



In-service Training Log - Parkway All Staff

Date:

11.2.2021

Training Time	Trainer Name	Content/Description
.75	Kennedy Norwick Jess Gunderson	Review CSSP & CSSPA responsibilities and where applicable the person's Individ. Abuse Prev. Plan (or any plan approp.) to achieve understanding of the person as a unique individual and how to implement these plans as they relate to the staff's job functions ZW & RM

Make up Date	Initial	Last Name
Lead DSP's/DSP's		
	RC	Ceragioli, Rey
	S	Gaines, Susan
	JG	Gebhardt, John
	AG	Green, Andrea
	NK	Kereluk, Nikki
11/4		Moua, Dennis
	CP	Peterson, Chelsie
	DP	Popp, Daniel
	RS	Schmidt, Renee
	NS	Snyder, Nancy
	KS	Stein, Kathryn
11/4		Turner, David
	ZW	Weinmann, Zach
	AW	Wrich, Anna

Make up Date	Initial	Last Name
Other (Subs)		
		Pratt, Anna
		Snodie, Josh
		Willis, Megan
Make up Date	Initial	Manager/Admin
		Kmetz, Kevin
		Gunderson, Jess
		Norwick, Kennedy

Staff: Dan



Service Recipient: Z.W.

Date: 11/2/21

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 checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other: <u>inability 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 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 verbally express wants/needs 1x Day</u>		Outcome #2 <u>Engaging in an activity with others</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>bite size pieces and verbal reminders to eat slowly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PRN for anxiety</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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 supervision in community and pedestrian safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Loud noises can bother him - offer headphones or/and sensory room</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offer verbal cues, break, verbal choices, and first, then, language</u>	
Important To: <u>Movies, breaks, headphones, choices</u>	Important For: <u>given choices, Praise for task completion and drinking all his best</u>
Likes: <u>Movies, Disney Music, BK, alone time</u>	Dislikes: <u>Loud noises, Dentist, Not having time to process</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Dan P.



Service Recipient: Ryan M

Date: 11/2/21

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 checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>When conversing Ryan will keep safe distance</u>		Outcome #2 <u>Work 1 x week (shredding)</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports: <u>On 1700 calorie Diet has eaten raw food in past</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Multivitamin and anxiety anxiety med at home</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Gets nose bleeds</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Needs supports and can't swim</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensitive to loud noises</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>history of inappropriate touching, Help with self regulation</u>	
Important To: <u>family, independence, being included</u>	Important For: <u>time to finish thoughts, Participates with peers, Quiet spot for relaxation</u>
Likes: <u>latchhook, Wii, arts and crafts, out to eat</u>	Dislikes: <u>being ignored and not feeling included</u>
Describe Communication Style: <u>Verbal - short explanations - give time to process</u>	

Staff: John Gebhardt

Service Recipient: Z. Westrum

Date: 11-2-21



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>Inability 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 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>He will verbally express his needs 1x Daily</u>		Outcome #2 <u>He will engage with a peer.</u>	
Technology Use: <u>yes</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:	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>Bite size food, eat slowly reminders</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>PRN assistance</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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 supervision in community</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Loud noises bother him, offer head phones and the sensory room.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Staff supports, first __, then, __</u>	
Important To: <u>Movies, Breaks, choices head phones,</u>	Important For: <u>Give him choices. Praise for completing tasks.</u>
Likes: <u>Movies, Disney songs Burger King. Alone Time</u>	Dislikes: <u>Dentist, noises, Not having time to process</u>
Describe Communication Style: <u>Verbal and vocalizations</u>	

Staff: John Gebhardt



Service Recipient: Ryan Mitchell

Date: 11-2-21

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' and 'No' and handwritten notes for Outcome #1 and Outcome #2.

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

Form with multiple sections for Allergies, Seizures, Choking/Specialized Dietary Needs, Chronic Medical Conditions, Medication Administration, Specific Health & Medical Needs, Mobility Supports, Community & Water Safety Skills, Sensory Disabilities, Self-Management of Behaviors, Important To/For, Likes/Dislikes, and Describe Communication Style.

Staff: Anna Wrich



Service Recipient: Ryan Mitchell

Date: 11/2/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input 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 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>Ryan will keep a safe distance from peers when conversing</u>		Outcome #2 <u>will work once a week on-site shredding.</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports:	<u>1700-2000 heart healthy diet.</u>
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:	<u>None at PAI anxiety med at home. \$ multivitamin</u>
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	<u>nose bleeds.</u>
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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
<input type="checkbox"/> Support straps/belts needed	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	<u>overly trusting. cannot swim needs support</u>
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	<u>sensitive to loud noise \$ routine changes.</u>
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	<u>history of inappropriate touching \$ boundaries. ask him to go to a quiet space.</u>
Important To: <u>family. independence. choices. being included.</u>	Important For: <u>participation w/ others. quiet spot. support to maintain appropriate work place boundaries.</u>
Likes: <u>latch hook. nintendo-wii. arts n crafts. out to eat. going out.</u>	Dislikes: <u>being ignored. not being included.</u>
Describe Communication Style:	<u>Verbal. short verbal prompts. paired w/ modeling</u>

Staff: Anna which



Service Recipient: Zach westrum

Date: 11/2/21

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>inability 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 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 type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>verbally express wants/needs once a day.</u>		Outcome #2 <u>engage in activity w/ Peer.</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 needs to be verbal reminders to slow down. bite size.</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>PRN - would need assistance.</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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 supervision. Pedestrian safety.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bothered by loud noise. uses headphones. offer sensory room.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>can offer verbal cues. offer break. Provide choices. first then language.</u>	
Important To: <u>movies. breaks. head-phones. choices.</u>	Important For: <u>choices. Praised for tasks drinks boost!</u>
Likes: <u>movies. disney burger king. alone time.</u>	Dislikes: <u>loud noise. Dentist. No time to process.</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Reef Ceragishi



Service Recipient: RM

Date: 11/2/21

Ryan

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports : on a 1700-2000 a day calories, healthy foods. Verbal reminders (eating raw foods)	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports : anxiety meds at home	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: nose bleeds	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff support, can't swim</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensory integration, loud noises, routine disruption/changes noises randomly behind him can startle</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>inappropriate touches, boundaries, asking him to go to a quiet place when overwhelmed or over stimulated.</u>	
Important To: <u>family, independence, choice making, being included.</u>	Important For: <u>participation with others, quiet space, support for work space boundaries, finished thoughts when answering the question</u>
Likes: <u>latch hooks, Nintendo wii, arts crafts, going out to eat, movies, outings</u>	Dislikes: <u>being ignored, not feeling included.</u>
Describe Communication Style: <u>Verbal, verbal prompts/modeling if new information processing time to think.</u>	

Staff: Rey Ceragioli



Service Recipient: Zach W
Z.W.

Date: 11/2/21

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>inability 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 type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>inability to report</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 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>Zach will verbally express his wants</u>		Outcome #2 <u>engaging with a peer with an activity</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>bite sized pieces</u> <u>verbal reminders to eat slow</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>PRN - anxiety</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<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>supports in the community and public</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bothered by noises, offer his headphones or sensory room.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offer verbal cues, offer a break first then language, offer choices</u>	
Important To: <u>movies, breaks, headphones, having choices</u>	Important For: <u>given choices, praise when completing tasks, drink boost for weight loss</u>
Likes: <u>movies, disney songs, burger king alone time.</u>	Dislikes: <u>loud noises, dentist, not having time to process</u>
Describe Communication Style: <u>verbal, pay attention to body language, scripts</u>	

Staff: Nikki Kerelak



Service Recipient: Zach W.

Date: 11/2/21

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>inability 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 type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>inability to report</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 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 verbally express wants & needs 1x/day</u>		Outcome #2 <u>engage in an activity w/ a peer.</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: -	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 in bite size pieces. Verbal reminders to eat slowly.</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PRN (anxiety)</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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>Supervision in community, pedestrian safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>loud noises - offer headphones or sensory room.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>staff offer verbal cues, break space, provide choices, first-then language.</u>	
Important To: <u>movies, breaks, headphones, choices,</u>	Important For: <u>choices, praised for completing tasks, drinks "Boost"</u>
Likes: <u>movies, disney songs, burger king, alone time.</u>	Dislikes: <u>loud noises, dentist, no time to process</u>
Describe Communication Style: <u>verbal, scripts, gestures</u>	

Staff: ANDREA G
 Date: 11/2/21



Service Recipient: Ryan M.

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 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: Keep safe distance from peers. walk once a week on shredding
 Outcome #2: work once a week on shredding
 Technology Use:

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports:	
<u>1700 heart healthy diet / give reminders to eat healthy</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<u>supp at home</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	
<u>nose bleeds</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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	<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	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	
<u>sensitive to loud noises & [scribble]</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:	
<u>inappropriate boundaries & touching</u>	
Important To: <u>being included decisions</u> <u>family, independent, choice making</u>	Important For: <u>quiet spot. ansn thoughts</u> <u>participate w/ others. maintain work</u> <u>place w/ others</u>
Likes: <u>watch news out to eat</u> <u>wii, arts n crafts movies outings</u>	Dislikes: <u>being ignored</u> <u>not included</u>
Describe Communication Style: <u>Verbal - prefers prompts (short) time to process.</u>	

Staff: ANNEKA B.
 Date: 11/2/21



Service Recipient: ZACH Western

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>inability 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 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>Beardley express wants needs once a day</u>		Outcome #2 <u>engaging in activities w/ peer</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>Bite size pieces / verbal reminders to eat slowly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PRN</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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>supervision, support to practice safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bothered by loud noises / offer headphones or sensory room</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>verbal ques. offer break provide choices first then bring</u>	
Important To: <u>movies, breaks, headphones, having choices</u>	Important For: <u>given choices, praised for completing task, drink, break</u>
Likes: <u>movies, disney songs, roleplaying, alone time</u>	Dislikes: <u>loud noises, dentist, not having time to process.</u>
Describe Communication Style: <u>Verbal.</u>	

Staff: Nancy Smyke



Service Recipient: Zach W

Date: 11-2-21

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 type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>Inability 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 type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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 checked="" type="checkbox"/> Other: <u>Inability to report</u>	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>verbally express wants & needs once per day.</u>		Outcome #2 <u>Engaging in activity with peers</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 bite size pieces</u> <u>verbal reminders to eat slowly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>PRN - assistance needed (anxiety)</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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>supervision in community, support ped. safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Bothered by loud noises, offer headphones or sensory room</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offered verbal cues, offer break, provide choices, "first-then" language</u>	
Important To: <u>movies, breaks, head phones</u> <u>choices</u>	Important For: <u>choices, praised for completely tasks</u> <u>Drinks his BOOST drink</u>
Likes: <u>movies, Disney songs, Burger King, alone time</u>	Dislikes: <u>loud noises, clutter, not having process time</u>
Describe Communication Style: <u>Verbal, watch face expressions</u>	

Staff: Jenny Snyder
 Date: 11-2-21



Service Recipient: Ryan Mitchell

Where People with Disabilities Connect with the Community and the World

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

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

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

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports <u>(In past eats raw food)</u> <u>1700-2000 calorie Heart Healthy Diet - encourage healthy foods</u>		
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Nut'l sup's at home</u>		
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Nose Bleeds - remind him to clean</u>		
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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
<input type="checkbox"/> Support straps/belts needed		
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Needs staff around</u>		
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensitive to loud noises, and disruption in routine</u>		
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>History of inappropriate touching (at home)</u>		
Important To: <u>family, independence choice making, included</u>	Important For: <u>participation w/ others quiet spot for regulation, workplace boundaries, time to finish thoughts</u>	
Likes: <u>latch hook, Nintendo WI, Arts & Crafts, going out to eat, movies</u>	Dislikes: <u>ignored, not feeling included</u>	
Describe Communication Style: <u>Verbal - prompts/shout, time to process</u>		

Staff: Chelsie



Service Recipient: Bryan Mitchell

Date: 11/21/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports: <u>1700 - 2000 diet A Day encourage healthy foods</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>nutrition supplement at home.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Nose Bleeds</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff around</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensitive loud noises, disruption in routine.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Inappropriate touching/boonelanics</u>	
Important To: <u>Family, independence, choices, being included.</u>	Important For: <u>participate with others/groups quiet place to re gather, time to finish thoughts ask A(?)</u>
Likes: <u>latch hooks, nintendo wii, arts and crafts, out to eat, movie outings</u>	Dislikes: <u>Being ignored/not feeling included</u>
Describe Communication Style: <u>Time to process Verbal, verbal prompts with short message</u>	

Staff: Chelsie



Service Recipient: Zach W. [unclear]

Date: 11/21/21

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>CAN'T REPORT</u>	<input type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>CAN'T REPORT</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 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>Zach verbally express wants/needs</u>		Outcome #2 <u>engage in activity with a peer.</u>	
Technology Use: <u>IPad</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:	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>Bite size pieces / verbal reminder to eat slowly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PRN: Anxiety</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<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>Supervision / pedestrian safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Loud noises / Breakout space / headphones</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Verbal cues, Breakout room. provide choices. First, then language</u>	
Important To: <u>MOVIES, Breaks, Headphones, Choices</u>	Important For: <u>Choices, praised for completing tasks, Drink his Boost.</u>
Likes: <u>movies, Disney, IPad, Burger King, Alone time</u>	Dislikes: <u>Loud noises, Dentist, no time to process</u>
Describe Communication Style: <u>Verbal, Character Script talking</u>	

Staff: Renee Schmitt



Service Recipient: Zack W

Date: 11-2-2021

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>inability 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 type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>inability to report</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 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>Verbally express wants need 1x aday</u>		Outcome #2 <u>imagining on a activity w/ peers</u>	
Technology Use: <u>IPad</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:	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 ditesize pieces verbal reminders to eat slowly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PRN - Anxiety</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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 <u>Supervision pedestrian safe</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>loud noises offer head phones / sensory room</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Staff offer verbal ques break, provide choices (first then)</u>	
Important To: <u>movies, breaks, head phones, choices.</u>	Important For: <u>beat drink given choices praise for completing tasks</u>
Likes: <u>movies, Disney songs, Burger King at anytime</u>	Dislikes: <u>loud noise, dentist, not having time to pusses</u>
Describe Communication Style: <u>Verbal facial expressions</u>	

Staff: Renee Schmidt
 Date: 11/2/2021



Service Recipient: Ryan M

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:		Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>encourage healthy snacks on 1700-2000 Cal diet heart healthy</u>			
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>nutritional supplement</u>			
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>nose bleeds</u>			
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed		<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	
		<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff supervision</u>			
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensory In/Integration</u> <u>loud noise disruption in routine redirecting to quiet area</u>			
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>history of throwing objects</u> <u>history of inappropriate touching</u>			
Important To: <u>being included</u> <u>family, independence choice-making,</u>		Important For: <u>work place boundaries time to</u> <u>participation w others quiet spot</u>	
Likes: <u>out to eat outings</u> <u>latch hook bingo w/ arts/crafts</u>		Dislikes: <u>ignord not feeling included</u>	
Describe Communication Style: <u>Verbal Short message time to process</u>			

Staff: Kathryn Stern
 Date: 11/2/21



Service Recipient: Ryan Mitchell

Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports: <u>on 1700-2000 calories a day diet</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>anxiety med at home</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>nose bleeds</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>can't swim</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensory integration issues difficulty with surprises</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>history of inappropriate touching, helping him with self regulation</u>	
Important To: <u>family, independence, choices, being included</u>	Important For: <u>participation with others in activities, quiet spot, work boundaries, time to process when asked a question</u>
Likes: <u>latch nook, nintendo wii, arts and crafts, restaurants, movie theaters</u>	Dislikes: <u>being ignored, not feeling included.</u>
Describe Communication Style: <u>Verbal, short verbal prompts, time to process what was said</u>	

Staff: Kathryn Steinh
Zach We



Service Recipient: Zach Westrum

Date: 11/2/21

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: inability to report	<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 checked="" type="checkbox"/> Other: inability to report	<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 verbal express his wants and needs once a day</u>		Outcome #2 <u>engaging in physical activity with a peer</u>	
Technology Use:			

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

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>bite sized pieces. verbal reminders to eat slowly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PRN for anxiety</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<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>Supervision in community, supports to practice pedestrian safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bothered by loud noises. offer headphones or sensory room</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>verbal ques from staff, break, choices, use "First" then" language</u>	
Important To: <u>movies, breaks, headphones, choices,</u>	Important For: <u>choices, praised for completing tasks, drinks boost drinks</u>
Likes: <u>movies, disney songs, burger king, alone time</u>	Dislikes: <u>loud noises, dentist, not having time to process</u>
Describe Communication Style: <u>verbal</u>	

Staff: Zach Weinmann



Service Recipient: Ryan Mitchell

Date: 11-2-21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports:	<u>Encourage healthy choices</u>
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	<u>Has staff at home for Diet Anxiety PRN @ Home</u>
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	<u>Nose Bleeds</u>
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes	<u>not trusting - can't swim</u>
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	<u>loud noises, disrupted routine</u>
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports:	<u>History of inappropriate touching. If he's upset ask him to go to a quiet place. History of Bigger Behaviors at home.</u>
Important To: <u>Family, independence, Choice making, Being included</u>	Important For: <u>Participate w/ others, quiet spot for regulation, work place Bandries</u>
Likes: <u>Latch hook, Nintendo Wii, Switch, arts & crafts, going out in general.</u>	Dislikes: <u>Being ignored, Not feeling included</u>
Describe Communication Style: <u>verbal,</u>	

Staff: Zach Weinmann



Service Recipient: Zach Westrum

Date: 11-2-21

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: <u>will 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 type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>No report</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 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>verbally express wants/needs</u>		Outcome #2 <u>Engage in activity w/ Peers</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>Bite Size, verbal Reminder to eat slowly.</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PRN - Anxiety</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<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>Supervision Pedestrian Safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>loud noises, after meal prn.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>staff can assist verbal cues</u>	
Important To: <u>Movies, Breaks, Headphones</u>	Important For: <u>Given choices, Name</u>
Likes: <u>Movies, Breaks</u>	Dislikes: <u>Drinks a Break</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Gaines, Suzie



Service Recipient: Zach W.

Date: 11/2/2021

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 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: <u>Im. 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 type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Zach will verb. his wants and needs x/daily</u>		Outcome #2 <u>engagement w/ a peer. ex: iPad / coloring!</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>Choking bite size. Verbal reminders to take it slow.</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>PRN - Anxiety.</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <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
<input type="checkbox"/> Support straps/belts needed	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>ped. safety.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>loud noises, offer headphones / or sensory room</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Staff can give verbal cues, breaks, give choices, 1st this, then 2nd</u> <u>Example: bathroom / iPad time.</u>	
Important To: <u>movies, breaks, headphones, having choices.</u>	Important For: <u>given choices, drinks his best.</u>
Likes: <u>movie, disney songs, B.K., alone time.</u>	Dislikes: <u>loud noises, dentist, not having time to process.</u>
Describe Communication Style: <u>Verbal.</u>	

Staff: Garnes, Sotie



Service Recipient: Ryan Mitchell

Date: 11/2/2021

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 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 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 type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>safe dis. when talking. (peers)</u>		Outcome #2 <u>Ryan will work 1 week on shedding to get paid.</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> Yes - Describe Equipment/Supports: <u>heart healthy \$700-3000</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>not here at PAI, At home. nose bleeds.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>nose bleeds</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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
<input type="checkbox"/> Support straps/belts needed	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>doesn't know to swim</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>loud noises. little things are harder for him; redirecting him. headphones.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>redirecting him. hand prompts make sure it's clear. asking him to talk a walk.</u>	
Important To: <u>family, choice making, being included.</u>	Important For: <u>quite spot (cs), work space, time to finish thoughts.</u>
Likes: <u>lata hook, Wii, arts/crafts, going out to eat, going outings / movies.</u>	Dislikes: <u>not feeling included.</u>
Describe Communication Style: <u>verb. prompts. time to process.</u>	

Staff: Dennis



Service Recipient: Zach Westman

Date: (1/4/21)

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:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input 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>express his wants & needs</u>		Outcome #2 <u>engage in an activity with a peer</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>bite sized</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>PRN for anxiety, need assistance for it</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> 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
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>get breaks, choices, time to process</u>	Important For:
Likes: <u>movies, disney songs, alone time, headphones</u>	Dislikes: <u>not given choices, being rushed</u>
Describe Communication Style: <u>verbal, gestures</u>	

Staff: Dennis



Service Recipient: Ryan Mitchell

Date: 11/4/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Help Ryan with reminders of Covid safety.</u>		Outcome #2 <u>Help Ryan participate in shredding once a week.</u>	
Technology Use: <u>Phone, tablet</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:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>take anxiety meds at home</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<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	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>noise level at minimum.</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>give choices</u>	Important For:
Likes: <u>games, movies, arts & crafts shopping</u>	Dislikes: <u>being ignored, not feeling included</u>
Describe Communication Style: <u>verbal</u>	

Staff: Dave Turner



Service Recipient: Zach Westrum

Date: 11/4/21

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:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input 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>To express wants + needs</u>		Outcome #2 <u>engage in activity with peer</u>	
Technology Use: <u>IPAD</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:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input 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 <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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Give time to process, offer breaks, offer choices</u>	Important For: <u>Give time to process, Give choices</u>
Likes: <u>Disney, Modics, headphones</u>	Dislikes: <u>NOT given choices, being touched</u>
Describe Communication Style: <u>Verbal, gestures</u>	

Staff: Dave True



Service Recipient: Ryan Mitchel

Date: 11/4/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Remind Ryan about covid safety</u>		Outcome #2 <u>Help Ryan participate in shuffling #1 weekly</u>	
Technology Use: <u>Phone Tablet</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 :	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input 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 <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>keep noise level down</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Give CHOICES</u>	Important For: <u>Likes Attention from staff Include Ryan</u>
Likes: <u>GAMES, MOVIES, ARTS+CRAFTS, Shopping</u>	Dislikes: <u>Being ignored NOT feeling included</u>
Describe Communication Style: <u>Verbal</u>	