

Staff: Amanda Diaz



Service Recipient: Tisha Ro

Date: 2/23/2021

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

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

Outcome #1

TBD @ 45 day

Outcome #2

TBD @ 45 day

Technology Use: TV, Ipad, wii,

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>masquito bites</u>	Epi Pen/Treatment <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes Location: _____
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: _____	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location: _____

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

Thick liquids, cup with straw, hand over hand to put fork in hand, divided plate

Chronic Medical Conditions No Yes - List:

Anxiety, CP, neurogenic bladder

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

Apple sauce and water

Specific Health & Medical Needs No Yes - List:

Personal cares, cath assistance, brief for comfort

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

power wheel chair

Verbal Cues

Physical Assistance

Posey / Gait Belt

Walker Arjo

2 Person Hoyer

staff in cares room: _____

1 Person Hoyer / Track

Manual Lift # staff _____

Support straps/belts needed

Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List: Glasses

Self-Management of Behaviors No Yes - Describe supports:

Important To: socializing with friends, staff, family, Art

Important For: Time to respond, Give prompts before doing activity

Likes: Going for walks, painting, dancing, coffee

Dislikes: being bored, people in her space (face)

Describe Communication Style:

Verbal and verbal prompts

Staff: Lisa Hartman



Service Recipient: T.R

Date: 2-22-21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>TBD @ 45 day</u>		Outcome #2 <u>TBD @ 45 day</u>	

Technology Use: TV / Smartboard iPad Wii

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

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>mosquito bites, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>- may have seizure like episodes</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>Thickened lyp. Normal cup/straw typical utensils - help her grab - divided plate w edges</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>anxiety, CP, Neurogenic bladder</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>all meds here - if PRN -> PRN -> applesauce or H₂O</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>catheter briefs for comfort will let you know if BM - help getting cleaned up & dressed</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>power wheel chair - seat belt</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> Arjo <input type="checkbox"/> 2 Person Hoyer <input type="checkbox"/> # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>socializing music art</u>	Important For: <u>time to respond prompts shortly before - 5 mins. request</u>
Likes: <u>walks, parenting, dances bowling coffee</u>	Dislikes: <u>being bored people in space/face</u>
Describe Communication Style: <u>Verbal - understands verbal communication</u>	

Staff: Tristen Lossing



Service Recipient: Teisha Rogozinski
T.R.

Date: 2/23/21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>TBD 45 day</u>		Outcome #2 <u>TBD 45 day</u>	

Technology Use: smart board, tv, iPad, wii

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 mosquito bites</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Thicken liquids, cup & straw, utensils - hand over hand to grab utensil, section plate</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Anxiety, CP, Neuro bladder</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>None were, apple sauce w/water</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Cares/catheter, briefs for comfort,</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Power wheel chair,</u> <input checked="" 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 checked="" type="checkbox"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Glasses</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>socializing, music, & Art</u>	Important For: <u>Time to respond, prompts before,</u>
Likes: <u>Waffles, painting, dances, bowling, & coffee</u>	Dislikes: <u>Bored, in her space,</u>
Describe Communication Style: <u>Verbal</u>	

Staff: Nancy Larson



Service Recipient: Tisha Rogowski

Date: 2/23/21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

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

Outcome #1

TBD

Outcome #2

TBD

Technology Use: T.V. Ipad, Wii sports

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>Mosquito bites, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:

Choking/Specialized Dietary Needs No Yes - Describe Equipment/Supports:
Inchined liquids, cup w/ straw, Divided plate

Chronic Medical Conditions No Yes - List:
Anxiety, CP, Neurogenic bladder

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

Specific Health & Medical Needs No Yes - List:
personal, cares, catheter, wears briefs for comfort
Will let you know for BM

Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>power wheelchair, Straps, Arjo</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input type="checkbox"/> Arjo	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
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Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List:
Glasses

Self-Management of Behaviors No Yes - Describe supports:

Important To: socializing w/ people
Music + Art

Important For: time to respond

Likes: walks, painting, dances
bowling & coffee

Dislikes: being bored, too close to face

Describe Communication Style:
Verbal - understands Verbal

Staff: Maurita Sweeney



Service Recipient: Trisha R.

Date: 2/23/21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input checked="" type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input 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>TBD</u>		Outcome #2 <u>TBD</u>	

Technology Use: T.V., I-PAD, Wii

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

Allergies No Yes - List: Seasonal, Mosquito Bites Epi Pen/Treatment No Yes
Location: _____

Seizures No Yes - Describe: May have seizure like episodes Seizure PRN No Yes
Location: _____

Choking/Specialized Dietary Needs No Yes - Describe Equipment/Supports: Devised Plate, Thicken liquids, Normal cup + straw + utensils assist with grabbing.

Chronic Medical Conditions No Yes - List: Anxiety, CP, Neurogenic Bladder

Medication Administration/Treatment Orders No Yes - Describe Equipment/Supports: PRN would be with applesauce + water

Specific Health & Medical Needs No Yes - List: Personal Care, Catheter, wears briefs for comfort, she will let staff know if has to use rest room.

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

Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List: glasses

Self-Management of Behaviors No Yes - Describe supports:

Important To: social / staff / peers / family, music / art

Important For: time to respond, prompts shortly ahead of activity

Likes: walks, painting, dances, coffee, bowling

Dislikes: Bored, people too close, or too close to face

Describe Communication Style: verbal, understands verbal communication

Staff: Galysa Pratt



Service Recipient: Tisha Rogowski

Date: 2/23/21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>TBD @ 45 day</u>		Outcome #2 <u>TBD @ 45 day</u>	

Technology Use: TV, Ipad, Wii

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>Misq. Bites, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe: <u>may have seizure like Ep.</u>	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:

Choking/Specialized Dietary Needs No Yes - Describe Equipment/Supports: Thicken liq, reg cup w straw, nor utensil, div plate.

Chronic Medical Conditions No Yes - List: anxiety, cp, neurogenic bladder

Medication Administration/Treatment Orders No Yes - Describe Equipment/Supports: apple sauce & water

Specific Health & Medical Needs No Yes - List: P.C, catheter, briefs

Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>power w/c, straps, belts</u>	<input checked="" type="checkbox"/> Verbal Cues <input checked="" type="checkbox"/> Physical Assistance <input checked="" type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> Arjo	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
<input type="checkbox"/> Support straps/belts needed		

Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List: glasses

Self-Management of Behaviors No Yes - Describe supports:

Important To: Social w/ friends and family, music and art.

Important For: time to response - prompt (5 mins)

Likes: walks, painting, dances, bowling, coffee.

Dislikes: bored, in personal space

Describe Communication Style: verbal

Staff: Katie Perales



Service Recipient: TR

Date: 2.23.21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

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

Technology Use: IPad, t.v., smart board, wii

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>mosquitos, seasonal 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:	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>thickened liquids, cup w/straw, typical utensils, divided plate</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>anxiety, cp, neurogenic bladder</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports: <u>would take w/applesauce & water</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personal cares, catheter, briefs</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>power chair</u> <input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Galt Belt <input type="checkbox"/> Walker <input checked="" type="checkbox"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>socializing, music, art</u>	Important For: <u>time to respond, prompts</u>
Likes: <u>walks, painting, dancing, bowling coffee</u>	Dislikes: <u>being bored, people too close to face</u>
Describe Communication Style: <u>verbal</u>	

Staff: Emily Eisenpeter
 Date: 2.23.2021



Service Recipient: Tisha Rogowski
 Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>TBD @ 45 day</u>		Outcome #2 <u>TBD at 45 day</u>	

Technology Use: TV, iPad, Wii

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>Mosquito Bites, seasonal 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:	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>Thickened liquids, straw, divided plate with edges, typical utensils</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Anxiety, Cerebral Palsy, Neurogenic bladder</u>	
Medication Administration/Treatment Orders <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>No scheduled meds, if she were to have PRN with apple sauce and water</u>	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>Personal cares - catheter, bag emptied at PAI. Will let staff know when she needs to use restroom. Wears briefs more for comfort assistance cleaning up and getting dressed.</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Power wheelchair, scoot up by pushing feet on pedals, Arjo for restroom</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"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>glasses</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>Socializes with friends, staff, & family, Music, and art</u>	Important For: <u>Time to respond, prompts shortly before</u>
Likes: <u>music, walks, painting, dances, bowling, coffee</u>	Dislikes: <u>Being bored, people in her space/face</u>
Describe Communication Style: <u>Verbal and understands verbal</u>	

Staff: Sara Berglund
 Date: 3/20/2021



Service Recipient: TR

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

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

Outcome #1

TO be determined at 45 days

Outcome #2

Technology Use: TV, iPad wii

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>several, many</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:

Choking/Specialized Dietary Needs No Yes - Describe Equipment/Supports: Thicken liquids w/ straw reg. silverware divided plate

Chronic Medical Conditions No Yes - List: ANXIETY, CP, neurogenic bladder

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

Specific Health & Medical Needs No Yes - List: personal care, catheter briefs offer comfort, she lets you know when she needs to go.

Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>powerwheel chair</u>	<input type="checkbox"/> Verbal Cues <input type="checkbox"/> Physical Assistance <input type="checkbox"/> Posey / Gait Belt <input type="checkbox"/> Walker <u>Arjo</u>	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
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Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List: glaucoma.

Self-Management of Behaviors No Yes - Describe supports:

Important To: family music, Met, socializing with staff

Important For: time to respond prompt shortly before

Likes: walks putting bowling dances, coffee.

Dislikes: being bored personal space

Describe Communication Style:

Verbal

Staff: Jessica Mueller



Service Recipient: TR

Date: 2/23/2021

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

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

Outcome #1

To Be Determined at

Outcome #2

45 day

Technology Use:

TV Ipad wii

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>most seasonal, mosquito bites</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>Thicken liquids, cup w/ straw, regular silverware, divided plate</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>anxiety, CP, Neurogenic bladder</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personal cares, catheter, Briefs for comfort, she lets you know when needing to go.</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports <u>Power wheelchair</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"/> Arjo
<input checked="" type="checkbox"/> Support straps/belts needed	<input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____

Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List: glasses

Self-Management of Behaviors No Yes - Describe supports:

Important To: Socializing w/ staff + family, music + Art

Important For: time to respond Prompt shortly before

Likes: walks, painting, Dances Bowling + coffee

Dislikes: Being Board, personal Space

Describe Communication Style:

verbal

Staff: Haleigh Bares



Service Recipient: TR

Date: 3/15/21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

Sexual Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physical Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Self-Abuse <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Financial Exploitation <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Lack of understanding of sexuality <input checked="" type="checkbox"/> Likely to seek/cooperate in an abusive situation <input checked="" type="checkbox"/> Inability to be assertive <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to identify dangerous situations <input checked="" type="checkbox"/> Lack of community orientation skills <input checked="" type="checkbox"/> Inappropriate interactions with others <input checked="" type="checkbox"/> Inability to deal with aggressive persons <input checked="" type="checkbox"/> Verbally/physically abusive to others <input type="checkbox"/> "Victim" history exists <input type="checkbox"/> Other:	<input type="checkbox"/> Dresses inappropriately <input type="checkbox"/> Refuses to eat <input checked="" type="checkbox"/> Inability to care for self-help needs <input checked="" type="checkbox"/> Lack of self-preservation/ safety skills <input type="checkbox"/> Engages in self-injurious behaviors <input type="checkbox"/> Neglects/refuses to take medications <input type="checkbox"/> Other:	<input checked="" type="checkbox"/> Inability to handle financial matters <input type="checkbox"/> Other:
Outcome #1 <u>TBD at 45 Day</u>		Outcome #2	
Technology Use: <u>TV, iPad, Wii</u>			

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

Allergies <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>seasonal, mosquito bites</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Choking/Specialized Dietary Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe Equipment/Supports: <u>thickened liquids, cup w/ straw, regular silverware, divided plate</u>	
Chronic Medical Conditions <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>anxiety, CP, neurogenic bladder</u>	
Medication Administration/Treatment Orders <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe Equipment/Supports:	
Specific Health & Medical Needs <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - List: <u>personal cares, catheter, briefs for comfort, she lets you know when she needs to go</u>	
Fall Risk/Mobility Supports <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes - Describe primary mobility & supports: <u>power wheelchair</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"/> Arjo <input type="checkbox"/> 2 Person Hoyer # staff in cares room: _____ <input type="checkbox"/> 1 Person Hoyer / Track <input type="checkbox"/> Manual Lift # staff _____
Community & Water Safety Skills <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
Sensory Disabilities <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - List: <u>glisser</u>	
Self-Management of Behaviors <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe supports:	
Important To: <u>socializing w/ staff and family, art, music</u>	Important For: <u>time to respond prompt shortly before</u>
Likes: <u>walks, paintings, dances, bowling, coffee</u>	Dislikes: <u>being bored, personal space</u>
Describe Communication Style: <u>verbal</u>	

Staff: Paris D



Service Recipient: Tisha R

Date: 2/23/21

Reviewed by: _____

Where People with Disabilities Connect with the Community and the World

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

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

Outcome #1

Outcome #2

Technology Use:

45 day -7
Tv ipad wii

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>mosquito bites, seasonal</u>	Epi Pen/Treatment <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:
Seizures <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Describe:	Seizure PRN <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes Location:

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

thickened liquids cup with straw, assist with grabbing
anxiety loss of bladder control
divided plate

Chronic Medical Conditions No Yes - List:

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

take prn w applesauce

Specific Health & Medical Needs No Yes - List:

Catheter

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

power wheelchair

Verbal Cues

Physical Assistance

Posey / Gait Belt

Walker Arjo

2 Person Hoyer

staff in cares room: _____

1 Person Hoyer / Track

Manual Lift # staff _____

Community & Water Safety Skills No Yes

Sensory Disabilities No Yes - List:

glasses

Self-Management of Behaviors No Yes - Describe supports:

Important To:

Socializing, music, art
bowling, coffee

Likes:

walks, painting, dances

Describe Communication Style:

Verbal

Important For:

time to respond ^{5min} window

Dislikes:

boredom, in space