



Service Training Log – Linden

Date:

04/28/2021

All Staff

NOTE: INFORMATION IN GRAY SHADED AREAS MUST BE TYPED IN

| Training Time | Trainer Name | Training ID | Area | Content/Description |
|---------------|--|---------------|---------|--|
| 0.5 | Beth Blackorbay, Designated Coordinator | P119/ P129 | Primary | Review the following documents IAPP, SMA, CSSPA: KP Intake CSSP/CSP: KP Responsibilities and where applicable the person's IAPP (or any other appropriate plan) to achieve an understanding of the person as a unique individual & how to implement these plans as they relate to the staff's job functions. |
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| | | | | |

| Make up Date | Initial | EE ID | Last Name | Make up Date | Initial | EE ID | Last Name |
|--------------|---------|-------|----------------------|--------------|---------|-------|---------------------|
| | MJ | | Larson, Nancy | | AC | | Cox, Alice |
| | JT | | Trimble, Jenny | | AN | | Robinson, Anneliese |
| | JCB | | Xiong, Ker | | JS | | Stacken, Laura |
| | DM | | Mendez, Danielle | | MB | | Bradshaw, Morgan |
| | CR | | Rice, Colette | | AB | | Bidwell, Aleshia |
| | ES | | Sandstrom, Erin | | HS | | Her, Bao |
| | | | Johnson, Natalie | | BH | | Ailport, Betsy |
| | | | | | KB | | Bauch, Kia |
| Make Up Date | Initial | EE ID | Managers /Admin | Make up Date | Initial | EE ID | Other Attendees |
| | | | Gunderson-Palmer, M. | | | | |
| | BH | E0676 | Hinzman, Briana | | | | |
| | BB | | Blackorbay, B. | | | | |

Staff: Laura Stacken



Service Recipient: Kelly Peterson

Date: 4/28/21

Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

Form with multiple sections: Allergies (Seasonal), Seizures, Choking/Specialized Dietary Needs (Eats fast, reminders to slow down), Chronic Medical Conditions (CP, Bipolar, HHH assistance), Medication Administration, Specific Health & Medical Needs (wheelchair, footpeds), Mobility Supports Fall Risk, Community & Water Safety Skills, Sensory Disabilities, Self-Management of Behaviors, Important To/For, Likes/Dislikes, Describe Communication Style.

Staff: Kelley Pederson →



Service Recipient: _____

Date: 4/28/21

Where People with Disabilities Connect with the Community and the World

Briana Himmelman 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>Lacks verbal skills to report</u> Outcome #1 <u>TBD</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input 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>TBD</u> | | Outcome #2 <u>TBD</u> | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|--|--|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>NA</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>Reminders to slow down - does not know when full</u> <u>Healthy food choices in community</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP - @ hand, 2 hip dislocation, limited use of @ hand, scoliosis</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>N/A at PAI</u> | |
| Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Scratches on legs from independently moving</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>15' above with the NLC</u> <u>Wear boot plates</u> <u>Go down stairs</u> <u>Use hand near seat belt</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Nearsighted - No glasses</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>When called attention's wrong</u> <u>I can't explain</u> <u>throw items if upset</u> <u>will withdraw</u> <u>depression 4/6 false reporting</u> <u>goes on toilet via track</u> <u>inconsistent injury reporting</u> | |
| Important To: <u>comfy music, being involved</u> <u>happy people</u> | Important For: <u>healthy choices</u> <u>help others</u> |
| Likes: <u>arts/crafts</u> <u>happy upbeat people</u> <u>crafty music, country, choices</u> <u>church, camp</u> | Dislikes: <u>bad weather/storms</u> |
| Describe Communication Style: <u>Verbal - can be hard to understand - ask to say it differently.</u> | |

Staff: Bae



Service Recipient: Kelly P.

Date: 4/28

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>Trust stay w/ strangers</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input 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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 | <u>N/A</u> | Outcome #2 | <u>N/A</u> |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|---|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>slow down, health food choices, low sodium, bite sized pieces</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Severely back, hip displaces, lult hand, scolios, depression</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>wheel chair, foot rest on - en conveyor belt seats</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Hoyer scratches, going down ramps too fast, encourage seat belt, bruises</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>near sides, poor areas in crafts, quiet space, depression</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: | |
| Important To: <u>helping, being a part of the group, allergies</u> | Important For: <u>healthier choices, schedule</u> |
| Likes: <u>weaving, arts & crafts, making choices, camp</u> | Dislikes: <u>bad weather, storms</u> |
| Describe Communication Style: <u>verbal</u> | |

Staff: Danielle Mendez
 Date: 4.28.21



Service Recipient: Kelly Peterson

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?

Trust Strangers

| Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|--|--|--|--|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>lacks verbal skills to report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input 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>N/A</u> | | Outcome #2 <u>N/A</u> | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|--|--|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: | 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>Needs hair cutting</u> <u>Reminders to slow down</u> <u>encourage healthy food choices</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP</u> <u>Neurogenic bladder</u> <u>limited use of L hand</u> <u>Scoliosis</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>NO Meds @ PAI</u> | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Depression</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <input checked="" type="checkbox"/> Support straps/belts needed <u>MC</u> <u>#15 mins alone time</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Nearsided</u> <u>doesn't like to wear glasses</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>throws things / give her space</u> <u>Quiet</u> <u>#Depression</u> <u>#false reporting</u> | |
| Important To: <u>Country music, crafts, plans schedule</u> | Important For: <u>make healthy choices, plan schedule</u> |
| Likes: <u>Happy up beat pple</u> <u>Church</u> | Dislikes: <u>Dad</u> <u>weather / storms</u> |
| Describe Communication Style: <u>Verbal</u> | |

Staff: Alice L. Cox



Service Recipient: Kelly PERSON

Date: 9/28/21

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 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 type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>lack verbal skills</u> | <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 checked="" type="checkbox"/> Other: <u>throw items</u> | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input 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 | | Outcome #2 | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|---|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: | 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>slow down Low Sodium + fats help cutting meat</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Scobsis</u> <u>Neogen's bladder CP = limited left hand</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Wheelchair w footrests - needs Reminders</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Go down Ramps too fast Reminders to help</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Myopia won't wear glasses / History of false reporting</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>Cuts + bruises on hands May throw items Becomes withdrawn Depression</u> | |
| Important To: <u>Mom</u> | Important For: <u>Schedule, staff she knows, Crafts</u> |
| Likes: <u>church, camps activities</u> | Dislikes: <u>Storms</u> |
| Describe Communication Style: | |

Staff: Anneliese Robinson



Service Recipient: Kelly Peterson

Date: 4/28/21

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>lacks to be verbal report</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 | | Outcome #2 | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|---|--|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>peas, nut</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>slow down, encourage to make healthy decisions, need help cutting</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>schizophrenia, CP, neurogenic bladder, limited use of L. hand</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>wheelchair, encourage to wear seat belt, 15m or alone time in building</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>do not let stand</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>myopia, refuses glasses</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>throw Herry at times, give her preferred activity, offer quiet space, has depression (becomes withdrawn), history of false reporting</u> | |
| Important To: <u>make healthy choices, making own schedule, mom</u> | Important For: <u>being involved, making schedule, healthy choices</u> |
| Likes: <u>being a part of team, schedule, surfing music, fun camp</u> | Dislikes: <u>bad weather (storms)</u> |
| Describe Communication Style: <u>verbal, body gestures</u> | |

Staff: Maregan



Service Recipient: Kelly Peterson

Date: 4/28

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>can't report loves everyone</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 | | Outcome #2 | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|---|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seasonal</u> | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: | Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>slow down eating, healthy food choices help cutting tough food</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral palsy, right hip dysplasia, trouble w/ hand scoliosis</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>wheelchair, going down ramp too fast, wear seat 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 type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>low sightedness, art + crafts</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>may need time alone, has depression, false reporting</u> | |
| Important To: <u>country music having schedule with crafts mom</u> | Important For: <u>healthy choices</u> |
| Likes: <u>music, art/crafts</u> | Dislikes: <u>Storm</u> |
| Describe Communication Style: <u>verbal</u> | |

Staff: ERIN SANDSTROM
 Date: 4-28-2021



Service Recipient: KELLY PETERSON

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>LACKS REPORTING SKILLS</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 <u>N/A</u> | Outcome #2 <u>N/A</u> | | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|---|--|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>SEASONAL</u> | Epi Pen/Treatment <input 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>SLOW DOWN, HEALTHY FOOD CHOICES, LOW SODIUM & SATURATED FATS</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP - NEUROGENIC BLADDER, SCOLIOSIS LIMITED LEFT HAND USE, DEPRESSION</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>W/C - EMBOUrage SEATBELT - 15 MIN - ALONE TIME</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>MYOPIA</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>THROW ITEMS AT TIMES - GIVE SPACE, ARTS & CRAFTS QUIET SPACE</u> | |
| Important To: <u>SCHEDULE, CHOICES</u> | Important For: <u>SCHEDULE, HEALTHY CHOICES</u> |
| Likes: <u>HAPPY PEOPLE ARTS & CRAFTS</u> | Dislikes: <u>BAD WEATHER / STORMS</u> |
| Describe Communication Style: <u>VERBAL</u> | |

Staff: Aleshia Bidner

Service Recipient: Kelly Peterson

Date: 4/28/21



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>LACK VERBAL SKILLS STRANGERS</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 | | Outcome #2 | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|--|--|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>SOY/SPINAL</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>Reminders to eat slow healthy food choices</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral Palsy, Right hip dysplasia depression</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>NEED GASSES</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Wheelchair, STRAPS/seatbelt</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker |
| <input checked="" type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>likes to throw things</u> | |
| Important To: <u>FROM</u> | Important For: <u>MAKE healthy choices help others</u> |
| Likes: <u>HAPPY, up beat people, Country music, Arts and crafts</u> | Dislikes: <u>BAD weather, STORMS</u> |
| Describe Communication Style: <u>VERBAL</u> | |

Staff: Kia L. Bauch



Service Recipient: Kelly Peterson

Date: 4/28/21

Where People with Disabilities Connect with the Community and the World

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

| Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
|--|---|---|--|
| <input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>lacks verbal skills</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input 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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 <u>N/A</u> | | Outcome #2 <u>N/A</u> | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|--|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seasonal</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>slow down</u> <u>make healthy food choices</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral Palsy scoliosis</u> <u>right hip displactia depression</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>wheelchair</u> <u>alone time</u> <input checked="" type="checkbox"/> Support straps/belts needed <u>seatbelt</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo <u>4-sling</u> |
| Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>needs glasses but doesn't wear them</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>keep busy, offer quiet space</u> | |
| Important To: <u>Family</u> | Important For: <u>help her make healthy choices</u> |
| Likes: <u>happy people, country music, arts/crafts</u> | Dislikes: <u>bad weather, storms</u> |
| Describe Communication Style: <u>verbal</u> | |

Staff: Colette Ricci

Service Recipient: Kelly Peterson

Date: 4-28-21



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 type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>Lacks Verbal Skills</u> | <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 checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input 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>Skills w/ Strangers</u> | | Outcome #2 | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|---|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u> | Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: | Seizure PRN <input 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>reminders to slow down/Choosing healthy food on outings</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cerebral palsy hip displacia Scoliosis</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>depression</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports: <u>Encourage to wear belt</u> | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: | |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>false reporting likes happy people</u> | |
| Important To: <u>Country music making choices</u> | Important For: |
| Likes: <u>Church Camp arts crafts</u> | Dislikes: <u>Bad weather Storms</u> |
| Describe Communication Style: <u>Verbal</u> | |

Staff: Jenny Trimble



Service Recipient: Kelly Peterson

Date: 4/28/21

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>Lack verbal skills to react w/ strangers</u> | <input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other: | <input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other: |
| Outcome #1 <u>N/A</u> | Outcome #2 <u>N/A</u> | | |
| Technology Use: | | | |

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

Does the person require support in this area?

| | |
|---|---|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>Reminders to slow down / choosing food</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP, hip Displagia, scoliosis</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>diagnosed w/ Depression</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>w/c encourage to wear seat takes off belt</u> <input checked="" type="checkbox"/> Support straps/belts needed | <input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo |
| Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes | |
| Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: | |
| Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>false reporting</u> | |
| Important To: <u>country music, making choices, going to church, arts & crafts, camp, family</u> | Important For: |
| Likes: | Dislikes: <u>Bad storms & weather</u> |
| Describe Communication Style: <u>Verbal</u> | |

Staff: Ker King



Service Recipient: Kelley P

Date: 4/27/2021

Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

| | |
|--|--|
| Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seasonal</u> | Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: |
| Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: | 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>slow down, healthy food diet, bite sizes</u> | |
| Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>CP, neuromuscular, limit use of hand, scoliosis, depression</u> | |
| Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: | |
| Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>hide cuts / bruises</u> | |
| Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>wheelchair / put foot rest on</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 checked="" type="checkbox"/> 2 Person Hoyer # staff in care 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 | |
| Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>limit of hand, new sunglasses don't like glasses</u> | |
| Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>throwing items, depression, false reporting</u> | |
| Important To: <u>family, friends, church</u> | Important For: <u>family, health, choice</u> |
| Likes: <u>are trips, music, choices, help other</u> | Dislikes: <u>bad weather</u> |
| Describe Communication Style: <u>verbally</u> | |