

Staff: Shirley Bonilla



Service Recipient: Molly Gasnett

Date: 12-31-21

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:
<b>Outcome #1</b> Molly will accurately identify important times in her schedule by 1 prompt or less.		<b>Outcome #2</b> Molly will personally hand her money to the cashier when purchasing items in the community at least once a month.	
<b>Technology Use:</b> iPad for work, class activities & games, phone at home to stay in contact w/ friends & family.			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NA</u>	<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location: <u>NA</u>
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>NA</u>	<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location: <u>NA</u>
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>cut food into bite sized pieces in the event molly were to choke, staff would provide CPR as needed</u>	
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NA</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff trained in medication administration would administer the medication per a physician's order signed</u>	
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Restroom assistance</u>	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NA</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>staff will offer molly a quiet place or different activity to do when upset. Staff will ask molly what is wrong &amp; break it down into yes or no questions. Molly hits herself when having a hard time expressing herself. Staff will ask molly to stop &amp; redirect her.</u>	
<b>Important To:</b> <u>her family, living w/ them, having fun activities to do, &amp; staying busy</u>	<b>Important For:</b> <u>having continued opportunities to work &amp; new varied activities in the community</u>
<b>Likes:</b> <u>taking classes at PAI especially cooking class &amp; gardening, cooking w/ mom, helping her clean, whole CEO shoes, Taylor Swift, cards and board games, watching tv, Kelly Clarkson</u>	<b>Dislikes:</b> <u>some vegetables, people who are loud, hard questions, feeling stressed</u>
<b>Describe Communication Style:</b> <u>verbal</u>	

Staff: Juan Bonilla



Service Recipient: Jason Gysbers

Date: 12-29-21

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 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:
<b>Outcome #1</b> Jason will choose a class each week that he is willing to attend.		<b>Outcome #2</b> Jason will go off-site & have an experience in the community at least once a month.	
<b>Technology Use:</b> mostly for leisure activities, has an iPad (pod x box) & phone at home. Jason calls into work, has never going to be absent & said he also has few friends he calls often to check up/bring paper to work.			

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>Keppra</u>		<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Absent Seizures</u>		<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>only eat too fast &amp; not chew food thoroughly. Staff will encourage Jason to make healthy food choices &amp; to eat in moderation when applicable. Staff will provide verbal reminders to slow down when he is eating as needed.</u>			
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Blood Clot Protocol</u>			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff trained in medication administration would administer the medication per a signed physician</u>			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed		<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker  <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo	
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Vision &amp; hearing</u>			
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Verbal &amp; physical aggression - staff will verbally redirect him to another area. If Jason is choosing not to leave the area, staff will assist the other person to another area. Once the area is quiet &amp; Jason has had some time to process, allow him time to talk with staff.</u>			
<b>Important To:</b> <u>playing video games, making a paycheck, talking to friends</u>		<b>Important For:</b> <u>following a healthy diet &amp; having opportunities to work.</u>	
<b>Likes:</b> <u>playing video games, going shopping, watching movies, making money</u>		<b>Dislikes:</b> <u>being ordered around, following his diet</u> <u>people who yell &amp; are mean,</u>	
<b>Describe Communication Style:</b> <u>Verbally</u>			

Staff: Juan Bonilla



Service Recipient: Craig Hartman

Date: 12-27-21

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 type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1:</b> Craig will practice money addition skills by identifying the correct bills & coins to make a given amount.		<b>Outcome #2:</b> Craig will volunteer at PAI once a month.	
<b>Technology Use:</b> headphones & music for relaxing at home. Craig uses the phone both at home to communicate with family & friends.			

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>Aspirin, Zantac, Depakote, perfumes &amp; dyes in soaps/detergents.</u>	<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>History of seizures</u>	<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>low cholesterol, limit caffeine</u>	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Pre-diabetes, bowel blockages.</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff trained in medication administration would administer the medication per a signed physician's orders.</u>	
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Loud noises causes Craig to become overwhelmed.</u>	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>Though uncommon, Craig may scratch, bite or hit himself when overwhelmed.</u>	
<b>Important To:</b> <u>receiving affirmations when doing a good job, opportunities to do activities where he feels like he's making a positive impact, helping the eagles spend time w/ Lisa, staying busy</u>	<b>Important For:</b> <u>follow a healthy diet, support from caregivers to stay safe &amp; incorporate into his community, opportunities to work</u>
<b>Likes:</b> <u>country &amp; top 40 music, volunteering, helping others, bowling, napping, watching the news, going shopping</u>	<b>Dislikes:</b> <u>eating junk food, loud noises, cleaning up icky messes</u>
<b>Describe Communication Style:</b> <u>Verbal</u>	

Staff: Juan Bailla



Service Recipient: Alvaro Gutierrez

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 type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> <u>talking to a peer daily</u>		<b>Outcome #2</b> <u>outings once a month</u>	
<b>Technology Use:</b> <u>ipad for Netflix &amp; games, cell phone for calling family</u>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>seizure disorder controlled by medication &amp; his corpus callosum surgery in 8/2004.</u>		<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>may not recognize the need to cut up certain foods.</u>			
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>does not have time/self-management skills to independently take medication in a consistent &amp; correct manner.</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		<input type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<input type="checkbox"/> Support straps/belts needed			
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <u>living w/ family, going to work, having a job, having people to chat &amp; laugh with,</u>		<b>Important For:</b> <u>having opportunities to work, having opportunities to engage in the community, having staff support with communication, having supports to stay happy &amp; healthy</u>	
<b>Likes:</b> <u>music especially Spanish music, dancing Mexican food, &amp; watching</u>		<b>Dislikes:</b> <u>says he doesn't dislike anything, but it has been observed that he can become anxious/frustrated when he starts a new job he finds confusing.</u>	
<b>Describe Communication Style:</b> <u>Verbal</u>			

Staff: Juan Parilla



Service Recipient: Jericho Frost

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

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input 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 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:
<b>Outcome #1</b> Jericho will practice counting/matching or budgeting money once a day		<b>Outcome #2</b> Jericho will volunteer at PAI once a month	
<b>Technology Use:</b> iPad for music & games occasionally.			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: isolated unknown		<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: low-sugar diet			
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: Due to his lack of reading ability, Jericho does not have the self management skills to take medication independently & in an accurate manner.			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed		<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: Picking scabs/ staff will redirect if or cue Jericho if he's ever engaging in self injurious behaviors & help Jericho to focus on something else.			
<b>Important To:</b> receiving affirmation when doing a good job, having opportunities to do activities to where he feels he's making a positive impact, staying busy		<b>Important For:</b> having support from staff to stay safe & incorporate into his community, having opportunities to volunteer & work.	
<b>Likes:</b> shopping, watching Disney movies, going on vacation		<b>Dislikes:</b> Loud noises, rude people, when people are arguing or fighting.	
<b>Describe Communication Style:</b> Verbally			

Staff: Juan Bonilla



Service Recipient: Nathan Pott

Date: 12-13-21

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input 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:
<b>Outcome #1</b> <i>Nate's long term goal is to work in the community. In order to be successful at a job skills training is needed to work on time management &amp; multi-step instructions.</i>		<b>Outcome #2</b> <i>Nathan will pick &amp; participate in 1 community outings per month until next review.</i>	
<b>Technology Use:</b> <i>PAI to play games &amp; listen to relaxing music. Telephone at home to contact family &amp; friends. Xbox &amp; playstation at home to play video games.</i>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe :		<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :			
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <i>Nate is unable to feed &amp; does not have the time management skills to take medication consistently &amp; correctly independently.</i>			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports		<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<input type="checkbox"/> Support straps/belts needed			
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <i>spending time w/ family, playing video games, listening to the radio, going out to eat, going shopping, having a friend to spend time with, finding a girlfriend, getting a job &amp; moving out of his parent's someday.</i>		<b>Important For:</b> <i>staying safe &amp; healthy, encouragement to be engaged in activities, &amp; participating in his community.</i>	
<b>Likes:</b> <i>going shopping for clothes &amp; going out to eat. Nate's favorite foods are chicken nuggets, hot pockets, chicken sandwiches at Subway, tacos, &amp; ice cream. Nate's favorite drinks are milk &amp; coke. Nathan likes going to McDonald's &amp; Subway.</i>		<b>Dislikes:</b> <i>fruits &amp; vegetables, when people yell &amp; scream, being told what to do, being pressured to do something.</i>	
<b>Describe Communication Style:</b> <i>verbally</i>			

Staff: Juan Bonilla



Service Recipient: Aaron Burns

Date: 12-6-21

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 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>Aaron will complete a chosen activity while at PAI.</u>		Outcome #2	
Technology Use: <u>will use ipads at commerce when he needs to, video games, watches TV/movies at home</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe :	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports :	
Chronic Medical Conditions <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>if the need arise, staff use trained in medication administration &amp; could administer the medication per assigned physician's order. Aaron &amp; his guardian would be responsible for providing any medications to PAI.</u>	
Specific Health & Medical Needs <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Mobility Supports Fall Risk <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Sticking to a schedule, working on his assigned jobs, video games &amp; movies, playing sports, Karate, staying busy.</u>	Important For: <u>Helping him stick to his schedule &amp; notifying him of changes ahead of time, not being bothered while working, praise when doing a good job, respect his personal space.</u>
Likes: <u>Helping, working out, puzzles, music hot dogs, mac &amp; cheese, milk, playing video games</u>	Dislikes: <u>Chicken legs, raisins, bananas, going to the grocery store when he cannot do what he wants without communication, when his schedule changes suddenly.</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Juan Bonilla  
 Date: 12-10-21



Service Recipient: Paul Dwyer

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 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 Paul will pick & participate in 1 community activities per month.		Outcome #2 Paul will choose a break time activity from two options provided by staff.	
Technology Use: iPad for class activities, phone at home to stay in contact w/ family & friends.			

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

Does the person require support in this area?

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seasonal Allergies</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>1250 calorie bite sized diet, spastic quadriplegia &amp; may need adaptations</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>reoccurring eye infections, vasovagal</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports : <u>Paul lacks time or self management skills to schedule &amp; attend appointments independently. May inaccurately answer questions &amp; positive answers he thinks others are looking for.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>DNR, No CPR, Non-Verbal communication.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input checked="" type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List:	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Spending time w/ family, having <del>time</del> <sup>fun</sup> activities to do, coming to PAI to see his friends.</u>	Important For: <u>having access to new &amp; varied community activities, staying active &amp; maintaining good health.</u>
Likes: <u>wrestling, Christmas music, coffee, music &amp; dancing, family, pasta, going to the library, working on cards, going on outings in the community.</u>	Dislikes: <u>being pushed, being picked on by others, when others are in Paul's personal space, when others are unhappy &amp; loud noises</u>
Describe Communication Style: <u>Non-Verbal</u>	

Staff: Juan Bonilla



Service Recipient: April Cozky

Date: 11-29-21

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 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 type="checkbox"/> Inability to care for self-help needs <input 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>April will seek out staff when feeling anxious.</u>		<b>Outcome #2</b> <u>April will participate in social skills class when offered</u>	
<b>Technology Use:</b> <u>Cell phone for phone calls/texting, laptop at home</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>Ability, Amoxicillin, Cymbalta, Wellbutrin, Lithium, Nystatin, dogs, grass &amp; ragweed.</u>	<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	<b>Seizure PRN</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Staff will administer any medication/treatment to April as written per the doctors orders.</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  <input type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Self-Management of Behaviors</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe supports: <u>April would like support from PAI staff when she appears unstable, taking PRN as needed, talking w/ staff, being reminded of her Crisis Action Plan, being reminded of the skills she is learning in her DBT classes, playing a game such as cribbage and calling her therapist when she needs an extra appointment. April would like to check in w/ PAI staff daily to discuss anything she may be anxious or concerned about in order for her to help manage some of her mental health concerns.</u>	
<b>Important To:</b> <u>Her brother Nick, having healthy relationships w/ people in her life, Dialectical Behavioral Therapy, coming to PAI pay program, opportunity to work make a pay check</u>	<b>Important For:</b> <u>support &amp; maintain &amp; continue to gain independence, opportunity to work make a paycheck to support herself, safe people to talk to, process w/ &amp; remind her to utilize her DBT skills.</u>
<b>Likes:</b> <u>Cats, Crosswords, work, being social &amp; music.</u>	<b>Dislikes:</b> <u>loud music &amp; noises, chaotic workdays, changes in schedules that do not allow for the things April finds important.</u>
<b>Describe Communication Style:</b> <u>Verbal</u>	

Staff: Juan Bonilla



Service Recipient: Bill Dobihal

Date: 11-29-21

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 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:
<b>Outcome #1</b> <u>Bill will practice copying his phone number daily upon arriving to PAI w/ 2 or fewer prompts</u>		<b>Outcome #2</b>	
<b>Technology Use:</b> <u>Bill enjoys listening to the radio, watching TV &amp; using the phone</u>			

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

Does the person require support in this area?

<b>Allergies</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:		<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>takes large bites of food, &amp; may swallow large portions of food</u>			
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Bill does not currently have any treatment orders, nor does he take any routine medication at PAI. If he should have a treatment order that is to be completed at PAI, trained staff will assist him per a signed physician's order</u>			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed		<input type="checkbox"/> Verbal Cues <input 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			
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <u>Having a positive attitude, doing the right thing, having the opportunity to participate in the community, keeping track of his belongings, feeling a part of a group, feeling proud &amp; happy everyday</u>		<b>Important For:</b> <u>Having opportunities to gain &amp; maintain independence, being a part of the community, having the opportunity to attend classes at PAI</u>	
<b>Likes:</b> <u>going to the state fair, doing puzzles, cartoon comics, classic rock, playing the harmonica, lasagna &amp; salad, going to Caribbean coffee, McDonald's Wendy's</u>		<b>Dislikes:</b> <u>Rude people, being poked, feeling disrespected, teasing</u>	
<b>Describe Communication Style:</b> <u>Verbal</u>			

Staff: Juan Bonilla



Service Recipient: Michelle Barrows

Date: 11-17-21

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 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 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> Michelle will recite her mom's phone number from memory each morning in her homeroom		<b>Outcome #2</b> When in the community making a purchase Michelle will hand her money to the cashier & receive the receipt & change.	
<b>Technology Use:</b> iPad at home for leisure activities & also used the iPad at work for classes & games, phone at home to stay in contact w/ family & friends			

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>Penicillin, Sulfa Antibiotics, Raspberries</u>		<b>Epi Pen/Treatment</b> <input 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 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>Lactose intolerant, 1250 calorie diet.</u>			
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Osteoporosis, Ataxia</u>			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Michelle doesn't have the skills to independently administer her medications. Michelle cannot read &amp; does not know the purpose of each medication she takes.</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  <input type="checkbox"/> Support straps/belts needed		<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input checked="" type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes			
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Michelle is legally blind &amp; needs glasses to be able to see, Michelle has a history of breaking her glasses &amp; not wearing them.</u>			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <u>her family, her favorite foods &amp; drinks, staying busy, &amp; doing fun activities.</u>		<b>Important For:</b> <u>consistent &amp; reliable supports at home &amp; continued opportunities to work &amp; incorporate in her community</u>	
<b>Likes:</b> <u>going to the fair, going shopping, going swimming, using her iPad, Pepsi chocolate milk, country music, pizza, &amp; spaghetti</u>		<b>Dislikes:</b> <u>living away from her family, going to appointments, when people fight &amp; when people are in her personal space or in the way of her propelling her wheelchair.</u>	
<b>Describe Communication Style:</b> <u>Verbal</u>			

Staff: Juan Bonilla  
 Date: 12-20-21



Service Recipient: Sam Engen

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input type="checkbox"/> Inability to care for self-help needs <input 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:
<b>Outcome #1</b> After attending at PAI & putting away her belongings, Sam will greet a peer		<b>Outcome #2</b> While attending a community outing featuring the use of funds, Sam will ask the cashier for a receipt after her purchase	
<b>Technology Use:</b> iPad to access a relaxation & stress reducing app, cell phone to listen to her music throughout the day.			

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>Codeine, Sulfa &amp; Cefixim</u>		<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Epilepsy Diagnosis</u>		<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:			
<b>Chronic Medical Conditions</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:			
<b>Specific Health &amp; Medical Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:			
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed		<input type="checkbox"/> Verbal Cues <input 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			
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Wears glasses &amp; is considered legally blind, trouble w/ depth perception &amp; can only see down &amp; to the left</u>			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <u>having her own music to listen to, volunteering, helping others, &amp; her coping skills book.</u>		<b>Important For:</b> <u>advocating for her needs, maintain her health &amp; safety, having social relationships.</u>	
<b>Likes:</b> <u>sorting crayons w/ friends, baking dog bones, her dog, church, animals, cartoon &amp; stuffing &amp; gravy</u>		<b>Dislikes:</b>	
<b>Describe Communication Style:</b> <u>Verbally</u>			

Staff: Juan Bonilla  
 Date: 11.22.21



Service Recipient: Brian Boxer

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 type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> Brian will identify a process, place, or thing he would like to learn more about 3 times a week		<b>Outcome #2</b> Brian will try out a volunteer opportunity at PAI once a month.	
<b>Technology Use:</b> Brian uses the phone at home & work to call/text with family & friends. In addition, Brian uses an iPad occasionally to listen to music & play games.			

**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>Ibuprofen</u>	<b>Epi Pen/Treatment</b> <input 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 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>avoid raw carrots, raw celery, corn popcorn, chinese vegetables, dried fruit, nuts wild rice, coconut, bean sprouts, cole slaw grapefruit, grapes, &amp; cabbage due to ileostomy.</u>	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Legal blindness, cerebral palsy, &amp; a history of bowel obstructions.</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Brian understands that medications prescribed by a doctor are important to his well-being. Brian can swallow pills due to his lack of reading ability. Brian lacks the self-management skills to take medication independently.</u>	
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Brian has an ileostomy &amp; cannot independently empty the bag or record the output.</u>	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer # staff in cares room: ____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
<b>Important To:</b> <u>To have multiple opportunities to do activities where he feels like he's directly involved staying busy whether that be working, volunteering, or outings in the community.</u>	<b>Important For:</b> <u>to have support from staff members to stay safe &amp; incorporate into his community &amp; for Brian to have opportunities to volunteer/work.</u>
<b>Likes:</b> <u>a variety of music, movies, going out to eat, cooking, and coming to PAI.</u>	<b>Dislikes:</b> <u>negative &amp; rude people &amp; working on some trans kits.</u>
<b>Describe Communication Style:</b> <u>Verbally</u>	

Staff: Juan B.



Service Recipient: Deb Hawthorth

Date: 12-7-22

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 type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> <u>work on iPad/technology skills once a week</u>		<b>Outcome #2</b> <u>participate in at least one community outing per month</u>	
<b>Technology Use:</b> <u>uses phones, tablets, iPads &amp; laptops to expand her knowledge of these.</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>Mold</u>		<b>Epi Pen/Treatment</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Seizures</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Petit Mal Seizures</u>		<b>Seizure PRN</b> <input type="checkbox"/> No <input type="checkbox"/> Yes Location:	
<b>Choking/Specialized Dietary Needs</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:			
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Sensitive to sunlight &amp; is legally blind</u>			
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff trained in medication administration would administer per medication to Deb per a signed physician's order.</u>			
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NA</u>			
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports  <input type="checkbox"/> Support straps/belts needed		<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input checked="" 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			
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Legally Blind</u>			
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:			
<b>Important To:</b> <u>being independent &amp; making decisions for herself, family, music.</u>		<b>Important For:</b> <u>having physical supports she needs &amp; maintaining her health.</u>	
<b>Likes:</b> <u>using her tablet, working, arts &amp; crafts, bowling, visiting family, &amp; exploring her community</u>		<b>Dislikes:</b> <u>individuals who are loud or gossip sitting too long &amp; being told where to sit on the bus.</u>	
<b>Describe Communication Style:</b> <u>verbal</u>			