



# In-service Training Log – Parkway All Staff

Date: 11/3/2021

Training Time	Trainer Name	Content/Description
1hr	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 AF, BH, FS, BG

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

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



Staff: Drea  
 Date: 11/4/21



Service Recipient: Brook Hamilton

Where People with Disabilities Connect with the Community and the World

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

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

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

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

Staff: DREA  
 Date: 11-4-21



Service Recipient: Bryan Gray

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input 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:
<b>Outcome #1</b> <u>Debra in group activity</u>		<b>Outcome #2</b> <u>To have sensory needs met</u>	
<b>Technology Use:</b>			

**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 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 checked="" type="checkbox"/> Yes			
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <u>is engaged &amp; active</u>		<b>Important For:</b> <u>sensory needs met</u>	
<b>Likes:</b> <u>puzzles, swings, cars</u>		<b>Dislikes:</b> <u>desserts, waiting, cold showers</u>	
<b>Describe Communication Style:</b> <u>non verbal (facial expressions)</u>			

Staff: Drea  
 Date: 11/4/21



Service Recipient: Frank Spiva K

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 checked="" 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 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 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  
engage in group lesson  
 Technology Use:

Outcome #2  
limit item going to work headphones only.

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sulfa</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>nyctal activity remind to take breaks</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <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>sensitive to light</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>physical emotional verbal aggression</u>	
Important To:	Important For:
Likes: <u>disney, basketball, olympics</u>	Dislikes: <u>not given choices</u>
Describe Communication Style: <u>verbal</u>	

Staff: DREA  
 Date: 11/4/21



Service Recipient: Adam Fish

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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>Monitor &amp; redirect social behavior</u>		Outcome #2 <u>plan schedule for next week</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>celebra, sulfa</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>loud noises (behavior)</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite size, gerd</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bipolar, hypol</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>soap operas music family pets</u>	Important For:
Likes: <u>games shows</u>	Dislikes: <u>loud noises</u>
Describe Communication Style: <u>verbal</u>	

Staff: Dennis



Service Recipient: Adam Fish

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 type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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>redirect social behavior</u>		Outcome #2 <u>plan schedule for next week</u>	
Technology Use:			

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

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Celebra, Sulfa</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>loud noises (behavior)</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite sized, gerd</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bipolar</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <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 checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>soap operas, music, family, PRS</u>	Important For:
Likes: <u>game shows, shredding</u>	Dislikes: <u>loud noises</u>
Describe Communication Style: <u>verbal</u>	

Staff: Dennis



Service Recipient: Frank SpivaK

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 type="checkbox"/> Yes <input checked="" 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 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 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>engage in group lesson/activity</u>		Outcome #2 <u>limit items going to work, ipod</u>	
Technology Use: <u>phone, tablet</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sulfa</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>hyper activity remind to take break</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>ff takes PRN, need staff support</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <del>physical, emotional, verbal aggression</del>	
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>sensitive to light</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>physical, emotional, verbal aggression</u>	
Important To: <del>physical, emotional, verbal aggression</del> <u>give choices</u>	Important For:
Likes: <u>disney, basketball, olympics, ipod, movies</u>	Dislikes: <u>not given choices</u>
Describe Communication Style: <u>verbal.</u>	

Staff: Dennis



Service Recipient: Brock Hamilton

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 type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>visit other peers</u>		Outcome #2 <u>make his own choices</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u><del>seasonal</del> seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 pieces</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>tabs with milk, staff support</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <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	
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>Dave + Chris friends</u>	Important For: <u>choice cards</u>
Likes: <u>soft sensory obscurng others</u>	Dislikes: <u>being told what to do, no choices</u>
Describe Communication Style: <u>nonverbal</u>	

Staff: Dennis



Service Recipient: Bryan Gray

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 type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>participate in group activities</u>		Outcome #2 <u>sensory needs met</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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 :	
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 checked="" type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seeking deep pressure sensory</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>engaged &amp; active</u>	Important For: <u>sensory, needs</u>
Likes: <u>puzzles, swings, car</u>	Dislikes: <u>dessert; waiting for bathroom</u>
Describe Communication Style: <u>vocalization, facial expressions, gestures</u>	

Staff: Rey Ceceagiori  
 Date: 11/2/21



Service Recipient: Brock H.

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

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors in <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:
<b>Outcome #1</b> <u>Brock will visit another program area</u>		<b>Outcome #2</b> <u>using his choice cards</u>	
<b>Technology Use:</b> <u>computer with touch screen, Kindle</u>			

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

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

Staff: Rey Ceragovi  
 Date: 11/3/21



Service Recipient: Bryan G.  
 Reviewed by: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

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

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

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

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>salt medications</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>seizure protocol call 911 after 3 minutes</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>meds at home, but if given meds at PAI, staff would need to assist</u>	
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>90° ↑ out door outing, is not allowed to go.</u>	
<b>Fall Risk/Mobility Supports</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <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"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff ____
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff will help Bryan follow rules and safety</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seeking deep sensory input</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>might eat things that aren't meant to be eaten. might lick.</u>	
<b>Important To:</b> <u>engage in sensory activities, engaged and active</u>	<b>Important For:</b> <u>able to engage in sensory activities having choices, encourage to be engaged and active.</u>
<b>Likes:</b> <u>puzzles, swings, car rides, swimming, sensory activities and music</u>	<b>Dislikes:</b> <u>deserts, going on walks when windy, tank tops, transitions, waiting</u>
<b>Describe Communication Style:</b> <u>non-verbal, vocalizations, body language.</u>	

Staff: Ray Crago  
 Date: 11/3/21



Service Recipient: Frank S. IV

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 checked="" 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 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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> <u>engage in activity or lessons</u>		<b>Outcome #2</b> <u>going to work, Frank will limit his personal items, to ipod and headphones and one other item</u>	
<b>Technology Use:</b> <u>computer, ipad, CD player, laptop</u>			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>celiac medications</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>surger and sweets intake redirecting to salty foods</u>	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tight chest muscles, hyperactivity, queing him to take a break, modding instead of verbal when he's overwhelmed</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>all</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff support in the community / able to swim</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>motor impairment, Dyspraxia, dilated pupils, shallow breathing</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Shoved others when overwhelmed, yelling, modding instead of verbal. leave him alone. One step directives when overwhelmed, checking up on him. running into the street when overwhelmed</u>	
<b>Important To:</b> <u>family, internet, watching movies, reading, his devices</u>	<b>Important For:</b> <u>participates and is engaged in activities, ipod, buying things, being out in the community</u>
<b>Likes:</b> <u>movies, ipad, quiet places</u>	<b>Dislikes:</b> <u>loud environments</u>
<b>Describe Communication Style:</b> <u>Verbal, short sentences.</u>	

Staff: Rey Cavagioni



Service Recipient: Adam F.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies  No  Yes - List: *tegretol and celebsa*

Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe: *Seizure like symptoms triggered by loud noises - Blank stare -*

Seizure PRN  No  Yes  
Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: *bite sized pieces, reminding to eat slowly, no milk, no sodicum, cereal*

Chronic Medical Conditions  No  Yes - List: *ADHD, Bipolar, anxiety, sleep disorder*

*Sweats easily - hyper hydro* *APOs*

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

Specific Health & Medical Needs  No  Yes - List: *APOs*

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
*Straps for his wheelchair, staff helps move his wheelchair*

Support straps/belts needed

Verbal Cues  
 Physical Assistance  
 Posey / Gait Belt  
 Walker

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

Community & Water Safety Skills  No  Yes *staying with Adam and helping*  
*can't swim*

Sensory Disabilities  No  Yes - List: *startle reflex to loud noises, vision impairment, headaches and eye phatque*

Self-Management of Behaviors  No  Yes - Describe supports: *thrashing in his chair, getting him on a mat if he won't calm down. call parents if he can't calm down. Quiet place to help, might start laughing in inappropriate situations*

Important To: *Soap operas, pet therapy, animals, being included.*

Important For: *calm, quiet environments, staff knowing his mental health, Straps are*

Likes: *music, sea operas, magazines, family, friends*

Dislikes: *Not being included, not loud noises, not being able to participate*

Describe Communication Style: *Verbal, prefers verbal ques*

Staff: Renee Sc



Service Recipient: Brock Hamilton

Date: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other: <u>Unable to 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 type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input checked="" type="checkbox"/> Other: <u>una</u>	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>met peer in other program am</u>		Outcome #2 <u>using choice cards</u>	
Technology Use: <u>Computer w/ touch screen Kandal Horn</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>History controlled by meds 1994</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bite size pieces nickel size slow down chew thoroughly</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>with chocolate milk will refuse keep offering</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Partial Paralysis - Support w/ left side</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Staff will walk by him offer hand/arm</u> <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>help w safety rules remain close in crowds</u> <u>personal space</u> <u>reduce staring</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Deaf</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>invite to join play date</u> <u>peers observe others soft sex</u>	Important For: <u>staff to understand him / his communication</u> <u>make noise and distinct</u>
Likes: <u>chocolate milk ripping paper</u> <u>around people iPad</u>	Dislikes: <u>pushing him to do things</u> <u>taking meds</u>
Describe Communication Style: <u>Deaf picture cards</u> <u>signing lip read</u>	

Staff: Renee Schmidt  
 Date: 11/3/2021



Service Recipient: Frank Spezak

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 type="checkbox"/> Yes <input checked="" 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 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 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>engage in group activities</u>		Outcome #2 <u>When going to work limit personal items to iPad one other item</u>	
Technology Use: <u>iPod Computer iPad CD Player</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa medications</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Sugar Restriction</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Verbal cues when over whelmed tight chest muscles Hyperactivity - walking fast + turning</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>None at PAI Staff help if needed</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <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>Can swim staff in community trusting</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>dilated pupil sensitive to light fine motor impairment dyspraxia - shallow breathing</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>yelling one step directions pushed over stimulated noise making may run into street redirect to parking lot</u>	
Important To: <u>iPod HIS devices family internet reading movies</u>	Important For: <u>participate and engaged inactive</u>
Likes: <u>movies iPod community buying things</u>	Dislikes: <u>waiting loud environment</u>
Describe Communication Style: <u>not multiple questions Verbal Short Sentence yes/no questions</u>	

Staff: Renee Schmoll  
 Date: 1/13/2021



Service Recipient: Brian Gray

Where People with Disabilities Connect with the Community and the World

**Individual Abuse Prevention Plan (IAPP)**

Is the person susceptible to abuse in this area?

Sexual Abuse <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: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> <u>part Group activities</u>		<b>Outcome #2</b> <u>Using a choice board to choose activities</u>	
<b>Technology Use:</b> <u>Home - 1 Pad - Apps</u>			

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

Does the person require support in this area?

<b>Allergies</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa meds.</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>longer than 3min call 911</u>	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Not at PAI</u> <u>Would need assistance.</u>	
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>NO outdoor outing 90°+</u>	
<b>Mobility Supports Fall Risk</b> <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
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Staff help out in community</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>History of deep sensory input</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>Pica like behaviors redirect when</u>	
<b>Important To:</b> <u>engaged and active</u> <u>engage in sensory activities</u>	<b>Important For:</b> <u>having choices</u> <u>able to engage in sensory activities</u>
<b>Likes:</b> <u>car rides swimming music</u> <u>Puzzles, Swings, sensory activities</u>	<b>Dislikes:</b> <u>lank tops transitions</u> <u>desserts, walk on windy, waiting</u>
<b>Describe Communication Style:</b> <u>any vocalization</u> <u>non verbal body language</u>	

Staff: Renee Schmitt  
 Date: 11/3/2021



Service Recipient: Adam fish

Where People with Disabilities Connect with the Community and the World

**Individual Abuse Prevention Plan (IAPP)**

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

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

Staff: Leahy Snyder  
 Date: 11-2-21



Service Recipient: Brian Grey

Where People with Disabilities Connect with the Community and the World

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

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

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

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa medications</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>call 911 after 3 minutes</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>AS</u> Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>None at PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Not to go on outings if above 90 - can do indoor outings</u>	
Mobility Supports Fall Risk <input 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>staff helps in community</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>History seeking Deep sensory - offer different things</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Pica like behavior - spit out things that aren't edible</u>	
Important To: <u>engage in sensory activities engaged &amp; active</u>	Important For: <u>choices / encourage to be active able to engage in sensory activities</u>
Likes: <u>Puzzles / swings / car rides / music swimming / sensory activities</u>	Dislikes: <u>Taxi / transitions / waiting NO deserts / going on windy walks</u>
Describe Communication Style: <u>Nonverbal / Gestures / Body Language</u>	

Staff: Adrienne Snyder  
 Date: 11-3-21



Service Recipient: Ashm Fish

Where People with Disabilities Connect with the Community and the World

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

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

Outcome #1: Follow redirection on inappropriate      Outcome #2: Fridays - sit w/ staff and plan

Technology Use: smart TV/ipld - subjects      schedule for next wk

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

Does the person require support in this area?

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

Staff: Amy Singh  
 Date: 11-3-21



Service Recipient: Frank Spivak

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 checked="" 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 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: Engage in group activities  
 Outcome #2: work = limit items to iPad w/ headphones  
 Technology Use: computer, iPad, iPod, CD Player / 1 other item  
 Self-Management Assessment (SMA) & Intensive CSSP Addendum (CSSPA)

Does the person require support in this area?

Allergies  No  Yes - List: Sulfas med's  
 Epi Pen/Treatment  No  Yes  
 Location:

Seizures  No  Yes - Describe:  
 Seizure PRN:  No  Yes  
 Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports:  
Diet = sweets restrictions

Chronic Medical Conditions  No  Yes - List:  
tight chest muscles, Hyperactivity = take breaks

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports:  
staff help if needed

Specific Health & Medical Needs  No  Yes - List:

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
 Support straps/belts needed  
 Verbal Cues  
 Physical Assistance  
 Posey / Gait Belt  
 Walker  
 2 Person Hoyer # staff in cares room: \_\_\_\_\_  
 1 Person Hoyer / Track  
 Arjo

Community & Water Safety Skills  No  Yes very trusting can swim Needs staff in community

Sensory Disabilities  No  Yes - List:  
dyspraxia = coordination affects sensitive to light shallow

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

Important To: Devices family / internet / movies / reading  
 Important For: engaged / quiet spot / movies

Likes: Movies / iPad / community  
 Dislikes: Writing / loud environment

Describe Communication Style:  
Verbal / short sentences

Staff: Drew Snyder  
 Date: 11-3-21



Service Recipient: Brock Hamilton

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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: <u>unable to report</u>	<input 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>visit his peers</u>		Outcome #2 <u>using choice cards for decision</u>	
Technology Use: <u>Home - computer / - Kindle</u>			

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

Does the person require support in this area?

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

Staff: Games, Julie

Service Recipient: Gray, Brian

Date: 11/1/2011



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 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>Unable to 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 type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>group activities, using a</u>		Outcome #2 <u>Using a Choice. Usually after lunch</u>	
Technology Use: <u>home - home - ipad w/apps</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>not outdoor or outdoor using if above 90°</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Staff will help when needed.</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>seeking deep sensory hand/arm rubs</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>eat things he shouldn't eat. If he puts "play dough" then him spit out. then explain why he can't eat.</u>	
Important To: <u>Engag. sensory - paint, play dough</u> <u>Stay active</u>	Important For: <u>Engag. and active.</u> <u>Keep hands busy. handling choices</u>
Likes: <u>puzzles, swings, car rides, swimming,</u> <u>Sensory activities, music.</u>	Dislikes: <u>desserts, going on walks - windy,</u> <u>park - tips. transmons. Waiting for anything.</u>
Describe Communication Style: <u>Non Verbal - body language</u>	

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



Service Recipient: Fish, Adam

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 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 checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Adam will listen to redirection by staff</u>		Outcome #2 <u>Friday Adam will sit w/ staff about plans for next week</u>	
Technology Use: <u>Smart t.v. / iPad</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tegretol, Celebra</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>has not had one in 20 years / seizures</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>cut up to bite size pieces eat slowly</u> <u>Food - no milk, drinks out of sports bottle w/ straw (water)</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Mood Swings - Bipolar - anxiety</u> <u>Sleep</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>apo's, risk of falling</u> <u>strips on wheel chair</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<input type="checkbox"/> Verbal Cues <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 checked="" type="checkbox"/> Support straps/belts needed	
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>strips - on wheel chair / needs support</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>loud noises, vision, headaches</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>throwing himself. place on mat on floor. sometimes stays at home. quite places to calm down.</u>	
Important To: <u>Soap operas, music, loves animals being inversed, game shows, family</u>	Important For: <u>Clam, quite, staff knowing high/low making sure strips are on.</u>
Likes: <u>game shows, friends, family</u>	Dislikes: <u>loud noises, not being inversed</u>
Describe Communication Style: <u>Verbal -</u>	

Staff: Gaines, Suzie



Service Recipient: Frank Spivak

Date: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input 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 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 Frank will engage in group activities.

Outcome #2 When going to work Frank will use iPod w/headphone, 1 other item of choice

Technology Use: uses, Computer, iPad, iPod - uses CD player. Laptop

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

Does the person require support in this area?

Allergies  No  Yes - List: Slatta meds Epi Pen/Treatment  No  Yes Location:

Seizures  No  Yes - Describe: Seizure PRN  No  Yes Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: Sugar sweets mood - salty - over sugar

Chronic Medical Conditions  No  Yes - List: tight chest muscles. loud noise, walking fast.

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: Staff would help if needed

Specific Health & Medical Needs  No  Yes - List:

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
 Verbal Cues  2 Person Hoyer # staff in cares room: \_\_\_\_\_  
 Physical Assistance  1 Person Hoyer / Track  
 Posey / Gait Belt  Arjo  
 Walker

Community & Water Safety Skills  No  Yes Strong swimmer / Staff to stay safe / Very trusting of others

Sensory Disabilities  No  Yes - List: fine motor, dyspraxia (physical), sensitive light, shallow breathing

Self-Management of Behaviors  No  Yes - Describe supports: Checking on him, pushed some one, trying to get some where, yelling + redirection. Quite place 1 step direction

Important To: family, being able to watch movies, reading, having his things. Important For: engage. Quite place to go.

Likes: being out in community Dislikes: having to wait / loud noises

Describe Communication Style: Label. Short sen. yes / no questions  
doesn't like alot of questions.

Staff: Games, Sotze  
 Date: 11/4/2021



Service Recipient: Block Hamilton

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 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 checked="" 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 checked="" 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>Visit his peers</u>		Outcome #2 <u>Using choice graphics</u>	
Technology Use: <u>home - Computer touch screen / Kindle!</u>			

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

Does the person require support in this area?

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

Personal Space of person

Staff: John Gebhardt

Service Recipient: Adam Fish



Date: 11-3-21

Where People with Disabilities Connect with the Community and the World

### Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

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

Staff: John Gebhardt

Service Recipient: Brian Gray

Date: 11-3-21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>Unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input 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>He participate in Group Down Time Activity</u>		Outcome #2 <u>Will use a choice Board</u>	
Technology Use: <u>I pad with Apps used at home</u>			

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

Does the person require support in this area?

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

Staff: John Gebhardt

Service Recipient: Brock Hamilton

Date: 11-3-21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> <del>Verbally/physically abusive to others</del> <input checked="" type="checkbox"/> "Victim" history exists. <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> <del>Engages in self-injurious behaviors</del> <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 visit peers in Program Area.</u>		Outcome #2 <u>use his choice Cards</u>	
Technology Use: <u>Has Touch screen Computer &amp; Kindle at home</u>			

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

Does the person require support in this area?

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

Staff: John Gebhardt

Service Recipient: Frank Spevak

Date: 11-3-21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 checked="" 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:	<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 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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:

Outcome #1

Will engage in lessons & activities

Outcome #2

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

Technology Use: Computer, Ipad, Ipad his I pod and headphones and 1 item,

Has own laptop

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

Does the person require support in this area?

Allergies  No  Yes - List: Sulfa meds Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe: Seizure PRN  No  Yes  
Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports :  
Must have alternative to sugars and sweets foods

Chronic Medical Conditions  No  Yes - List: Limit physical activity. (Deep Breaths)  
Hyperactivity history. Allow a space to calm down

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

Specific Health & Medical Needs  No  Yes - List:  
Needs help with advocating his feelings/symptoms,

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
If he runs. Tell him "No Street."  
 Support straps/belts needed

Verbal Cues  
 Physical Assistance  
 Posey / Gait Belt  
 Walker  
 2 Person Hoyer  
# staff in cares room: \_\_\_\_\_  
 1 Person Hoyer / Track  
 Arjo

Community & Water Safety Skills  No  Yes He can swim. and get ground plcer

Sensory Disabilities  No  Yes - List:  
Dyspraxia Disorder. Has light sensitivity

Self-Management of Behaviors  No  Yes - Describe supports:  
Ax of yelling and pushing people out of his way. Running. Redirect him to a quiet space. Check on him.

Important To: Family. Internet. Movies, reading. His devices

Important For: Participation and Enggement.

Likes: Movies, I pod. Buying Things

Dislikes: loud environments,

Describe Communication Style: Too many questions can overwhelm him. Verbal. has short sentences and phrases.

Staff: Dave Tice



Service Recipient: Byron G.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>unable to self-Report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input 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>Participate in group activity</u>		Outcome #2 <u>Using a choice board to choose activity</u>	
Technology Use: <u>At home he uses IPAD NOT AT PAI.</u>			

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

Does the person require support in this area?

Allergies  No  Yes - List: SULFA

Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe: HAS A PROTOCOL BUT NO PRN MED.

Seizure PRN  No  Yes  
Location:

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

Chronic Medical Conditions  No  Yes - List:

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: Would need assistance if he were to take meds at PAI

Specific Health & Medical Needs  No  Yes - List: Not to go on outings if Above 90° F.

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

Verbal Cues  2 Person Hoyer  
 Physical Assistance # staff in cares room: \_\_\_\_\_  
 Posey / Gait Belt  1 Person Hoyer / Track  
 Walker  Arjo

Support straps/belts needed

Community & Water Safety Skills  No  Yes Staff will help him follow rules

Sensory Disabilities  No  Yes - List: Used to throw self on floor. Hx of wanting deep input.

Self-Management of Behaviors  No  Yes - Describe supports: Will eat things that are not food. Tell him to not eat objects

Important To: Painting, Playdoh Engage in sensory activity

Important For: Engaged & active in sensory activity, having choices

Likes: Car rides, swimming, sensory activity, music, Playdoh, painting, puzzles, swings

Dislikes: Desserts, going on walks, Tank tops, Transitions, waiting

Describe Communication Style: NON-VERBAL, Vocalizations

acted touch.

Staff: Aimee Jones



Service Recipient: Adam K.

Date: 11.3.21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 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

Outcome #2

Adam will follow staff redirection when inappropriate 2. Fridays - Adam will sit with staff and Technology Use: IPAD, TV, IPOD schedule following week

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

Does the person require support in this area?

Allergies  No  Yes - List: Tyquetol, Celebra Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe: Abxst - Triggered from loud repetitive noises  
No seizures in twenty years

Seizure PRN  No  Yes  
Location:

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

Difficulty swallowing. Remind Adam to eat slower, GERD

Chronic Medical Conditions  No  Yes - List: (Mood swings - excessive talking to & talking.

BIPOLAR Anxiety, Sleep Disturbances, Hyperhidrosis

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

Specific Health & Medical Needs  No  Yes - List:

AFO's

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
Straps in chair - throw himself from chair.  
- supervision, check straps,  
 Support straps/belts needed

Verbal Cues  
 Physical Assistance  
 Posey / Gait Belt  
 Walker

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

Community & Water Safety Skills  No  Yes

(NOT SAFE IN WATER)

Sensory Disabilities  No  Yes - List:

Startled by loud noises. Visual impairment, Eye Fatigue, Headaches

Self-Management of Behaviors  No  Yes - Describe supports:

- calm self in chair. Quiet place to calm.  
- THROW SELF out of chair, Redirection.

Important To: Music Soap, Operas

Important For: calm quiet environment,  
staff knows highs + lows, Straps secured

Likes: Music, soap operas, Magazines  
Being included, Game Shows, Family

Dislikes: Not being included,  
stalling loud noises

Describe Communication Style:

Verbal communication, Gentle Reminders, verbal cues

Staff: Dave



Service Recipient: Block H.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

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

Staff: Dave Tumb



Service Recipient: Frank Spivak IV

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 checked="" 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 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 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>Frank will engage in group lesson/activities</u>		Outcome #2 <u>When going to work Frank will limit items to IPAD + one other</u>	
Technology Use: <u>computer, IPAD, IPOD, DVD player, laptop.</u>			

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

Does the person require support in this area?

Allergies  No  Yes - List: SO LFA

Epi Pen/Treatment  No  Yes  
Location:

Seizures  No  Yes - Describe:

Seizure PRN  No  Yes  
Location:

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

Sugar Restrictions Redirect to SALT vs. sugar.

Chronic Medical Conditions  No  Yes - List:  
- Model vs verbalizing instructions  
Tight chest muscles - limit certain physical activities hyperactivity

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

Specific Health & Medical Needs  No  Yes - List:

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

Verbal Cues  
 Physical Assistance  
 Posey / Gait Belt  
 Walker

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

Support straps/belts needed

Community & Water Safety Skills  No  Yes strong swimmer, staff needs to be with him.

Sensory Disabilities  No  Yes - List:  
Some fine motor disability, dyspraxia (physical), Dilated Pillows.

Self-Management of Behaviors  No  Yes - Describe supports:  
- model redirection  
- letting him be  
(Shoved others) (yelling) (Elope to street) one step direction

Important To: Family, movies, internet, Reading devices

Important For: Participate + engages in activities.

Likes: Movies, IPOD, Shopping, Community

Dislikes: having to wait, loud environments

Describe Communication Style:  
Verbal - short sentences, one word questions

Staff: Kathryn Stern



Service Recipient: Bryan Gray

Date: 1/13/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other: <u>unable 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 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>participate in group activity</u>		Outcome #2 <u>using a choice board to choose down-time activity after lunch</u>	
Technology Use: <u>IPAD at home</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa meds</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>has protocol seizure for 3 mins call 911</u>	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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>NO current meds at PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>No outings or outdoors if weather about 90 degrees</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seeks deep sensory input</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Pica like behaviors, puts objects in his mouth</u>	
Important To: <u>engage in sensory activities, engaged and active</u>	Important For: <u>Sensory activities, choices, encouraged to be engaged and active</u>
Likes: <u>puzzles, swings, car rides, swimming, sensory activities, music</u>	Dislikes: <u>desserts, going on walks when it's windy, tank tops, transitions, waiting</u>
Describe Communication Style: <u>Vocalizations, Nonverbal, gestures, body language</u>	

Staff: Kathryn Stein



Service Recipient: Adam Fish

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

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

Staff: Kathryn Stern



Service Recipient: Brock Hamelton  
Brock Hamelton

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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>unable 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 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>visit peers or other program</u> Area	Outcome #2 <u>using choice cards to make a decision</u>		
Technology Use: <u>Computer with touch screen, kindle</u>			

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

Does the person require support in this area?

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

Staff: Kathryn Stern



Service Recipient: Frank Spevak

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 checked="" 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 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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 will engage in group lesson or activities		Outcome #2 When going to work, will limit personal items to IPOD w/ headphones and one other item of his choice	
Technology Use: <u>Computer, IPAD, IPOD, CD Player</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa meds</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>Sugar sweets restriction</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tight chest muscles, hyperactivity</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> 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	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Some fine motor impairment; Dyspraxia, dilated pupils, shallow breathing</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>History of being physical with others</u> <u>Modeling to help regulate history of running into the street</u>	
Important To: <u>family, internet, movies, reading</u>	Important For: <u>participates, quiet place to go,</u>
Likes: <u>Disney, movies, IPOD, being out in community</u>	Dislikes: <u>waiting, loud environment</u>
Describe Communication Style: <u>verbal</u>	

Staff: Chelsie  
 Date: 11/3/21



Service Recipient: Brock H

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1: visit peers another room  
 Outcome #2: using choice cards to make decision

Technology Use: Computer with touch screen / Kindle

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

Does the person require support in this area?

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

Staff: Chelsie  
 Date: 11/3/21



Service Recipient: Frank Spavak

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 checked="" 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 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>engage group lesson/activities</u>		Outcome #2 <u>When going to work Frank will limit his bag to Ipad/headphones</u>	
Technology Use: <u>CD player Ipad/computer/Ipad</u>		<u>one other item of his choice</u>	

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

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa medications</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Sugar &amp; Sweets</u> <u>redirect to salt hot sugar</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tight chest muscles</u> <u>Hyper activity -</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>ASK</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>Strong swim/needs staff</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Fine motor impairments / dyspraxia</u> <u>Shallow breathing</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>He has shoved others. Yelling. (running to street) outside</u> <u>Written or modeling assistances. 1 step directions</u>	
Important To: <u>Family / internet</u> <u>watch movies / reading / devices</u>	Important For: <u>Participates / engaged.</u> <u>Ipad / movie / buying things</u> <u>Quiet place to go</u>
Likes: <u>Ipad / movie / buying things</u>	Dislikes: <u>Waiting / loud noises</u>
Describe Communication Style: <u>- NO Street -</u> <u>Verbal / no several questions</u>	

Staff: Chelsie



Service Recipient: Adam Fish

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

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

Staff: Chelsea



Service Recipient: Bryan Gray

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa medications</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Protocol - call 911 after 10m</u>	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
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>Antibiotic if needed</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>no outings on 90° days unless its inside</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 <u>Staff assist</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seeking deep sensory - throw himself against wall.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Eat stuff not suppose too.</u>	
Important To: <u>engage in sensory activities engaged and active</u>	Important For: <u>Able to engage in activities/choices/encourage engaged and active.</u>
Likes: <u>puzzles/swings/car rides/swimming/sensory/music</u>	Dislikes: <u>Desserts, going windy walks Tank tops/transistions/waiting</u>
Describe Communication Style: <u>Non-verbal / Body Language</u>	

Staff: Anna wrich



Service Recipient: Adam fish

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1 will follow staffs redirection when being inappropriate

Outcome #2 on fridays Adam will sit w/ staff and plan schedule for the next week

Technology Use: ipad, smart TV.

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

Does the person require support in this area?

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

Staff: Anna Wrich



Service Recipient: Bryan Gray

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>unable to report.</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input 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>participate in group activity</u>		Outcome #2 <u>use choice board to choose down-time activity</u>	
Technology Use: <u>IPad</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa medications</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>PAI protocol - over 3 mins call all</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>none at PAI. would need assistance.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>not to go outdoors above 90°</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <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 will help follow pedestrian safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>deep sensory input. ← history.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>sometimes eats inedible things pica like behaviors.</u>	
Important To: <u>sensory activities, staying active.</u>	Important For: <u>sensory activities. choices encouraged to be active</u>
Likes: <u>puzzles, swings, car rides swimming, sensory, music.</u>	Dislikes: <u>desserts, walks when its windy, tank tops, transitions waiting</u>
Describe Communication Style: <u>non-verbal. vocalizations, body lang, gestures.</u>	

Staff: Anna Wrich



Service Recipient: Brock Hamilton

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

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

Staff: Anna Wrich



Service Recipient: Frank Spevak

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 checked="" 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 checked="" 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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:

Outcome #1 will engage in group activity

Outcome #2 When going to work Frank will limit items to ipod, headphones and one other item of choice.

Technology Use: Computer iPad iPod

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

Does the person require support in this area?

Allergies  No  Yes - List: sulfa meds Epi Pen/Treatment  No  Yes Location:

Seizures  No  Yes - Describe: Seizure PRN  No  Yes Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: Sugar/sweet restrictions sugar free or salty instead.

Chronic Medical Conditions  No  Yes - List: tight chest muscles hyperactivity rapid body movements, walking quickly.

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: none at PAI would need assistance.

Specific Health & Medical Needs  No  Yes - List:

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
 Verbal Cues  2 Person Hoyer # staff in cares room: \_\_\_\_\_  
 Physical Assistance  1 Person Hoyer / Track  
 Posey / Gait Belt  Arjo  
 Walker

Community & Water Safety Skills  No  Yes needs staff in community. overly trusting

Sensory Disabilities  No  Yes - List: fine motor impairments, dyspraxia shallow breathing.

Self-Management of Behaviors  No  Yes - Describe supports: has shoved others, yelling modeling redirection. not asking to many questions. calm area. short one step directions, ran into street

Important To: family. internet. movies reading devices Important For: Participation, having a quiet place to relax

Likes: ipod. community. movies. Dislikes: waiting. loud noise

Describe Communication Style: verbal

Staff: Nikki Kereluk



Service Recipient: Bryan G.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>participate in group activity</u>		Outcome #2 <u>using choice board for sensory activity</u>	
Technology Use: <u>ipad @ home</u>			

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

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>su/fa meds</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>history and protocol</u>	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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>not @ PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>not to go outdoors in above 90°F.</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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, <del>some</del> safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seeking deep sensory input (history)</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>tendency to eat items not edible - pika behaviors</u>	
Important To: <u>Sensory <del>and</del> activities engaged/active</u>	Important For: <u>sensory, choices, encouraged to engage</u>
Likes: <u>puzzles, swings, car rides, swimming, sensory, music</u>	Dislikes: <u>deserts, walks in wind, tank tops, transitions, waiting</u>
Describe Communication Style: <u>nonverbal, vocalizations</u>	

Staff: Nikki Kereluk



Service Recipient: Adam F.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

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

Staff: Nikki Kereluk



Service Recipient: ~~Brook H~~  
Brock H

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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>cust 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 checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>visit peers in another room</u>		Outcome #2 <u>choice cards</u>	
Technology Use: <u>computer @ home, Kindle</u>			

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

Does the person require support in this area?

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

Staff: Nikki Kereluk



Service Recipient: Frank S.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 checked="" 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 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 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>engage in lesson/activity</u>		Outcome #2 <u>going to work, Frank limits personal items - ipod/headphones &amp; 1 item</u>	
Technology Use: <u>computer, ipad, ipod, CD player</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sulfa meds</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>sugar/sweets restrictions - mood</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>tight chest muscles, hyperactivity.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>not @ PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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 / safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>fine motor impairments, dyspraxia, dilated pupils, shallow breathing</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>spc history of shoving peers, yelling, time to process, one step directions, elope to street</u>	
Important To: <u>family, internet, movies, readings, devices</u>	Important For: <u>participates/engaged</u>
Likes: <u>movies, ipod, buying things, community.</u>	Dislikes: <u>waiting, loud environments</u>
Describe Communication Style: <u>verbal, short phrases, yes/no</u>	

Staff: Broick  
 Date: 11-3-21



Service Recipient: Zach

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <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 checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>visit program area</u>		Outcome #2 <u>choice cards</u>	
Technology Use: <u>CPU, Kindle</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" 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,</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Chocolate milk</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Partial Paralysis</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>staff with him</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<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>stay close</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Deaf</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Peers, observe others Invite to join</u>	Important For: <u>Make own choices, Take time to understand him.</u>
Likes: <u>Soft Manipulatives Dave Being around people</u>	Dislikes: <u>Being made to do stuff</u>
Describe Communication Style: <u>Non Verbal, Some ASL</u>	

Staff: Frank S



Service Recipient: Zach Weinmann

Date: 11-3-21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input type="checkbox"/> Yes <input checked="" 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 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 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>Engage in Group</u>		Outcome #2 <u>Going to work limit personal items to Ipad &amp; 1 other item</u>	
Technology Use: <u>CPU, Ipad, Ipad CD Players, lap top</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>Sugar/Sweets restriction</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Tight chest muscles, Hyperactive</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> 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 swim, staff with him Runs into Street.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Some fine motor impairment dyspraxia, Dilated Pupils Shallow breathing.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Has shoved others, yelling,</u>	
Important To: <u>Family, Internet, reading, Having his devices</u>	Important For: <u>Participates &amp; is engaged. Buying stuff</u>
Likes: <u>Going out, Buying stuff</u>	Dislikes: <u>loud environs</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Zach W.

Service Recipient: Adam Fish

Date: 11-3-21



Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

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

Staff: Zach W

Service Recipient: Bryan G

Date: 11-3-21



Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" 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 type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>No outings or outdoors over 90'</u>	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports	<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>Staff w/ him</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Seeks deep sensory input</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>PICA like behaviors</u>	
Important To: <u>Engage in sensory &amp; Active</u>	Important For: <u>Able to engage in sensory activities, choices, engaged &amp; Active</u>
Likes: <u>Puzzles, Swings, car rides, swimming sensory, Music</u>	Dislikes: <u>Desserts, Going on walks when its windy, Tank Tops, Transitions</u>
Describe Communication Style: <u>Non Verbal.</u>	

Staff: Dan P.



Service Recipient: Brook H.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 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 checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:

Outcome #1  
Visit peers in another program area

Outcome #2  
Using Choice Card

Technology Use: Computer with touch screen and Kindle

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

Does the person require support in this area?

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

Seizures  No  Yes - Describe: Controlled by meds \* Not since 1994 \* Seizure PRN  No  Yes Location:

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: Bite Size pieces, reminders to chew and slow down

Chronic Medical Conditions  No  Yes - List:

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports: Meds with Chocolate Milk

Specific Health & Medical Needs  No  Yes - List: Partial Paralysis on left side (arm)

Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Stiff walk by him, prompt when obstacles</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: ___ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
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Support straps/belts needed

Community & Water Safety Skills  No  Yes remain close if in crowd. Redirect if staring

Sensory Disabilities  No  Yes - List: Deaf but responds to gestures and signs

Self-Management of Behaviors  No  Yes - Describe supports:

Important To: observes others, being included

Important For: Makes own choices

Likes: playdough, being involved, ipad, observing

Dislikes: not being included, taking meds

Describe Communication Style: Some Signs and gestures

Staff: Dan P.



Service Recipient: Frank S.

Date: 11/3/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 checked="" 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:	<input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input 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>engage in group lessons and activities</u>		Outcome #2 <u>when going to work, limits personal items</u>	
Technology Use: <u>computer, ipad, CD player, owns laptop</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sulfa</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes 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>Sugar and Sweets reduced</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>hyperactivity</u> <u>Tight Chest muscles, limit some physical activities.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Doesn't have scheduled meds at day program</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Doesn't always report</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 checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # 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>Very trusting, Once ran in street</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>shallow breathing</u> <u>Dispraxia (affects coordination)</u> <u>Sensitive to light</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>- redirect with written directions</u> <u>- one step directions</u> <u>has shoved others, yelling if over stimulated</u>	
Important To: <u>Family, internet, reading, having devices</u>	Important For: <u>Participates in activities, having quiet spot</u>
Likes: <u>ipod, buying things in community</u>	Dislikes: <u>loud environment</u>
Describe Communication Style: <u>Verbal</u> <u>short, stilted phrases,</u> <u>Does not like multiple questions in a row</u>	

Staff: Don P

Service Recipient: Brian G.

Date: 11/3/21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <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 type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Participating in groups</u>		Outcome #2 <u>Using choice board</u>	
Technology Use: <u>at home uses ipad</u>			

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

Does the person require support in this area?

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

Staff: Dan P.



Service Recipient: Adam F

Date: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

**Individual Abuse Prevention Plan (IAPP)**

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

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