

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Megan Gagne Date of hire: \_\_\_\_\_  
 Date of background study submission: \_\_\_\_\_ Date of background study clearance: \_\_\_\_\_  
 Ongoing annual training period: \_\_\_\_\_  
 Date of first supervised contact: \_\_\_\_\_ Date of first unsupervised contact: \_\_\_\_\_

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. \*Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterisk (\*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: ALAN

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing	<del>Observed</del> 11-2-21 11-3-21	<del>Observed</del> 11-2-21 11-3-21	15 min	Danielle Natavia Alice
Care of teeth, gums, and oral prosthetic devices	11-8-21			
Other activities of daily living (ADLs) per 256B.0659-specify: 11-9-21 11-11-21	11-9-21 11-11-21			
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	NPO	Verbally told 10-29-21		
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify: 11-2-21 11-3-21 11-8-21 11-9-21 11-11-21	<del>Observed</del> 11-2-21 11-3-21 11-8-21 11-9-21 11-11-21	<del>Observed</del> 11-2-21 11-3-21	15 min	↓
CPR, if required by the CSSP or CSSP Addendum	Full Cycle			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>	<p>Feeding Pump g-tube</p>	<p>Verbally told 11-3-21 11-2-21 (observed)</p>			
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: <del>WWT</del> Bw lift Topic: Topic:</p>	<p>11-4-21</p>	<p>11-4-21</p>	<p>15 min</p>		

Staff signature

Date

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Megan Gagne Date of hire: \_\_\_\_\_  
 Date of background study submission: \_\_\_\_\_ Date of background study clearance: \_\_\_\_\_  
 Ongoing annual training period: \_\_\_\_\_  
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Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterisk (\*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Gregory Bayne

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	<del>Observed</del> <del>11-2-21</del> <del>11-3-21</del> 11-8-21 11-9-21 11-11-21	Observed 11-2-21 11-3-21	15 min	Danielle Natalie Alice
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	Reg. diet Assist Section Plate w/ drink Curved spoon	Observed 11-4-21 11-3-21	15 min	
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	<del>Observed</del> <del>11-2-21</del> <del>11-3-21</del> 11-8 11-9 11-11	Observed 11-2-21 11-3-21	15 min	↓
CPR, if required by the CSSP or CSSP Addendum	Full Code			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>					
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:          Topic: Bus lift          Topic:          Topic:</p>	11-4-21	11-4-21	11-4-21	15 min	

Staff signature

Date

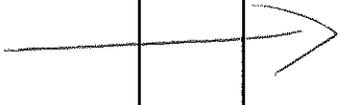
## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

**Staff name:** Megan Gagne **Date of hire:**  
**Date of background study submission:** **Date of background study clearance:**  
**Ongoing annual training period:** **Date of first unsupervised contact:**  
**Date of first supervised contact:**

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Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterisk (\*) if identified in the *Coordinated Service and Support Plan*.

**Name of person served:** Matt Braiker

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	<del>Observed</del> <del>11-7-21</del> <del>11-3-21</del> 11-8-21 11-9-21 11-11-21	<del>Observed</del> 11-2-21 11-3-21	15 min	Danielle Natalia Alice
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	Prepared Full GRIP Specimen <del>Observed</del> 11-17-21	Observed 11-5-21	20 min	
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	<del>11-7-21</del> <del>11-3-21</del> 11-8 11-9 11-11	<del>Observed</del> 11-2-21 11-3-21	15 min	
CPR, if required by the CSSP or CSSP Addendum	Full Code			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person.</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:          Topic: Bvs UFA          Topic:          Topic:</p>	11-4-21	11-4-21	15 min	

Staff signature \_\_\_\_\_ Date \_\_\_\_\_

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

**Staff name:** *Megan Gagne*  
**Date of background study submission:** \_\_\_\_\_  
**Ongoing annual training period:** \_\_\_\_\_  
**Date of first supervised contact:** \_\_\_\_\_  
**Date of hire:** \_\_\_\_\_  
**Date of background study clearance:** \_\_\_\_\_  
**Date of first unsupervised contact:** \_\_\_\_\_

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Training topics for community residential services (Settings): training and competency evaluations must include the following topics, marked with an asterick (\*) if identified in the *Coordinated Service and Support Plan*.

**Name of person served:** *John Beck*

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	Nurse Completed	Nurse Completed	NA	Danielle Natalie Alice
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	NPU	Verbally told 11-3-21	—	↓
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	Nurse Completed	Nurse Completed	NA	↓
CPR, if required by the CSSP or CSSP Addendum	Full Code			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>		<p>TRACH (Nurse) 10-29-21</p>			
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Bus lift Topic: Topic:</p>		<p>11-4-21</p>	<p>11-4-21</p>	<p>15 min</p>	

Staff signature

Date

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Megan Gagne  
 Date of background study submission:  
 Ongoing annual training period:  
 Date of first supervised contact:

Date of hire:  
 Date of background study clearance:  
 Date of first unsupervised contact:

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. \*Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterisk (\*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Sam Stagerman

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	<del>Observed</del> <del>11-2-21</del> 11-5-21	<del>Observed</del> 11-2-21 11-3-21	Needs to be signed off from nurse for catheter	Danielle NATALIE Alice
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	lunch from home No Reg spoon assist	Verbally told 10-29-21		
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	<del>Observed</del> <del>11-2-21</del> 11-5-21	<del>Observed</del> 11-2-21 11-3-21		
CPR, if required by the CSSP or CSSP Addendum	Fulli Cook			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>	<p>g-tube Catheter</p>	<p>Verbally told 10-29-21</p>		
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Bw lift Topic: Topic:</p>	<p>BW 11-4-21</p>	<p>11-4-21</p>	<p>15 min</p>	

Staff signature

Date

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Megan Gagne  
 Date of hire: \_\_\_\_\_  
 Date of background study submission: \_\_\_\_\_  
 Ongoing annual training period: \_\_\_\_\_  
 Date of first supervised contact: \_\_\_\_\_  
 Date of first unsupervised contact: \_\_\_\_\_

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Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (\*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Jamie Drew

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	<del>Observed</del> <del>11.2.21</del> <del>11.3.21</del> 11.8.21 11.9.21 11.11.21	<del>Observed</del> 11.2.21 11.3.21	15 min	Danielle Natalie Alice
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	NPO	Verbally told 10.29.21		
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	<del>Observed</del> <del>11.2.21</del> <del>11.3.21</del> 11.8 11.9 11.11	<del>Observed</del> 11.2.21 11.3.21	15 min	
CPR, if required by the CSSP or CSSP Addendum	Full code			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>	<p>Feeding Pump g/J-tube</p>	<p>Verbally told 10-29-21 Shown 11-2-21 11-3-21</p>			
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Bus Unit Topic: Topic:</p>	<p>11-4-21</p>	<p>11-4-21</p>	<p>15 min</p>		

Staff signature

Date

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

**Staff name:** *McGee Gagne*  
**Date of background study submission:** \_\_\_\_\_  
**Ongoing annual training period:** \_\_\_\_\_  
**Date of first supervised contact:** \_\_\_\_\_  
**Date of hire:** \_\_\_\_\_  
**Date of background study clearance:** \_\_\_\_\_  
**Date of first unsupervised contact:** \_\_\_\_\_

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Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (\*) if identified in the *Coordinated Service and Support Plan*.

**Name of person served:** *LARRY DEKARD*

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	11-18-21	11-3-21 11-16-21	15 min	Danielle Natavie Alia
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet *Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	Bite size/soft coated spoon Reg. Cup 11-23-21	VerDally told 10-29-21 11-3-21 11-16-21	15 min	↓
CPR, if required by the CSSP or CSSP Addendum	DNR/DNI			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>				
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>				
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>				
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>				
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>				
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:          Topic: Bus lift          Topic:          Topic:</p>	15 min	11-14-21	11-14-21	

Staff signature \_\_\_\_\_ Date \_\_\_\_\_

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

Staff name: Mcqan Gagné  
 Date of background study submission:  
 Ongoing annual training period:  
 Date of first supervised contact:

Date of hire:  
 Date of background study clearance:  
 Date of first unsupervised contact:

Before having unsupervised direct contact with persons served or for whom the staff has not previously provided direct support or any time these plans or procedures are revised, staff must review and receive instruction in the following areas as they relate to the staff's job functions for that person. \*Complete this form for each person served to whom the staff person will be providing direct contact services.

Training topics for community residential services (settings): training and competency evaluations must include the following topics, marked with an asterick (\*) if identified in the *Coordinated Service and Support Plan*.

Name of person served: Tomás Morales

Orientation to individual service recipient needs	Date of completion	Date and type of demonstrated competency	Length of training	Name of trainer and company, if applicable
*Appropriate and safe techniques in personal hygiene and grooming including: Hair care Bathing Care of teeth, gums, and oral prosthetic devices Other activities of daily living (ADLs) per 256B.0659-specify:	<del>Observed</del> <del>11-2-21</del> <del>11-3-21</del> 11-9-21 11-11-21	<del>Observed</del> 11-2-21 11-3-21 11-8-21	15 min	Danielle Nataul Alice
*Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet	N/P	Verbally told 10-29-21		↑
*Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:	<del>Observed</del> <del>11-2-21</del> <del>11-3-21</del> 11-9 11-11	<del>Observed</del> 11-2-21 11-3-21 11-8-21	15 min	
CPR, if required by the CSSP or CSSP Addendum	DNR/DNF			

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>	<p>g-tube</p>	<p>Verbally told 10-29 shown 11-2-21 11-3-21</p>			
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company: Topic: Bus lift Topic: Topic:</p>	<p>11-4-21</p>	<p>11-4-21</p>	<p>15 min</p>		

Staff signature \_\_\_\_\_ Date \_\_\_\_\_

## STAFF ORIENTATION AND ANNUAL TRAINING PLAN - PERSON SPECIFIC

**Staff name:** *Megan Gagne*  
**Date of background study submission:** \_\_\_\_\_  
**Ongoing annual training period:** \_\_\_\_\_  
**Date of first supervised contact:** \_\_\_\_\_  
**Date of hire:** \_\_\_\_\_  
**Date of background study clearance:** \_\_\_\_\_  
**Date of first unsupervised contact:** \_\_\_\_\_

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**Name of person served:** *Don*

**Orientation to individual service recipient needs**

\* Appropriate and safe techniques in personal hygiene and grooming including:  
 Hair care  
 Bathing  
 Care of teeth, gums, and oral prosthetic devices  
 Other activities of daily living (ADLs) per 256B.0659-specify:

**Date of completion**

*11-8-21*  
*11-9-21*  
*11-11-21*

**Date and type of demonstrated competency**

*Observed*  
*11-2-21*  
*11-3-21*

**Length of training**

*15 min*

**Name of trainer and company, if applicable**

*Danielle*  
*Natalie*  
*Alice*

\* Understanding of what constitutes a healthy diet according to data from the CDC and the skills necessary to prepare that diet

*Understand*  
*Need assistance*  
*small cup*

*Observed*  
*11-2-21*

*75 min*

\* Skills necessary to provide appropriate support in instrumental activities of daily living (IADLs) per 256B.0659-specify:

*11-8-21*  
*11-9-21*  
*11-11-21*

*Observed*  
*11-2-21*  
*11-3-21*

*15 min*

CPR, if required by the CSSP or CSSP Addendum

*Full Circle*

<p>CSSP, CSSP Addendum, and Self-Management Assessment to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans. Include outcomes, behavior plans, and any document specific to the person</p>					
<p>Individual Abuse Prevention Plan to achieve and demonstrate an understanding of the person as a unique individual and how to implement those plans</p>					
<p>Medication set up or medication administration training when staff set up or administer medications. Training also includes specific medication set up or administration procedures for the person</p>					
<p>The safe and correct operation of medical equipment used by the person to sustain life or to monitor a medical condition that could become life threatening. This training must be provided by a licensed health care professional or manufacturer's representative</p>					
<p>Mental health crisis response, de-escalation techniques, and suicide intervention when providing direct support to a person with a serious mental illness</p>					
<p>Other topics as determined necessary according to the person's Coordinated Service and Support Plan or identified by the company:          Topic: BWS LFT          Topic:          Topic:</p>	11-11-21	11-11-21	15 min		

Staff signature \_\_\_\_\_

Date \_\_\_\_\_

Staff: Tomas Morales

Date: 11/4/2021



Service Recipient: Hegeen Gagner

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 checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Tomas will choose a type of music to listen to</u>		Outcome #2 <u>Tomas will indicate what group he would like to join</u>	
Technology Use: <u>Ipad for choice making and music</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NO KNOWN ALLERGIES</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>He does experience seizures</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>NPO diet, g-tube feedings</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>SCOLIOSIS, HARRINGTON RODS, HYPOTHERMIA, PMR, Hip dislocation, hearing loss, legally blind</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff support with medication administration</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>DNR/DNI</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>limited limb and trunk control, staff support with mobility</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: <u>2</u> <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <u>unknown if he possesses water safety, unable to identify potential dangers</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>legally blind, hearing loss</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>friends/family, outings, being warm, making choices</u>	Important For: <u>his family/staff support, feedings, medications, being warm</u>
Likes: <u>all genres of music, being comfortable, involved in activities</u>	Dislikes: <u>cold/can't warm up, uncomfortable, in pain</u>
Describe Communication Style: <u>facial expressions, vocalizations</u>	



Staff: Megan Wagner  
 Date: 11/4/2021



Service Recipient: Larry Decker

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 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 checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> <u>Daily Larry will place his manipulative in his basket at the end of the</u>		<b>Outcome #2</b> <u>weekly Larry will choose a room to visit using a mack switch</u>	
<b>Technology Use:</b> <u>uses iPad for choice making and music</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>perphenazine, tritafon, anti- psychotics</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>NO KNOWN seizure disorder</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>no teeth, may make it hard to chew food efficiently, may need help due to DICA</u>	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>hepatitis B, cerebral palsy, Barrett's esophagus, congenital acid, sliding hernia with reflux, circumferential hemmorrhoids, GERD</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff support needed for medication administration</u>	
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>PNR/DNI, Geographic tongue, self induced vomiting,</u>	
<b>Mobility Supports Fall Risk</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>edema in feet, cerebral palsy</u> <input checked="" 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 <u>not able to comprehend danger, unknown water safety skills</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>sensitive to loud noise</u>	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
<b>Important To:</b> <u>His friends, His guardian, making choices, manipulatives</u>	<b>Important For:</b> <u>dietary orders, medications, his teams to help advocacy for him</u>
<b>Likes:</b> <u>warm clats, no socks/shoes, quiet calm environment</u>	<b>Dislikes:</b> <u>pain/discomfort, environment that is loud/chaotic, not being able to move around</u>
<b>Describe Communication Style:</b> <u>vocalizations, Body language, facial expressions.</u>	



Staff: Megan Gagner  
 Date: 11/4/2021



Service Recipient: Mary Bayne

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>inaccurate self-reporter</u>	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1: <u>what Mary will choose which item of his food he would like to eat first</u>		Outcome #2: <u>weekly gang will choose an art project to participate in</u>	
Technology Use: <u>Mary utilize iPad for sensory videos, working shows</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NO KNOWN ALLERGIES</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>seizure disorder - breakthrough in 2014</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>diet consists of solid foods with honey thickened liquids</u>	<u>may be at risk of choking</u>
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>B, BRUXISM, Edema, osteoarthritis, finger atrophy, diabetes insipidus, deaf</u>	<u>hepa tests</u>
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>with medication administration</u>	<u>Mary requires assistance</u>
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>spinal fusion, history of pressure sores</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>Mary is at risk of falling due to not being able to safely bear weight.</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: <u>2</u> <input checked="" type="checkbox"/> Person Hoyer / Track <input type="checkbox"/> Arjo
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>Mary has not had water safety issues take precaution</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Deaf</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Food, family &amp; friends, water, joking around, gang for walks, being included in groups</u>	Important For: <u>have his needs met by caregiver, stay active, encourage him to propel wheelchair</u>
Likes: <u>going to basketball games, playing games like connect 4, spending time with family</u>	Dislikes: <u>pain/discomfort, feeling thirsty, feeling like he didn't get enough to eat</u>
Describe Communication Style: <u>facial expressions, vocalizations, hand gestures</u>	



Staff: Megan Wagner  
 Date: 1/13/2021



Service Recipient: Alan Flader

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 to appropriate person</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 checked="" type="checkbox"/> Other: <u>unable to report to appropriate person</u>	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily alan will choose a sensory activity to participate in 80% of all trials</u>		Outcome #2 <u>Daily alan will choose a video or music during lunch time 80% of all trials</u>	
Technology Use: <u>may utilize by using iPad for choice making music, games</u>			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NO KNOWN ALLERGIES</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>seizure disorder, controlled</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>He receives feedings/ feeds via g-tube, does not attempt to eat/drink orally.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>osteoporosis, chronic Hematuria, chronic constipation</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff help administer medications, he does take medications at PAI</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>prone to bruising</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>spastic quadriplegia, Huntington rods, may roll.</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer <input checked="" type="checkbox"/> # staff in cares room: <u>2</u> <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>May indicate water is unappetizing by moving away</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>astigmatism, history of cataracts, significant vision loss.</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>music / musical shakers, spending time outdoors, walks, activities, van rides to work, listening to music</u>	Important For: <u>comfortable beds, clothing, medications, positioning, nutrition, npt orders</u>
Likes: <u>soft and hard rock music, animals, time in the community</u>	Dislikes: <u>Being touched in the face, changes to routine, people in his personal space,</u>
Describe Communication Style: <u>Vocalizations, facial expressions, body language, hand clapping.</u>	



Staff: Megan Gagner



Service Recipient: James Drew

Date: 11/3/2021

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input 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 checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>weekly James will choose a music genre to listen to on iPad/computer 85% of time</u>		Outcome #2 <u>daily James will choose a room to visit and verbally greet his peers 85% of all trials.</u>	
Technology Use:			

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

Does the person require support in this area?

Allergies <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>NO KNOWN ALLERGIES</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>NO KNOWN SEIZURE DISORDER</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>NPO diet, not able to eat or drink orally.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>spastic quadriplegia cerebral palsy, congenital hydrocephalus - left ventriculoperitoneal shunt, neuromuscular disorders, dysphagia, history of transient aspiration pneumonia, asthma, DM II</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>JAMES DOES RECEIVE STAFF SUPPORT IN ADMINISTERING MEDICATIONS - <del>ORAL MEDICATIONS</del></u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>SKIN INTEGRITY</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>spastic quadriplegia cerebral palsy, staff support with transfers and personal care.</u>	<input checked="" type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <u>JAMES IS AWARE HE IS UNABLE TO SWIM, STAFF WILL TEST WATER</u>	<input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: <u>2</u> <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>JAMES IS AWARE AND ABLE TO ADVOCATE HIS NEEDS FOR HIMSELF.</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Family and Friends, Being comfortable, coming to day program, sensory activities, going on outings</u>	Important For: <u>Being in a quiet space, spending time in the community</u>
Likes: <u>stay busy and active during day, likes different options</u>	Dislikes: <u>feeling excluded/bored</u>
Describe Communication Style: <u>answering yes/no questions, facial expressions, body language, vocalizations</u>	



Staff: Megan Wagner  
 Date: 11/3/2021



Service Recipient: Matt Bealka

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input type="checkbox"/> Inability to be assertive <input checked="" type="checkbox"/> Other: unlikely to report to the appropriate person.	<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 checked="" type="checkbox"/> Other: unlikely to report to appropriate person.	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Matthew will participate person in a group activity for 3 mins or longer 3 times a week in 75% of trials in 12 month period</u>		Outcome #2 <u>Daily, Matthew will independently greet a peer or staff with his "hello song" at least 80% of more times in a 2 month period</u>	
Technology Use: <u>IPad - choice making and music</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>absorbable sulfonamides, sulfa, ceflor, Augmentin</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>Epilepsy, controlled with medication</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>no choking, Pureed diet, matt is at risk of choking, may put non-nutritive items in mouth</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>severe intellectual disability, cerebellar Hypoplasia, choreoathetoid cerebral palsy</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff will help support matt in taking medications, tables with appliances</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personal cares, transfers</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>seizure disorder and chronic medical conditions increase risk of falling.</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer # staff in cares room: <u>2</u> <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>staff test water on wrist, should be near of body of water staff will engage breaks</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Functional blindness</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Family, staff, friends, one on one time with staff, being included in activities</u>	Important For: <u>his diet, seizure protocol, being encouraged to participate</u>
Likes: <u>sit by window, listen to music particularly rock n roll, likes to go for walks outside</u>	Dislikes: <u>does not like eating sandwiches or bananas, having to wait for tasks, having to wait for bus</u>
Describe Communication Style: <u>communicates through facial expressions, vocalizations, gestures</u>	



Staff: Megan Gagner  
 Date: 1/13/2021



Service Recipient: John Boeck

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 checked="" type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> John will choose a group to participate in		<b>Outcome #2</b> John will invite a peer from another room using a mark switch to play a game or watch a movie	
Technology Use:			

**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: penicillin, amoxicillin, Baethm, high fat milk/milk products	<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: partially controlled, staff support, follow seizure protocol	<b>Seizure PRN</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location: 200a Diazepam-g-tube
<b>Choking/Specialized Dietary Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: He is at risk of choking, John is able to eat and drink thickened liquids, may be difficult to swallow due to oropharyngeal dysphagia	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: agenesis of corpus callosum, cerebral palsy, spastic quad, hypothyroidism, tachycardia, adrenal insufficiency, colitis, pain hypopituitarism, severe aspiration pneumonia, complicated by sepsis	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: staff support needed in taking medications, cooperative	
<b>Specific Health &amp; Medical Needs</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: equipment failure, staff support required in propelling wheelchair	
<b>Mobility Supports Fall Risk</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe primary mobility & supports spastic quad cerebral palsy <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> 2 Person Hoyer <input checked="" type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Arjo
<b>Community &amp; Water Safety Skills</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Sensory Disabilities</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List:	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
<b>Important To:</b> one on one time, singing, game shows, time on iPod, playing board games	<b>Important For:</b> family, music, spending time outside
<b>Likes:</b> when others sing to him	<b>Dislikes:</b> pianos or piano music
<b>Describe Communication Style:</b> communicates with body gestures and some vocalizations, facial expressions	



Staff: Megan Gagner  
 Date: ~~###~~ 11/3/2021



Service Recipient: Sam Slagerman

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Dresses inappropriately <input checked="" type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
<b>Outcome #1</b> Sam will practice a new sign weekly 75% of trials over a 12 month recording period.		<b>Outcome #2</b> Daily Sam will set up his schedule 75% of all trials over a 12 month recording period.	
<b>Technology Use:</b> <u>enables using iPad</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: <u>no known allergies</u>	<b>Epi Pen/Treatment</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
<b>Seizures</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>no known seizure disorder</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>prefers food to be pureed, <del>mixed</del>, mashed or ground.</u>	
<b>Chronic Medical Conditions</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Jacobson Syndrome which is comorbid with Pans Trosseau syndrome. scoliosis.</u>	
<b>Medication Administration/Treatment Orders</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>water flush</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>scissors, Jacobson syndrome; prevent distraction</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer <input checked="" type="checkbox"/> staff in cares room: <u>2</u> <input checked="" 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 will check water, no athings in water</u>	
<b>Sensory Disabilities</b> <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>wandering left eye, myopia, bilateral sensorineural hearing loss, allow some time to locate voice.</u>	
<b>Self-Management of Behaviors</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
<b>Important To:</b> <u>Family and friends, spending time outside, being understood, iPad time</u>	<b>Important For:</b> <u>likes to know whats next, wheelchair working properly,</u>
<b>Likes:</b> <u>playing on iPad, Books</u>	<b>Dislikes:</b> <u>when his wheelchair is not working</u>
<b>Describe Communication Style:</b> <u>some sign language, body language, facial expressions</u>	



Staff: Megan Wagner



Service Recipient: Ron Harvieux

Date: 1/3/2021

Where People with Disabilities Connect with the Community and the World

Individual Abuse Prevention Plan (IAPP)

Is the person susceptible to abuse in this area?

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input type="checkbox"/> Likely to seek/cooperate in an abusive situation <input 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 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 checked="" type="checkbox"/> Other: <u>unable to report</u>	<input checked="" type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input checked="" type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>Daily Ron will communicate a sensory preference in 80% or more trials</u>		Outcome #2 <u>Daily Ron will answer with a yes/no question by sticking his tongue at per yes.</u>	
Technology Use: <u>May utilize using iPad for online, making music and videos.</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>Amino phylline, Keftex, m erique, pineapple, sephra, terramycin</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe: <u>history of seizures, last one in 2001</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>pureed diet, staff support with eating.</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>cerebral palsy, spastic quadriplegia, scoliosis, constipation, GERD, Hiatal Hernia</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>staff will help administer other medications.</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personal cares, support with skin integrity and restroom. Ron does not take medication while at PAI.</u>	
Mobility Supports Fall Risk <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Ron uses wheelchairs a wheelchair, support with propelling wheel chair needed and with transfers</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> 2 Person Hoyer #staff in cares room: <u>2</u> <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>accepting of support when near bodies of water</u>	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u><del>color blindness, hearing loss, etc</del> Rotoritis pigmentosa, right exotropia blindness, sand sens away,</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Food, warm meals pudding, ice cream, calm environment, familiar routine, time to relax in recliner or wheelchair.</u>	Important For: <u>to drink adequate fluids throughout the day.</u>
Likes: <u>calm environments, water/ocean sounds, woodbury library, pudding, ice cream</u>	Dislikes: <u>being in loud/chaotic environment, false wiped/cleaned, crinkle sounding sensory items.</u>
Describe Communication Style: <u>through facial expressions and body language. Sticks at tongue to communicate he is thirsty.</u>	

