





Staff: Rey Ceragioni



Service Recipient: Liz Rawon

Date: 12/29/24

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>she will play her music for her peers</u>		Outcome #2 <u>renew her daily schedule everyday.</u>	
Technology Use: <u>boom box, casset 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>eye drops,</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>regular diet,</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>blockoma,</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>staff assistance it needed</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>picca, eats non-food items</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Blind, uses cane</u>  <input type="checkbox"/> Support straps/belts needed <u>staff will help her navigate</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>uses cane, needs staff help. staff model community safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>blind, can see bright colors in her right eye</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>bites her fingers or hands. Bangs head against hard surfaced</u>	
Important To: <u>music, family, outings, walking, choices, resitais</u>	Important For: <u>music, family, outings having her cane, participation</u>
Likes: <u>"</u>	Dislikes: <u>Liver, onions, mash potatoes loud places, movie theatres, routin is off</u>
Describe Communication Style: <u>verbal (short phrases) vocalizations,</u>	

Staff: Rey Cerdeira



Service Recipient: Marrisa Volenc

Date: 12/20/24

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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>will pick which manipulatives</u>		Outcome #2 <u>two food outings each month</u>	
Technology Use: <u>Ipad, T.V.</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>hay fever, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite sized pieces</u>  <u>1500-1800 cal diet</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff 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 <u>legally blind,</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>model community skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to auditory sound, overstimulated, bites hand of hits head.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>(bite hands) walks, head rubs, fan.</u>	
Important To: <u>music, ipad, walks, outings</u>	Important For: <u>space, calm environment 1500-1800 cal diet</u>
Likes: <u>sensory, books, food, looking out the window</u>	Dislikes: <u>transitions, chaotic environment limited ipad use</u>
Describe Communication Style: <u>vocalizations, body language, yes or no questions. <del>handwriting</del></u>	

Staff: Rey Ceragioni  
 Date: 12/30/21



Service Recipient: Tawny D.

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 <u>conversation with a store employee in the community</u>		Outcome #2 <u>calming activity when upset</u>	
Technology Use: <u>laptop</u>			

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

Does the person require support in this area?

Allergies  No  Yes - List: possible allergies to flu vaccine Epi Pen/Treatment  No  Yes  
 Location:

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

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports: mild history of choking if excited or laughing. Nickel sized pieces. sip from her cup

Chronic Medical Conditions  No  Yes - List: BPD, OCD, depression

help her calm down if having an emotional moment

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

Specific Health & Medical Needs  No  Yes - List: may get herself to throw up by accident  
dental bridge / hard food can break, helping her relax

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

CP, Scoliosis, spastic quad, purposely making herself  
 Support straps/belts needed (wheel chair) fall out of hoyer

Community & Water Safety Skills  No  Yes with people and staff will operate her chair

Sensory Disabilities  No  Yes - List: glasses

Self-Management of Behaviors  No  Yes - Describe supports: ask private questions or try to listen to private conversations. Re-directing it needed with boundaries  
making advancements to make staff. Biting her hand, saying mean things

Important To: ELVIS, socialize, joking around, coffee group, Important For: avoiding too many jokes,

Likes: " " Dislikes: being ignored.

Describe Communication Style: verbal  
gentle reminders - verbal ques

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	Seizure PRN: <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Suzie Gaines



Service Recipient: Liz Rawh

Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input 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:
Outcome #1 <u>play her music for her peers</u>		Outcome #2 <u>review day schedule</u>	
Technology Use: <u>boom box,</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>eye drops</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>Skim milk (signal)</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bad eyes</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>not here</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>cat's uh food items</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>She is blind staff with help out because of cane</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>USES a cane, needs help out</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>blind. no sight in left eye / bright colors in eye</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>hits head w/ hand or hard things</u>	
Important To: <u>music, family, outings, walks, choice</u>	Important For: <u>music, family, having care, being encourage to peers.</u>
Likes: <u>MUSIC, family outings</u>	Dislikes: <u>liver, eggs, salad, loud places,</u>
Describe Communication Style: <u>Verbally, lead places with her hand (s)</u>	

Staff: Suzie, Gaines



Service Recipient: Tayna D.

Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>talk to a store employ.</u>		Outcome #2 <u>Claiming activity.</u>	
Technology Use: <u>laptop-remote services</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>flu shot (possible)</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>mild history when happy</u> <u>cut NICK size, load on fork, can feed herself.</u> <u>sip from cup.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personality disor</u> <u>o.c.d</u> <u>depression</u> <u>Staff talk through anything upsetting.</u> <u>Redirect her.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff full help</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>bridge in front teeth.</u> <u>could possible to make herself throw up.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>C.P.</u> <u>fasted quad</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in 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 help w/ wheel chair</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>wears glasses</u> <u>bring things into visible range</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>will ask private talk between staff</u> <u>make staff can't be trusted</u> <u>make false statements-against</u> <u>use private against others</u> <u>make horrible things to others</u>	
Important To: <u>loves Elvis, loves to be with peers, joking, coffee group.</u>	Important For: <u>VOID JOKES,</u>
Likes: <u>↓ ↓</u>	Dislikes: <u>NOT being left out.</u>
Describe Communication Style: <u>Verbal, Verbal cues</u>	

Staff: Suzie Gaines  
 Date: 12/20/21



Service Recipient: Marvis Volence

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input 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>Marvis will pick out fidgets</u>		Outcome #2 <u>go on 2 food outings a month</u>	
Technology Use: <u>Lpad / t.v.</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>hay fever seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>. bite size food</u> <u>. 15-1800 Cal.</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>Not here - but full staff help.</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <input type="checkbox"/> Support straps/belts needed <u>. leg. blind</u> <u>. able to walking alone</u>	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Model might not see danger</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>. loud noise</u> <u>. bite hand</u> <u>. Rock back / forth</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>. go for walks</u> <u>. head rubs</u> <u>. fan</u>	
Important To: <u>MUSIC, Lpad, WALKS, OUTINGS</u>	Important For: <u>Space, Calm, 15-1800 diet</u>
Likes: <u>books, looking out window, food</u>	Dislikes: <u>. transitions,</u> <u>. crowds</u>
Describe Communication Style: <u>Non Verbal. body language.</u>	

Staff: Suzie Games



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: John Gebhardt

Service Recipient: Tawnya Dally



Date: 12-20-21

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 - <u>Con</u> <u>Conversation with store employee</u>		Outcome #2 <u>Choose A calming activity - Anxious</u>	
Technology Use: <u>I pad, Laptop - Remote services,</u>			

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

Does the person require support in this area?

Allergies  No  Yes - List: Possible Allergy to Flu Vaccine Epi Pen/Treatment  No  Yes  
Location:

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

Choking/Specialized Dietary Needs  No  Yes - Describe Equipment/Supports :  
History of choking at times. Bite size - nickel sizes  
Must sip from cup.

Chronic Medical Conditions  No  Yes - List: Borderline Personality Disorder  
Calm her down, OCD & Depression, Redirect,

Medication Administration/Treatment Orders  No  Yes - Describe Equipment/Supports :  
Assistance with all Meds.

Specific Health & Medical Needs  No  Yes - List: C.P. scoliosis, Spartic Quad,  
Dental bridge - Front Teeth, No Hard Foods,

Mobility Supports Fall Risk  No  Yes - Describe primary mobility & supports  
Use Hoyer or Arjo Lifter.  
 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 Help with her Wheelchair.

Sensory Disabilities  No  Yes - List: wears Glasses and bring things  
into her visual range to see.

Self-Management of Behaviors  No  Yes - Describe supports:  
Reminders to respect Privacy and boundaries, Be aware  
Occasional inappropriate conduct, or comments,

Important To: Elvis Music, Socializing  
Joking, coffee, Talking

Important For: To avoid excessive  
Jokes and questions

Likes: Coffee, Music

Dislikes: Too many reminders,  
Being told "NO"

Describe Communication Style: Verbal.

Staff: John Gebhardt  
 Date: 12/20/24



Service Recipient: Liz Rawn

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 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 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>Liz will play music for her peers.</u>		Outcome #2 <u>Review Daily Schedule</u>	
Technology Use: <u>cassette player - tapes.</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>Alfagen hydrox</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>single servings of skim Milk.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glaucoma-Eyes</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>only at home</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Has Pika, eats inedible items</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>She's blind - uses cane in unfamiliar places - verbal cues, Assistance,</u> <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>uses cane in community. Staff assist</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind in left eye, sees light in Right Eye</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Bites fingers and hand when anxious</u>	
Important To: <u>Music, walks, sings Routine, choices</u>	Important For: <u>Having her cane, Participating in groups.</u>
Likes: <u>Musing, singing, Family. Routine</u>	Dislikes: <u>Egg Salad, onions, Liver. Loud places, Crowds.</u>
Describe Communication Style: <u>Verbal + vocalizations. Gives short sentences</u>	

Staff: John Gebhardt

Service Recipient: Marissa Volenec

Date: 12/20/21



Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input 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>will pick what manipulative she will use</u>		Outcome #2 <u>Go on 2 food outings each month</u>	
Technology Use: <u>I Pad - radios</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>Hay fever &amp; seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bite sizes only, 1500 to 1800 calorie diet,</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>none</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>None at PAI,</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Blind - Staff to help always</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>Model community safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to auditory input and loud vocalizations</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Help her calm, and go for slow walks</u>	
Important To: <u>walking, Music, I pad outings,</u>	Important For: <u>Her space, calm environment, 1500-1800 calorie diet,</u>
Likes: <u>outings, books, food sensory items</u>	Dislikes: <u>Crowds, Chaotic Environment</u>
Describe Communication Style: <u>Non Verbal, uses body language vocalizations, Expressions,</u>	

Staff: John Gebhardt  
 Date: 12/20/21



Service Recipient: \_\_\_\_\_

Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe :	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Andrea Green  
 Date: 12.20.21



Service Recipient: Tanya Dally

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 <u>Talk with store employee</u>		Outcome #2 <u>Calm when anxious</u>	
Technology Use: <u>Laptop for remote</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>possible flu vac</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>when excited or laugh well eating nickel size pieces, reminders to sip cup</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>borderline personality disorder depression anxiety knowledge &amp; redirect</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>dental bridge</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>CP braces spackquad Risk to falling using Arjo</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: ___ <input type="checkbox"/> 1 Person Hoyer / Track <input checked="" type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>role model Assst w/ chair</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>will ask private questions (reminder to privacy) boundaries w/ male staff. biting hands being polite</u>	
Important To: <u>elvis, social, joking, coffee</u>	Important For: <u>avoid jokes that will trigger</u>
Likes: ↓	Dislikes: ↓
Describe Communication Style: <u>Verbal gentle reminder</u>	

Staff: ANDREA GREEN  
 Date: 12/20/21



Service Recipient: LIZ LAWN

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>play music for peers</u>		Outcome #2 <u>Review schedule every morning</u>	
Technology Use: <u>phones</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>eye drops</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>skim milk</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glaucoma</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>not needed @ school</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>PIA. eat enroute item</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Blind. staff help</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>Cane (needs help / model safety</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind in left cobles in right eye</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>bites hands head w/ hands or other hard surface</u>	
Important To: <u>music, family, outings</u>	Important For: <u>showering routine choices cane</u>
Likes: <u>music</u>	Dislikes: <u>iver onion egg salad used places move theater</u>
Describe Communication Style: <u>Verbal / short phrases / loud you when needs help.</u>	

Staff: ANDREA CILLEN



Service Recipient: MARISSA VIOLENCE

Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other: <u>unable to report</u>	<input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input 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 type="checkbox"/> Dresses inappropriately <input checked="" 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 checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Dick make she wants</u>		Outcome #2 <u>2 food cooking a month</u>	
Technology Use: <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>None seasonal hayfever</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bite size 1500-1000 calorie diet</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>None @ PAI</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>legally blind walk in know places</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>model safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>overstimulated. loud words</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>walks head rubs, sleep fan</u>	
Important To: <u>music, iPad walks cooking</u>	Important For: <u>space, calm environment</u>
Likes: <u>Book looking out window food</u>	Dislikes: <u>Transitions, level places</u>
Describe Communication Style: <u>non verbal   use body language &amp; gestures</u>	

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

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

Staff: Nikki Kureluk



Service Recipient: Marissa V.

Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input 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 pick out a manipulative		Outcome #2 will go on 2 food outings / month	
Technology Use: <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>hay fever, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: _____
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: _____	Seizure PRN: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: _____
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>1500-1800 cal. diet bite size pieces, may eat inedible objects</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>NO @ PAI</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: _____	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>legally blind, assist w/ obstacles</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>observe, model safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to auditory input rock, bite hard, loud vocalizations</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offer manipulatives, go on walks, head rubs, fans</u>	
Important To: <u>music, ipad, walks, outings</u>	Important For: <u>space when needed, calm env. 1500-1800 diet</u>
Likes: <u>sensory, books, being by window food</u>	Dislikes: <u>transitions, crowds, chaotic environments</u>
Describe Communication Style: <u>non-verbal → vocalizations, gestures, body language</u>	



Staff: Nikki Kereluk



Service Recipient: Tawnya D.

Date: 12/20/21

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 <u>conversation w/ store employee in community.</u>		Outcome #2 <u>choose calming activity when anxious.</u>	
Technology Use: <u>laptop -&gt; remote services</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>possible reaction to flu vaccine</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>_____</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>mild history -&gt; <del>chuck</del> nickle size pieces. chocking</u> <u>staff loads fork and she feeds herself.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>borderline personality disorder, OCD, depression. *help and report* redirected*</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>assistance from staff</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>dent dental bridge front teeth. forces herself to throw up from straining -&gt; "relax"</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>CP, scoliosis, spastic quad</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 # staff in cares room: <u>2</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>observe, assist w/ wheelchair</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>personal boundaries -&gt; pry into others' conversations - redirect</u> <u>history of advances on male staff --- set boundaries</u> <u>• SIB - bite hands</u>	
Important To: <u>elvis, coffee, socialize, joking around</u>	Important For: <u>avoiding too many jokes, redirections, boundaries</u>
Likes: <u>friends, family, coffee, music</u>	Dislikes: <u>female staff, being left out</u>
Describe Communication Style: <u>verbal - gentle reminders/verbal cues</u>	

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

Technology Use: \_\_\_\_\_

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	Seizure PRN: <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Dennis Mona



Service Recipient: Liz Rawn

Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input 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 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>play music for peers</u>		Outcome #2 <u>review her daily schedule each morning</u>	
Technology Use: <u>Cassette player, piano, boom box</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>eye drops, alphen</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>regular diet single serving of skim milk</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glaucoma,</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff assistance if needed</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>pica essential items in kitchen</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>around obstacles, blind, staff assist</u>	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>uses cane, never help around lake</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>blind, see bright a light in right eye.</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>bites wrist, hands, bang on head</u>	
Important To: <u>music, family, (cycle), family, routine</u>	Important For: <u>music family 2 hours, punting encouraged to participate</u>
Likes: <u>chicks</u>	Dislikes: <u>liver onions, egg salad, new red potatoes, es, pond, grass</u>
Describe Communication Style: <u>verbal, short phrases,</u>	

Staff: Dennis Moore



Service Recipient: Tanya D.

Date: 12/20/21

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 <u>conversation with a store employee while out in community</u>		Outcome #2 <u>calming activity when she is anxious</u>	
Technology Use: <u>computer laptop, remote services</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>flu vaccine (possible)</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN: <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>while eating may laugh cause choking, nickel size pieces, load fork with food (stuff), sip from her cup near and there</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>borderline personality disorder, OCD, depression</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff assistance</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>dental bridge (front teeth) forced herself to throw up, ask her to relax</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>cerebral <del>palsy</del>, scoliosis, spastic quad</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> Person Hoyer # staff in cares room: _____ <input checked="" 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>staff assistance in community</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>wears glasses,</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>will ask private questions, easy drop on private conversations, use what she has learned to make ppl upset, false accusation to make self better, biting nails</u>	
Important To: <u>ehis, play around, sitting, talking</u>	Important For:
Likes: <u>ppl, friends,</u>	Dislikes:
Describe Communication Style: <u>verbal gentle reminders, verbal cues</u>	

Staff: Dennis Moore



Service Recipient: Marissa Valenc

Date: 12/20/21

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 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>pick a manipulative to use</u>		Outcome #2 <u>will go on 2 food outings each month</u>	
Technology Use: <u>ipad, t.v.</u>			

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

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>hay fever seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>may eat on edible items, 1500-1800 cal diet, bite sized pieces,</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>none here, need full 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: <u>legally blind, may trip over obstacles</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>model community safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to auditory input, but hears, low vocalizations</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>often preferred manipulation</u> <u>head rubs, fans</u>	
Important To: <u>music, ipad, walk, outings</u>	Important For: <u>space when needed, cal m environment, 1500-1800 cal diet</u>
Likes: <u>sensory, music, food, look out window,</u>	Dislikes: <u>transitions, crowds, chaotic environments</u>
Describe Communication Style: <u>vocalization, gestures, body language,</u>	

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:		Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :		Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :		
Chronic Medical Conditions <input 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 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		
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:		
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:		
Important To:	Important For:	
Likes:	Dislikes:	
Describe Communication Style:		

Staff: Chelsie



Service Recipient: Marissa V.

Date: 12/20/21

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 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>Multiplicative she wants</u>		<b>Outcome #2</b> <u>2 food outings each month</u>	
<b>Technology Use:</b> <u>Ipad / 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>HAY FEVER, 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:	<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 size pieces</u> <u>15-1800 calorie diet</u>	
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Medication Administration/Treatment Orders</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>NO PAI STAFF SUPPORT</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>legally blind</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	
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff assist / model safety skills</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensitive to Rock, Bite hand, loud vocalization</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Head rubs, walks, and fan</u>	
<b>Important To:</b> <u>MUSIC, Ipad, Micheal Jackson</u>	<b>Important For:</b> <u>calm environment, space</u>
<b>Likes:</b> <u>Books, sensory, looking out window</u>	<b>Dislikes:</b> <u>Transitions, crowds and chaos environment</u>
<b>Describe Communication Style:</b> <u>non verbal, vocalizations, body language</u>	

Staff: Chelsie  
 Date: 12/20/21



Service Recipient: Liz Bawn

Where People with Disabilities Connect with the Community and the World

**Individual Abuse Prevention Plan (IAPP)**

Is the person susceptible to abuse in this area?

Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input 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 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:
<b>Outcome #1</b> <u>She will play her music for Peers</u>		<b>Outcome #2</b> <u>Review daily schedule each morning</u>	
<b>Technology Use:</b> <u>Cassette player, BoomBox.</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>avargin Eyedrops</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>Regular diet Skim milk</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glaucoma,</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Not At Pai</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>pika, ineditable stems</u>	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Blind / uses can</u> <input type="checkbox"/> Support straps/belts needed <u>Staff assist</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
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Staff assist / model safety/cain</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind, no sight in left eye, can see bright colors in right eye</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>when anxious, she bangs head, bites hand</u>	
<b>Important To:</b> <u>Music Family, reatials routine, choices, shredding</u>	<b>Important For:</b> <u>Music Family, Family, Cain, Being encouraged</u>
<b>Likes:</b>	<b>Dislikes:</b> <u>Liven, onions, egg salad, potatoes, loud places, crowds</u>
<b>Describe Communication Style:</b> <u>Verbal - vocalization - short phrases</u>	

Staff: Chelsie



Service Recipient: Tawnya Dally

Date: 12/20/21

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>Conversation with store employee</u>		Outcome #2 <u>chose activity when anxious</u>	
Technology Use: <u>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>Possible reaction to flu vaccine</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>Mild History while laughing</u> <u>ASK to drink from cup while eating</u> <u>middle size pieces, staff put food on fork</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Border line personality disorder,</u> <u>OCD, Depression</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff assist</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Dental Bridge</u> <u>Hard food can damage it,</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Cerebral palsy, Schillios, spastic quad</u>	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
<input type="checkbox"/> Support straps/belts needed	<input checked="" 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>Staff assist</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glasses, visual range</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Crying, private questions,</u> <u>Redirect to respect privacy, Taunting others, Biting hands</u> <u>Boundaries with male staff</u>	
Important To: <u>Elvis, socialize, joking,</u> <u>1:1, coffee</u>	Important For: <u>Avoid to many jokes</u>
Likes:	Dislikes:
Describe Communication Style: <u>Verbal cues</u>	

Staff: Chelsie



Service Recipient: \_\_\_\_\_

Date: 1/21

Where People with Disabilities Connect with the Community and the World

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

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe :	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Daniel P.



Service Recipient: Liz R.

Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

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

Table with 4 columns: Sexual Abuse, Physical Abuse, Self-Abuse, Financial Exploitation. Includes checkboxes for 'Yes' and 'No' and various behavioral indicators.

Outcome #1 Play music for peers
Outcome #2 review daily schedule each morning

Technology Use: Keyboard, boombox

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

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

Staff: Daniel P.

Service Recipient: Tonya D.



Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

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

Table with 4 columns: Sexual Abuse, Physical Abuse, Self-Abuse, Financial Exploitation. Includes checkboxes for 'Yes' and 'No' and handwritten notes for 'Outcome #1' and 'Outcome #2'.

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

Does the person require support in this area?

Large form with multiple sections for allergies, seizures, choking, chronic medical conditions, medication, health needs, mobility, safety skills, sensory disabilities, and behaviors. Includes handwritten notes such as 'possible reaction to flu vaccine' and 'borderline personality, depression, O.C.D.'.

Staff: Daniel P

Service Recipient: Marisa V.

Date: 12/20/21



Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input 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>Pick which manipulatives to use</u>		Outcome #2 <u>go on 2 food outings/month</u>	
Technology Use: <u>ipad and 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>Hay fever, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bite size pieces, 1500-1800 cal diet. Can eat nonedible food</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>would need help</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>legally blind, can navigate in familiar</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>model safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensitive to auditory input and loud situations</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>prefers manipulatives prefers head rubs and fans</u>	
Important To: <u>music (Beatles) walks</u>	Important For: <u>1500-1800 cal diet space, calm environment</u>
Likes: <u>looking out window, magazines, walks</u>	Dislikes: <u>transitions, crowds</u>
Describe Communication Style: <u>nonverbal but uses body language and voices out</u>	

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	Seizure PRN: <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Renee Schmidt  
 Date: 12/21/21



Service Recipient: Marissa V

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 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 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>multimotive she wants</u>		Outcome #2 <u>60 or 2 food outings each month</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>Hay fever, Seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>1500-1800 Calorie diet Bite size pieces</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Not at PAI would need 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 type="checkbox"/> Yes - Describe primary mobility & supports: <u>legally Blind</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 assist / model safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>sensitive to loud vocalizations, Rocks Bit hard</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>Head rubs, walks, and fan</u>	
Important To: <u>music, iPad, Micheal Jackson</u>	Important For: <u>Calm Environment space</u>
Likes: <u>Books Sensory Looking out the window</u>	Dislikes: <u>Transitions, crowds Chaos in Environment</u>
Describe Communication Style: <u>non verbal, vocalizations Body Language</u>	

Staff: Renee Schmidt



Service Recipient: Tawnya Dally

Date: 12/21/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input 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 <u>Conversation with store employee</u>		Outcome #2 <u>Choose activity when anxious</u>	
Technology Use: <u>laptop</u>			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Possible reaction to flu vacc</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff put food on fork</u> <u>Nickle size pieces</u> <u>Ask for help to drink from cup</u> <u>mid history of laughing when eating</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Border Line personality disorder, OCD, Depression</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff assist</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Dental Bridae</u> <u>Hard food can damage it</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>Cerebral palsy Scoliosis, spastic quad</u>	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input type="checkbox"/> Yes <u>Staff assist</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glasses</u> <u>visional range</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>Crying, private questions</u> <u>direct to respect privacy, biting hands</u> <u>Taunting others</u> <u>Boundaries w/male staff</u>	
Important To: <u>Elvis, socializing</u> <u>Joking</u> <u>Coffee</u>	Important For: <u>Avoid to many jokes - go too far</u>
Likes: <u>Coffee</u> <u>Socializing</u>	Dislikes:
Describe Communication Style: <u>Verbal Cues</u>	

Staff: Renee S



Service Recipient: Liz Rawn

Date: 12/21/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses Inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>She will play her music for Peers</u>		Outcome #2 <u>Review daily schedule each morning</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>alvagin Eye drops</u>	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>Regular diet skim milk</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>gula coma</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports : <u>Not at PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Pica, Eats inedible items</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports <u>Blind uses cane</u> <input type="checkbox"/> Support straps/belts needed <u>staff assist</u>	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # 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 assist / model safety / cane</u>	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Blind, no sight in left eye can see bright colors in right eye</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports: <u>When anxious she bangs her head and bites hand/fingers</u>	
Important To: <u>music family recitals routine, choices, shredding</u>	Important For: <u>music, family, cane being encouraged</u>
Likes: <u>music keyboard her tapes</u>	Dislikes: <u>Loud places crowds Liver onions egg salad potatoes</u>
Describe Communication Style: <u>Verbal - vocalization - short phrases</u>	

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

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

Staff: Mary Snyder  
 Date: 12-08-01



Service Recipient: Liz R

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input 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 type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input 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>Play music for her peers</u>		Outcome #2 <u>Review Daily Schedule</u>	
Technology Use: <u>Boom Box, Cassette 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>eye drops</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>Regular Diet</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glaucoma</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff help when needed</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Pica - eating non-food items</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Blind, uses can, staff help w/ navigating</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 models in community. uses cane</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind, can see some bright lights</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Bang head, bites fingers &amp; hands</u>	
Important To: <u>Music, art, family</u>	Important For: <u>having care, being included</u> <u>Music, family, art</u>
Likes: <u>music, art, family</u>	Dislikes: <u>loud places, movie theater</u> <u>routine is off</u>
Describe Communication Style: <u>Verbal, vocalizations</u>	

Staff: Nancy Snyder  
 Date: 12-21-21



Service Recipient: Tawnya D.

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 <u>Conversation with store employee in community</u>		Outcome #2 <u>calming activity</u>	
Technology Use: <u>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>poss. allergies to flu shot</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>Nickel size piecer, sip from cup</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>OCD, depression Borderline Personality Disorder</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff support if needed</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>can throw up by accident</u> <u>Dental Bridge - avoid hard foods</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Cerebral palsy, scoliosis, spastic Quad</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 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>staff operates chair</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Redirect with boundaries, biting hands, saying mean things</u>	
Important To: <u>Elvis, socializing, coffee group</u>	Important For: <u>Being included, socializing</u>
Likes: <u>Elvis, independence</u>	Dislikes: <u>Avoid triggers - weather, water, big events too many jokes, being ignored</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Nancy Snyder



Service Recipient: Marissa

Date: 12-21-21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: <u>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 type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>will pick which manipulates</u>		Outcome #2 <del>will use Mac switch</del> <u>will use Mac switch when she leaves the room</u>	
Technology Use: <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>HAY FEVER, SEASONAL</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>1500-1800 calorie diet, bite size 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>Staff support</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>Respiratory</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>legally blind</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>model community skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to auditory sound, overstimulated bites hand, hits head</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Head rubs, fan</u>	
Important To: <u>music, ipad, walks outside</u>	Important For: <u>space, calm, 1500-1800 calorie diet</u>
Likes: <u>sensory, books, food, looking out the window</u>	Dislikes: <u>chaos, transitions, limited ipad use</u>
Describe Communication Style: <u>Vocalizations, body language, yes or no questions</u>	

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

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

Staff: Kathryn Stein  
 Date: 12/20/21



Service Recipient: Tawnya Daily

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 <u>conversation with store employee in community</u>		Outcome #2 <u>chooses calming activity when anxious</u>	
Technology Use: <u>Laptop to access remote services</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>possible reaction to flu vaccine</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>mild history of choking when laughing while eating, nickel sized pieces, staff load her fork with food, staff help with her drinking</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>borderline personality disorder, OCD, depression</u> <u>acknowledge, redirect</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>dental bridge on front teeth - avoid hard foods</u> <u>forced emesis</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>cerebral palsy, scoliosis, spastic quad</u> <input type="checkbox"/> Support straps/belts needed <u>risk of falling in Arjo</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input checked="" type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>staff help with wheelchair</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>asks private questions, listens in on conversations, boundaries with male staff can be inappropriate</u> <u>self-injurious - bites hands, makes comments to others</u>	
Important To: <u>Elvis, socialize, joking, talking, coffee group</u>	Important For: <u>avoiding joking too much</u>
Likes: <u>SEE important to</u>	Dislikes: <u>see important for</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Kathryn Stein



Service Recipient: Manissa Volence

Date: 12/20/21

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 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>pick a manipulative to use</u>		Outcome #2 <u>will go on 2 food outings each month</u>	
Technology Use: <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>Hayfever, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite sized pieces, eats inedible items</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>no meds at PAI</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>legally blind - needs help with 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
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Model community safety skills</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to auditory input, rocks/loud vocalizations</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offer prefer manipulatives, walks help, head rubs, Fan</u>	
Important To: <u>music/IPAD, walks, outings,</u>	Important For: <u>space, calm environment, 1,500 diet</u>
Likes: <u>sensory, books, looking out window, food</u>	Dislikes: <u>transitions, crowds, loud areas</u>
Describe Communication Style: <u>non verbal, vocalizations, body language</u>	

Staff: Kathryn Stein



Service Recipient: Liz Rawn

Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input 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>Liz will play her music for her peers</u>		Outcome #2 <u>Liz will review her daily schedule each morning</u>	
Technology Use: <u>Keyboard/cassette player/boom box</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>Alphagen eye drops</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>Regular diet with single servings of skim milk</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glaucoma</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>no meds at PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>PICA/Band-aids eats in-edible items</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Blind - uses a cane in unfamiliar areas</u> <u>Staff will help Liz with navigating around obstacles</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>uses cane in community, needs help getting around obstacles</u> <u>staff will model pedestrian/community safety practices</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind - no sight in left eye, can see bright colors/lights with right eye. staff will help Liz navigate around obstacles</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>When anxious, biting finger/wrists and banging her head with her hand or on other hard surfaces</u>	
Important To: <u>music, family, recitals, outings, walks, shredding, routine, choices</u>	Important For: <u>MUSIC, seeing family, outings, choices, routine/schedule, having her cane, being encouraged to participate</u>
Likes: <u>MUSIC/playing piano/keyboard, contract work, eating out</u>	Dislikes: <u>Liver, onions, egg salad, mashed potatoes, loud places, crowds, movie theaters</u>
Describe Communication Style: <u>Verbal - short phrases, vocalizations, leading you with her hand</u>	

Staff: Kathryn Stein



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	Seizure PRN: <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Dave Turner

Service Recipient: Liz Rawn



Date: 12/20/21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

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

Outcome #1

She will play music for peers

Outcome #2

she will review schedule in room w/ staff

Technology Use:

piano/keyboard, boom box

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>Alphagel eye drops</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:

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

glucose  
Regular diet - single serving milk

Chronic Medical Conditions  No  Yes - List:

Bob does not take meds AT PAI

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

Pico

Specific Health & Medical Needs  No  Yes - List:

Pico

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

Blind - Liz uses a cane.

Support straps/belts needed

Staff will help w/ navigate

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

Staff will make sure Liz is safe. Liz uses cane, help getting around obstacles

Sensory Disabilities  No  Yes - List:

Blind

Self-Management of Behaviors  No  Yes - Describe supports:

When anxious will hit head & bite wrist

Important To: Radi

Music, Family, work, Rentals, Shopping

Likes: Routine choices

Important For: Music, Family outings

having love encouraged to participate

Dislikes: Clowns, Loud areas.  
Lives/antics, c/a soled, m/c and p/c

Describe Communication Style:

Verbal (Short phrases.)

Staff: Townyo Dave Trow



Service Recipient: Bunya Daily

Date: 12/20/21

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 <u>Conversation with employee in community</u>		Outcome #2 <u>Chooses a relaxing activity when a window</u>	
Technology Use: <u>Laptop for access to Remote Services.</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>Possible to Flu vaccine</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>Mild history of choking, not into nickel-size piece. Take sips between bites</u>	<u>Load food onto fork + she will eat</u>
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Borderline, OCD, Depression</u>	<u>Staff will attempt to calm her down if she is on remote services. Acknowledge + then redirect</u>
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>If she took meds at PAI we would help her.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Dental Bridges, forced emesis - Telling her to relax</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & support: <u>Sciosis, spodic quad.</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in 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>Be with people (staff will help with chair)</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glasses - might need help with adjustments. Bring items close to Townyo</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Have her respect others. She gathers info to potentially use later.</u>	<u>self-injurious behavior - saying hurtful things to others.</u>
Important To: <u>Elvis, socializing, joking, coffee group</u>	Important For: <u>Avoiding to many jokes.</u>
Likes: <u>Elvis socializing joking coffee group</u>	Dislikes: <u>Avoiding to many jokes</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Dave Turner



Service Recipient: Maliss Volentow

Date: 12.20.21

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 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 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>She will choose manipulative</u>		Outcome #2 <u>Two food items monthly</u>	
Technology Use: <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>May fever (seasonal)</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite size pieces, w/ no cut objects, 1500-1800 daily diet</u>	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>Does not take any Meds, would need staff</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>legally blind, watch for obstacles</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 care room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>May not recognize dangerous situations</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to loud noises (May start rocking)</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offer manipulative head rub, leaving room &amp; fan.</u>	
Important To: <u>Micha Jackson, Bower</u> <u>Music, IPAD, walks</u>	Important For: <u>space when needed</u> <u>1500-1800 diet</u>
Likes: <u>Food, looking out window</u>	Dislikes: <u>Transitions, Crowds</u>

Describe Communication Style:

Non-verbal - does use gestures & some vocal sounds.

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

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

Staff: Zach Weinmann



Service Recipient: Tawnya Dally

Date: 12-20-21

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 <u>Conversation w/ store Employee</u>		Outcome #2 <u>Choose calming activity when anxious</u>	
Technology Use: <u>Remove Sucs 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>Possible flu vaccine</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>chokes while excited, nickel size pieces staff lead fork, sip from cup</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>BPD, OCD, Depression</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>Dental Bridge, No hand feed, forced emesis, Tell her to relax</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>CP Scissors, spastic quad.</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input checked="" type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>with staff</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glasses</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Has made advances toward Male staff</u> <u>SIB, Bite Hands</u> <u>Asks private questions, eavesdrops, Agitates others</u>	
Important To: <u>Elvis, Socializing, Joking, Chatting</u> <u>Coffee</u>	Important For: <u>Avoid too many jokes.</u>
Likes:	Dislikes:
Describe Communication Style: <u>Verbal, Gentle reminders &amp; verbal cues</u>	

Staff: Zach Weinmann



Service Recipient: Liz Rawn

Date: 12-21-21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input 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>Play music for Peers</u>		Outcome #2 <u>Review daily schedule</u>	
Technology Use: <u>Keyboard, Cassette 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>Alphagen Eyedrops</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>Regular diet, single serving milk</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glaucoma</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Doesnt Take Here</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>PICA, e eats inedible items</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Blind uses cane staff help navigate.</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>staff with her.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blind, can see lights and bright colors R eye</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Anxious, Bites hands or wrists. Bangs head</u>	
Important To: <u>Music, Family, recitals, outings, walks, Shedding Routine, Choice</u>	Important For: <u>Music, Fam. Having Cane, encouraged to Participate</u>
Likes: <u>[Handwritten mark]</u>	Dislikes: <u>Liver, onions, egg salad, Mashed Loud Places, crowds, theaters.</u>
Describe Communication Style: <u>Verbal, Short Phrases.</u>	

Staff: Zach Weinmann



Service Recipient: Montissa Voterec

Date: 12-20-21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input 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>Pick which Manipulative</u>		Outcome #2 <u>Go on 2 food outings / Mo</u>	
Technology Use: <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>Hayfever Seasonal</u>	Epi Pen/Treatment <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports:	<u>Bite-sized, May eat inedibles 1500-1800 cal</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>None @ PAI</u>
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Legally blind</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Model skills, staff assist</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to audio, Rocks, Bites Hands,</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offer Preferred Manipulatives, Head Rubs @ the farm</u>	
Important To: <u>Music, Ipad walks, outings</u>	Important For: <u>Space, Calm environment</u>
Likes: <u>sensory, Books, Looking out the window</u>	Dislikes: <u>Transitions, discomfort, Crowds Chaotic environments</u>
Describe Communication Style: <u>Non-verbal, Vocalizations,</u>	

Staff: Zach Weinmann



Service Recipient: \_\_\_\_\_

Date: 12-20-21

Where People with Disabilities Connect with the Community and the World

**Individual Abuse Prevention Plan (IAPP)**

Is the person susceptible to abuse in this area?

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

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	Epi Pen/Treatment <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe :	Seizure PRN: <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe Equipment/Supports :	
Chronic Medical Conditions <input 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 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	
Sensory Disabilities <input type="checkbox"/> No <input type="checkbox"/> Yes – List:	
Self-Management of Behaviors <input type="checkbox"/> No <input type="checkbox"/> Yes – Describe supports:	
Important To:	Important For:
Likes:	Dislikes:
Describe Communication Style:	

Staff: Anna which



Service Recipient: marissa

Date: 12/20/21

volehec

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 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>marissa will pick which manipulative she wants to use.</u>		Outcome #2 <u>will go on two food outings each month.</u>	
Technology Use: <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>Hayfever, seasonal.</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>bite size pieces. may eat inedible items. 1500-1800 cal diet.</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>none at PAI would need full 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: <u>legally blind, may trip over obstacles. able to walk alone, may need verbal cues</u> <input type="checkbox"/> Support straps/belts needed <u>accepting of help.</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>needs help adjusting water temp. model comm. safety skills.</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to auditory input. - may become over stimulated - rock, bite hand, loud vocalizations</u> <u>(may not recognize dangerous situations)</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>offer preferred manipulatives likes walks when over stimulated. head rubs.</u>	
Important To: <u>music/ipad. MJ. Beatles walks. outings</u>	Important For: <u>space when needed calm environment. 1500-1800 cal diet.</u>
Likes: <u>sensory, books, looking out the window. food</u>	Dislikes: <u>transitions. when she is uncomfortable. needs to use bathroom. Crowds. chaotic environment.</u>
Describe Communication Style: <u>non-verbal vocalizations. gestures. body language.</u>	

Staff: Anna Wnch  
 Date: 12/10/21



Service Recipient: Tawnya Dally  
 (remote services)

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input 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 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 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>Convo w/ store employee</u>		Outcome #2 <u>chooses a calming activity when anxious</u>	
Technology Use: <u>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>Possible reaction to flu vac.</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>history of choking when laughing while eating. Nickle size pieces. staff will load fork and she will feed self</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>borderline personality disorder. OCD. depression. - report alarming subjects.</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>would need support</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>dental bridge on front teeth. forced emesis. (avoid hard food)</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>CP. scoliosis. spastic quad. Hoyer. Arched back while in Arjo</u>	<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>stay w/ group. staff PROPEIS</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses. (chair)</u>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>may ask private questions. reminders to respect boundaries. agitate peers w/ convos. false asquations to male staff. - inform supervisors. biting</u>	
Important To: <u>ELVIS. socializing.</u>	Important For: <u>avoiding to many hands jokes. boundaries</u>
Likes: <u>joking. talking. coffee group</u>	Dislikes: <u>↓</u>
Describe Communication Style: <u>Verbal. - gentel reminders &amp; verbal ques.</u>	

Staff: Anna Wrich  
 Date: 12/20/21



Service Recipient: Liz Rawn

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 will play music for Peers.		Outcome #2 review daily schedule	
Technology Use: <u>keyboard. boom box. cassette</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>Alphagen eyedrops</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>regular diet. single servings of skim milk.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glacouma</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>PAI - would need support. none at</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Pica.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>blind. uses cane. staff will help her navigate.</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>uses cane. needs support. model</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>blind. no sight in (L) eye. bright colors in (R) eye</u> <span style="float: right;">Safety Skills</span>	
Self-Management of Behaviors <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>bites fingers. bangs head when frustrated.</u>	
Important To: <u>music, outings, choices.</u>	Important For: <u>music, fam. outings routines. cane. encourages to</u>
Likes: <u>fam, recitals, routine.</u>	Dislikes: <u>disrupted routine. (participate liver, onions, mashed potatoes crowds loud areas)</u>
Describe Communication Style: <u>Verbal. short phrases. vocalizations. gestures.</u>	

Staff: \_\_\_\_\_



Service Recipient: \_\_\_\_\_

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

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

Does the person require support in this area?

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