Dislikes: <u>Not giving time, transitions being rushed, loud areas.</u>
Describe Communication Style: <u>understands verbal. short verbal prompts. vocalizations, gestures, body lang, few signs.</u>	

Staff: Anna Wrich



Service Recipient: Melissa Coffey

Date: 11/23/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>3x week take a 5 min walk.</u>		Outcome #2 <u>will independently put away one project before choosing another.</u>	
Technology Use: <u>ipad, T.V.</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>history of seizures. not since 80's follow PAI protocol</u>	Seizure PRN: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>eats quickly. cut food reminders to slow down. "Put your spoon down." ileostomy bag - avoid raw veg. No Popcorn or nuts</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>∅</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>would need full support. NO meds at PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>heat sensitive. Provide shade &amp; Bring wheelchair. Pica-eats inedible things. water.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>unsteady. slow walking. walk hand in hand. allow her to take breaks. tell her</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>model community safety. overly trusting.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>struggles w/ fine motor tasks.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>history of biting herself. digging nails into self. firm/direct redirection. yes/no questions.</u>	
Important To: <u>music, shredding, walks sensory.</u>	Important For: <u>dietary needs, walking. Prompting communication.</u>
Likes: <u>music, coloring, books, jokes, helping out.</u>	Dislikes: <u>being rushed. Physical touch.</u>
Describe Communication Style: <u>(allow time to respond) few words, signs, vocalizations, gestures, body language.</u>	