



Competency Tracking Form

Linden Site

Participant: **Jim M** Annual Service Span: **45-Day**

Annual Meeting Date: _____ Date Assigned to Lead: _____ Quiz Due: _____

Documents Reviewed: Support Plan Addendum, IAPP, SMA, One-Page Profile, Outcomes.

*Your initials below indicate you have reviewed and understand all assigned documents and have completed a competency quiz on the individual. This document is to be done in conjunction with on-site instruction on how to implement the reviewed plans and your demonstration of the understanding of the person as a unique individual.

Date Completed	Initials	Full Name
	KB	Bauch, Kia
	A	Cox, Alice
	NY	Johnson, Natalie
	fu	Kalu, Festus
	MN	Kessler, Madeline
	DL	Lepley, Deanne
	SM	Mafi, Sommer
		McKnight, Kyla
	BO	Olson, Britain
	CR	Rice, Colette
	J	Sales, Jill
	E	Sandstrom, Erin
	AS	Sims, Aija
	CS	Stacken, Laura

Date Completed	Initials	Full Name
	E	Tieszen, Ellie
	W	Yang, Lisa
	R	Ralph Yekaldo
	LB	Bludorn, Leslie

Date Uploaded to LMS: _____

Staff: Kia L. Bauch



Service Recipient: Jim Mason

Date: 4/11/23

Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>sensitive to gluten</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>gluten free diet</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Mild intellectual disability, Down Syndrome GERD, Gout</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>by mouth</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses restroom independently, requires verbal cues</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks independently in familiar environments</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>hearing impairment Distortion of vision</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Adjustment disorder</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>outings, weekly lunch w/ parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color + draw, play cards, Target</u>		
Dislikes: <u>taking rewards taken away, loud environments</u>		
Communication Style: <u>verbally</u>		
Learning Style: <u>routine + repetition</u>		

Lead Review Completed: _____

Staff: Leslie Bludorn
 Date: 4-11-23



Service Recipient: Jim Mason
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>sensitive to gluten required</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>support</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>mild intellectual, Down syndrome, Hurd, Gout, Menloconus</u>	DNR/DNI? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>By mouth independently</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>restroom independently in familiar environments, May use a cane for knee pain</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports:	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1 to 1</u> <input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs	
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Hearing impairment - Has bi-lateral hearing aids</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>adjustment disorders, (frustrations) by hitting or kicking and may yell</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>outing, weekly lunch with parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color and draw, playing cards, listening music, using his phone & headphones - Target - Walmart</u>		
Dislikes: <u>having rewards taken away - loud environments being rushed</u>		
Communication Style: <u>Verbally -</u>		
Learning Style: <u>Routine & repetition</u>		

Lead Review Completed: _____

Staff: Alice L. Cox
 Date: 4/11/23



Service Recipient: Jim Mason
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Sensitive to gluten</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports:	
Choking/ Specialized Diet: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Gluten free, low fat, healthy food</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>MR-mild, Downs, GERD, Gout, Keratoconus, Osteoarthritis</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>By mouth, staff assist</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Needs help w/ cleaning up + wash hands</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Uses cane for knee pain and unfamiliar areas</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Protect + Serve</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Bilateral hearing aids, wears glasses, Keratoconus</u>	
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Adjustment disorder, May yell and call names, needs quiet space</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>Outings, weekly lunch w/ folks, Routine</u>		
Important for: <u>Outings, walking daily, Gluten free diet</u>		
Likes: <u>Color, Draw, play cards, Music, Target, Wal-Mart, Goodwill, Bowling, phone + headphones</u>		
Dislikes: <u>Rewards taken away, loud environments, Being pushed</u>		
Communication Style: <u>Verbally</u>		
Learning Style: <u>Routine, Reptition</u>		

Lead Review Completed: _____

Staff: Natalie Johnson
 Date: 4-11-2023



Service Recipient: Jim M
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>sensitiv to gluten</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Gluten free diet, encouraged to eat low fat diet</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>down syndrome, GERD, Gout, Keratoconus</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>By mouth</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Independent w/ staff support</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks independently w/ staff support</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks independently 1:1 in community</u>	<input type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Hearing impairment</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>adjustment disorder</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u> outings, weekly lunch w/ parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color and draw, play cards, beach boys, target, bowling</u>		
Dislikes: <u>having rewards taken away, loud environments being pushed</u>		
Communication Style: <u>verbally</u>		
Learning Style: <u>routine & repetition</u>		

Staff: C. Jones
 Date: 3/11/23



Service Recipient: Jim Mason
 Service Span: 45 Day

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Gluten NKDA</u>	Medication Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports:	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>low fat food</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>GERD, gout, Down's synd, ASD, large bowel disability</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>no med at PAI</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Restroom independently & part with support and w/ toilet paper.</u>	
Mobility/Fall Risk: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Cons for knee pain, 6 Aft. an - ask needed</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Hearing impairment, the sibling hearing aids, wears glasses</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Adjustment disorder, my cell, provide quiet environment.</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>outings, weekly meal - not parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color, draw, cards, happy music, social games, free time, using phone, hearing phone, laptop, watching TV, hearing</u>		
Dislikes: <u>long rewards, the away, loud environments, long outdoor</u>		
Communication Style: <u>verbally</u>		
Learning Style: <u>Reps & repetition.</u>		

Staff: Deanne Lepley



Service Recipient: Jim Mason

Date: 4-11-23

Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Sensitive to gluten</u> <u>Req. support to avoid foods w/ gluten</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
Seizures: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Gluten free diet - encouraged to eat low fat items in serving size portions</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>mild intellectual disability</u> <u>Down Syndrome, GERD, Gout, Keratoconus</u> <u>Osteoarthritis</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>By mouth independently</u> <u>when prescribed to him</u> <u>Staff will assist w/ his medication</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Uses Rostrum independently.</u> <u>Cleaning Self</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks independently - may use cane for knee pain</u> <u>offer arm when needed</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Hearing impairment - Has bi-lateral hearing aids.</u> <u>will let Staff know when needs new batteries</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>adjustment disorder. may comm frustration</u> <u>by hitting or kicking + may yell or call peers names</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>Outings, weekly lunch w/ parents, routine</u>		
Important for: <u>Gluten free diet, walking daily</u>		
Likes: <u>Color & draw, cards, music, phone & headphones</u> <u>Target & Walmart, Goodwill, bowling</u>		
Dislikes: <u>Rewards taken away, loud environments, being rushed</u>		
Communication Style: <u>Verbal</u>		
Learning Style: <u>Routine + Repetition</u>		

Lead Review Completed: _____

Staff: Sommer



Service Recipient: Jim M

Date: _____

Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: gluten allergy - avoid gluten	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: N/A	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Gluten free diet, eat low fat diet	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: MID, Down Syndrome, GERD, Gout	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: By mouth; independently	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Ind. need assistance cleaning up	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Walks ind. may use cane for knee pain	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: 1:1 in comm	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: hearing impairment, distortion of vision	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: may hit/kick, yell or call peers name	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: outings, weekly lunch, routine		
Important for: gluten free diet w/ taking daily		
Likes: music, cards, bowling		
Dislikes: rewards taken away		
Communication Style: verbally		
Learning Style: routine / rep		

Lead Review Completed: _____

Staff: Colette Rice
 Date: 4.11.23



Service Recipient: Jim Mason
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Gluten</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Gluten free diet, encourage to eat slow</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>mild intellectual disability Down Syndrome, Gerd, Gout</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>By mouth independently assist w/ meds</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>needs assistance cleaning him self toilets independently</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Walks independently in familiar environments, may use cane for</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Hearing impairment, has bi-lateral hearing aids.</u>	
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Adjustment disorders may yell or call peers names</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>Outings, lunch w/ parents, routine</u>		
Important for: <u>Gluten free diet, walking daily</u>		
Likes: <u>Color and draw, cards, target, wal-mart bowling</u>		
Dislikes: <u>having rewards taken away, being rushed</u>		
Communication Style: <u>verbally</u>		
Learning Style: <u>Routine, repetition</u>		

Lead Review Completed: _____

Staff: Jill
 Date: 4-11-23



Service Recipient: Jim Mason
 Service Span: 45 day

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>sensitive to gluten, avoid foods with</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>n/a</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>gluten free diet, encourage low fat diet, proper serving size sizes</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Autism, Down syndrome, OERD, Coarct, Keratoconus, osteoarthritis</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>takes by mouth when presented to him</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*A trained staff will administer meds per a signed dr. order*</small>
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses bathroom independently, needs asst for cleaning + washing</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>may use cane, walks independently</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>!!! in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A <u>glasses</u>	List & Describe Supports: <u>hearing impairment, bilateral hearing aids, will let staff know when needs battery</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>adjustment disorder, may kick or hit</u> <u>call people names.</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>outings, weekly lunch w/ parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color, draw, cards, music, phone/headphones, Target, wal-mart goodwill + bowling</u>		
Dislikes: <u>having rewards taken away, loud and environments, being rushed</u>		
Communication style: <u>verbally</u>		
Learning Style: <u>Routine & Repetition</u>		

Staff: ELIN SANDSTROM
 Date: 4.11.2023



Service Recipient: JIM MASON
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>SENSITIVE TO GLUTEN</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>NA</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>GLUTEN FREE DIET, LOW FAT FOODS,</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>MILD ID, DOWN SYNDROME, GERD, GAST</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>BY MOUTH</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>USES INDEPENDENTLY, ASSIST W/ CLEANING HIMSELF VERBAL CUES TO WIPE/WASH HANDS</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>WALKS INDEPENDENTLY IN FAMILIAR ENVIRONMENTS, MAY USE CANE FOR KNEE PAIN, WALK NEXT TO HIM - OFFER ASSISTANCE</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1:1 IN COMMUNITY</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>HEARING IMPAIRMENTS, BI-LATERAL HEARING AIDS KERATOCONUS - DISTORTION OF VISION</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>ADJUSTMENT DISORDER, MAY HIT/KICK/YELL OR CALL PEERS NAMES</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>OVNMS, WEEKLY LUNCH WITH PARENTS, ROUTINE</u>		
Important for: <u>GLUTEN FREE DIET, WALKING DAILY</u>		
Likes: <u>COLOR/DRAW, PLAY CARDS, MUSIC-PREACH BOYS, JESSE, OLDIES USING PHONE/HEADPHONES, TARGET, WALMART, GOODWILL, BOWLING</u>		
Dislikes: <u>HAVING PENNARDS TAKEN AWAY, LOUD ENVIRONMENTS BEING PUSHED</u>		
Communication Style: <u>VERBALLY</u>		
Learning Style: <u>ROUTINE/REPETITION</u>		

Staff: Aija Smy
 Date: _____



Service Recipient: Jim M
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>sensitivity to gluten, avoid foods w/ gluten</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <p style="text-align: center;">N/A</p>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>gluten free diet, encouraged to eat low fat foods.</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>mild intellectual disability, down syndrome, GERD, gout, keratoconus, osteoarthritis</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>By mouth independently when presented to him</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses restroom independently, needs assistance w/ cleaning himself, requires verbal cues to wash hands.</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks independently in familiar environments, may use cane for knee pain. staff assist when needed.</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>may use 1:1 in community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>adjustment disorder, may communicate frustrations by hitting or kicking or calling people names. staff will talk w/ Jim about frustrations and redirect.</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Hearing impairment, has hearing aids. Also wears glasses and is encouraged to use handrails.</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>outings, weekly lunch w/ parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color and draw, play cards, listen to music, using his phone, target, walmart, good will, bowling</u>		
Dislikes: <u>having rewards taken away, loud environment, being rushed</u>		
Communication Style: <u>verbally</u>		
Learning Style: <u>routine and repetition</u>		



Staff: Laura Stacken
 Date: April 11th, 2023



Service Recipient: Jim Mason
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Sensitive to gluten</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Gluten-free diet</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>mild intellectual disability, Down syndrome, GERD, Keratoconus, Osteoarthritis.</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>by mouth independently when presented to him</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>uses restroom independently</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks independently in familiar environments</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: walks <u>1:1 in the community</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Hearing impairments, Distortion of Vision</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>may hit/kick, yell at all peers names</u>	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u>Outings, Weekly lunch w/ parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color & draw, play cards, listen to music, (beach boys, oldies), using his phone & headphones, target, Wal-Mart, Goodwill</u>		
Dislikes: <u>having rewards taken away, loud environment, being rushed</u>		
Communication Style: <u>verbally</u>		
Learning Style: <u>Routine & repetition</u>		

Lead Review Completed: _____

Staff: Ellie

Date: 4/11/23



Service Recipient: Jim m

Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: support sensitive to gluten needs to avoid food with gluten	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports:	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: gluten free diet encouraged to eat low fat foods in serving size portions	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: mild intellectual disability down syndrome broad	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: by mouth independently when presented to him	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: uses restroom independently needs assistance in cleaning himself needs verbal cues to wipe hands	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: walks independently needs in familiar environments may use a cane for knee pain	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: live in the community	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: hearing impairment has bilateral hearing aides keratoconus distortion of vision	
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: adjustment disorder may communicate frustrations by hitting or kicking and may yell	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: outings weekly lunch with parents routine		
Important for: gluten free diet walking daily		
Likes: color idraw play cards listen to music using headphones		
Dislikes: having rewards taken away loud environments being rushed		
Communication Style: verbally		
Learning Style: routine repetition		

Lead Review Completed: _____

Staff: Lisa G.
 Date: 4/11/2023



Service Recipient: Jim Mason
 Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Sensitive to gluten.	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: NA	
Choking/ Specialized Diet: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Eat slow. Eat low fat food. Serving size portions.	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Mild Intellectual Disability Down Syndrome GERD Gout. Keratocornus Osteoarthritis	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: By mouth independently	Daily medication at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Restroom independently Cleaning himself. Verbal cues to wipe & wash hands.	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Walks independently in familiar environment Care for knee pains. Offer arms when needed.	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: 1:1 In the community	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Hearing Impairment. Bi-lateral hearing. Needs new batteries.	
Behavior Support: <input type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: Frustration Adjustment disorder. Communicate hitting/kicking/yelling/call peers names.	
Unsupervised time while at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: Outings. Weekly lunch w/ parents. Routine		
Important for: Gluten free diet. Walking daily		
Likes: Color. Draw. Play cards. Music. (Beach Boys Jesse. Oldies) Using phone. head phones. Target Wal-mart. Goodwill. Bowling.		
Dislikes: Having rewards taken away. Loud environments. Being rushed.		
Communication Style: Verbally		
Learning Style: Routine & Repetition.		

Lead Review Completed: _____

Staff: Ralph YEMALD



Service Recipient: Jim Mason

Date: 4-12-2023

Service Span: _____

Is this person able to self-manage according to the IAPP, SMA & Support Plan Addendum – check yes or no below

Allergies: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Sensitive to gluten - Requires support to avoid foods</u>	Medication Allergies? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
Seizures: <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports:	
Choking/ Specialized Diet: <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Gluten Free diet, Low Fat Food</u>	
Chronic Medical Conditions: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Mild intellectual Disability, Down Syndrome, GERD, Gout, Keratoconus, Osteoarthritis.</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
Medication: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>By mouth independently</u>	Daily medication at PAI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
Personal Cares: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Use Bathroom independently in familiar environments. may use a cane for knees</u>	
Mobility/Fall Risk: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks independently with familiar environments, may use a cane for knee pain</u>	
Community Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>1-1</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
Sensory Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Hearing impairment, has bilateral hearing aids and will let staff know when he needs new ones</u>	
Behavior Support: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Adjustment Disorder</u>	
Unsupervised time while at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Important to: <u> outings, Parents, routine</u>		
Important for: <u>gluten free diet, walking daily</u>		
Likes: <u>color and draw, Play Cards Listen to music</u>		
Dislikes: <u>having rewards taken away, Loud environments, being pushed</u>		
Communication Style: <u>verbally</u>		
Learning Style: <u>Routine and repetition</u>		

Lead Review Completed: _____