



# Competency Tracking Form Linden Site

**Participant: Kelsey 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
	AC	Cox, Alice
	UM	Johnson, Natalie
	KK	Kalu, Festus
	MH	Kessler, Madeline
	DZ	Lepley, Deanne
	SM	Mafi, Sommer
		McKnight, Kyla
	BO	Olson, Britain
	CE	Rice, Colette
	JS	Sales, Jill
	ES	Sandstrom, Erin
	AS	Sims, Aija
	PP	Stacken, Laura

Date Completed	Initials	Full Name
	RT	Tieszen, Ellie
	LD	Yang, Lisa
	Ry	Ralph Yekaldo
	LB	Bludorn, Lurdie

Date Uploaded to LMS: \_\_\_\_\_

Staff: Kia L. Bauch



Service Recipient: Kelsey Martin

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>bite sized to prevent choking, eats independently</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, Hypotonia, scoliosis</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>staff administer when need arises</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>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>transfers to toilet, wears disposable brief</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>manual wheelchair in community, walk with assistance</u>	
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>delayed response to sounds/speech, legally blind + wears glasses</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety like behaviors, may yell out, cry or hyperventilate.</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>maintaining her quality of life, happy + healthy</u>		
<b>Important for:</b> <u>staying busy + engaged in the community</u>		
<b>Likes:</b> <u>food, horseback riding</u>		
<b>Dislikes:</b> <u>chips, spicy foods</u>		
<b>Communication Style:</b> <u>signs, gestures, verbal,</u>		
<b>Learning Style:</b> <u>routine + repetition</u>		

Lead Review Completed: \_\_\_\_\_

Staff: Leslie Bludorn  
 Date: 4-11-23



Service Recipient: Kelsey Martin  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin</u> <u>Staff will not administer this medication</u> Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite size, staff will cutting up food, Can eat finger foods independently, Can eat with fork if food is put on for her</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>C. Palsy, Hypotonia, neuromuscular scoliosis, mild leg hemiparesis</u> DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>would be taken in soft food -</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*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>transfer to toilet using gait belt - Requires time on toilet to have BM - Wears briefs full assistance with changing and cleaning</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Manual wheelchair, Can walk with assistance - Wears AFO's both legs -</u>
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Legally blind wears glasses</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety like behaviors - may bite wrist or ground teeth</u>
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Important to:</b> <u>Maintaining her quality of life &amp; staying happy and healthy</u>	
<b>Important for:</b> <u>staying busy &amp; engaged in her community -</u>	
<b>Likes:</b> <u>fish, pizza, shopping for jewelry, going out to eat, horseback riding, church</u>	
<b>Dislikes:</b> <u>Chips, carbonated drinks, spicy foods, garlic</u>	
<b>Communication Style:</b> <u>Signs, gestures &amp; few words/phrases Can choose between two items</u>	
<b>Learning Style:</b> <u>Routine &amp; repetition</u>	

Staff: Alice L. Cox



Service Recipient: Kelsey M

Date: April 11

Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin -</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports:	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Diets sized diet to prevent choking. Staff will supply cup cut up food. Can eat finger food. Can use silverware</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, Hypotonia, Neuromuscular occlusion, mild left hemiparesis</u>	DNR/DNI? <input type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>W soft foods then a drink</u>	Daily medication at PAI? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Transfer w/ gait belt. Requires time on toilet for a BM. Uses brief, full assistance</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Manual wheelchair, AFO's on both legs w/ a gait belt</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Protected + Severe</u>	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Delayed response to sounds + speech</u> <u>legally blind, wears glasses</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety, yell out, cry, grind teeth PubT Dumb</u> <u>Obsessive + other quiet space</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>Maintain quality of life staying happy</u>		
<b>Important for:</b> <u>Staying Busy + Engaged.</u>		
<b>Likes:</b> <u>Cash, Pizza, cheeseburgers, fries ice cream Chet's</u> <u>Jewelry, horse back riding, music</u>		
<b>Dislikes:</b> <u>Chips Spicy + Garlic foods</u>		
<b>Communication Style:</b> <u>Signs, gestures, choice between items</u>		
<b>Learning Style:</b> <u>Routine + Repetition</u>		

Lead Review Completed: \_\_\_\_\_

Staff: Natalie Johnson  
 Date: 4-11-2023



Service Recipient: Kelsey M  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>amoxicillian</u>	Medication Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite Sized, staff assist w/ cutting</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, hypotonia, scoliosis,</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>if needed - by mouth w/ staff</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*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>walks to bathroom, disposable brief</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Wheel chair in community - gait belt</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>delayed response</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>anxiety like behaviors, trouble regulating emotions, biting herself.</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>maintaining quality of life and staying happy and healthy</u>		
<b>Important for:</b> <u>staying busy &amp; engaged w/ peers</u>		
<b>Likes:</b> <u>fish, pizza, cheeseburgers - no garlic</u>		
<b>Dislikes:</b> <u>chips, carbonated drinks,</u>		
<b>Communication Style:</b> <u>signs, gestures or few words or phrases</u> <b>Learning Style:</b> <u>routine &amp; repetition</u>		

Staff: Reshma  
 Date: 10/11/23



Service Recipient: Wlsy  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Anxiety 11 u</u>	Medication Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	Describe Supports: <u>NA</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Baby Size Diet finger foods        fork or spoon</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chronic, Hypertension, Schizophrenia        med by parents</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>meds via sgt food</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*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Get self, train on a ticket for BA        full assistance</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Manual wheelchair - manual,        w/elic you assistance        11 feet on both legs</u>	
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Delayed accept to sound &amp; speed        wears glasses, allow time to process</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety, Emotional sometimes        no assent and offer quiet space</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>maintain quality of life</u>		
<b>Important for:</b> <u>Eyes &amp; quality</u>		
<b>Likes:</b> <u>fast pizza, go out to eat, church, music, movies</u>		
<b>Dislikes:</b> <u>sleep, crowded places</u>		
<b>Communication Style:</b> <u>Signs, gestures, words of praise</u>		
<b>Learning Style:</b> <u>routine &amp; repetition</u>		

Lead Review Completed: \_\_\_\_\_

Staff: Deanne Leplay



Service Recipient: Kelsey Martin

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin</u> <u>staff will not administer this to Kelsey</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite sized diet to prevent choking. cut her food. can eat finger foods independently. drinks from sippy cup</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, Hypotonia</u> <u>Neuro muscular scoliosis, mild left hip dysplasia</u> <u>Staff will walk w/ Kelsey + report any concerns</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>If the need did arise</u> <u>licensed staff will administer per a</u> <u>signed physician's order. taken w/ soft food + drink</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*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Toileting using a seat belt + staff assistance</u> <u>Reg. time on toilet for BM. wears disposable briefs + Reg.</u> <u>full assistance with changing + cleaning</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>manual WC, uber in community. Can walk w/</u> <u>assistance. wears ASOs on both legs + supported w/ seat belt</u>	
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Delayed response to sounds (speech. Usually</u> <u>blind + wears glasses. items presented at close range</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety like behaviors + can have table</u> <u>regulation her emotions. may bite wrist, rub them</u> <u>until raw, scratch or clean teeth</u>	

Unsupervised time while at PAI?  No  Yes

Important to: maintaining her quality of life + staying happy + healthy

Important for: staying busy + engaged in her community + w/ peers

Likes: fish, pizza, cheeseburgers, fries, ice cream, cheddar, shopping for  
jewelry, horse back riding.

Dislikes: chips, carbonated drinks, spicy foods, salty food

Communication Style: Signs, gestures + few verbal words/phrases

Learning Style: Routine + Repetition

Staff: Sommer  
 Date: \_\_\_\_\_



Service Recipient: Kelsey M  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillian</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite sized, Ind, Sippy cup, can use fork</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, hypotonia, Scoliosis</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Inset food followed by drink</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*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>gait belt, disp brkt, full assistance</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Manual chair, walk with assistance, AFOs</u>	
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Delayed response, legally blind</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Trouble regulating emotions, cry, bite wrist, grind teeth</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>happy, healthy</u>		
<b>Important for:</b> <u>being busy</u>		
<b>Likes:</b> <u>fish, pizza, music, shopping, fries, cheeseburgers</u>		
<b>Dislikes:</b> <u>chips, spicy food, gummy</u>		
<b>Communication Style:</b> <u>Signs, gestures, few verbal words</u>		
<b>Learning Style:</b> <u>Routine/Rep</u>		

Staff: Colette Rice  
 Date: 4.11.23



Service Recipient: Kelsey Martin  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Staff will not administer meds to Kelsey	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: N/A	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Bite Size diet, eat some finger foods Drinks from sippy cup	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: Chorea, Hypotonia, Scoliosis mild left hemiparesis	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: If the need arise staff will administer the meds.	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>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: Transfers to toilet w/ gait belt disposable briefs.	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: manual wheel chair when in community. walk w/ assistance.	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: 1:1 in community	<input checked="" type="checkbox"/> Staff will model pedestrian & stranger safety, provide transportation in the community, & provide supervision to meet health & safety needs
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: delayed response to sounds/speech Legally blind	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: Anxiety like behaviors, may bite her wrist, rub thumbs until raw	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> maintaining her quality of life staying happy & healthy		
<b>Important for:</b> staying busy and engaged in her community		
<b>Likes:</b> Church. Fish, Pizza, cheeseburgers, going out to eat		
<b>Dislikes:</b> chips, carbonated drinks. Spicy food		
<b>Communication Style:</b> Signs, gestures, few verbal words		
<b>Learning Style:</b> Routine, Repetition		

Staff: Jim Sales  
 Date: 4-11-23



Service Recipient: Kelsey M.  
 Service Span: 45 day

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>amoxicillin</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>o</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>wife crized to prevent choking - can eat some independently.</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, hypotonia, neuromuscular scoliosis, mild left hemiparesis.</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>soft foods followed by drink</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*
<b>Personal Cares:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>transfers to toilet + transfers w/ gait belt. uses briefs.</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>manual w/c - can walk with <del>car</del> asst. AFO's + gait belt</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>lil 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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>delayed response, legally blind, w/ glasses.</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>anxiety like issues, may yell out, hyperventilate, clench or grind teeth</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>maintaining her quality of life, staying happy &amp; healthy</u>		
<b>Important for:</b> <u>staying busy + engaged in community + w/ peers</u>		
<b>Likes:</b> <u>Fish, pizza, eating in general, music, shopping for jewelry, horse back riding, special olympics</u>		
<b>Dislikes:</b> <u>chips, spicy foods, carbonated beverages</u>		
<b>Communication Style:</b> <u>signs, gestures, a few words, can choose between 2 items</u>		
<b>Learning Style:</b> <u>Routine + Repetition</u>		

Staff: Erin Sandstrom  
 Date: 4-11-2023



Service Recipient: KELSEY MARTIN  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>AMOXICILLIAN</u> <u>STAFF W/ NOT ADMINISTER</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>MA</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>BITE SIZE, SOME FINGER FOODS, CAN USE FORK IF STAFF PUT IT ON IT.</u> <u>SUPPLY CUP</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>CHOREA HYPTONIA SCLIOSIS, MILD LEFT HEMIPARESIS</u> <u>STAFF WALK W/ KELSEY</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>WOULD GIVE SOFT ORAL FEED</u>	Daily medication at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>TRANSFER TO TOILET W/ GAIT, TIME ON TOILET TO HAVE BM,</u> <u>DISPOSABLE BRIEFS</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>MANUAL W/C, AFO'S ON BOTH LEGS W/ GAIT BELT</u>	
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>DELAYED RESPONSE TO SOUNDS/SPEECH. LEGALLY BLIND,</u> <u>-ITEMS CLOSE RANGE</u>	<u>WEARS GLASSES</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>ANXIETY LIKE BEHAVIORS, MAY BITE HER WRIST, RUB THUMBS</u> <u>GRIND/CLENCH TEETH</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>MAINTAIN QUALITY OF LIFE, STAYING HAPPY/HEALTHY</u>		
<b>Important for:</b> <u>STAYING BUSY ENGAGED IN COMMUNITY, W/ PEERS</u>		
<b>Likes:</b> <u>FISH, PIZZA, CHEESEBURGERS, FRIES, SHOPPING FOR JEWELRY</u> <u>GOING OUT TO EAT</u>		
<b>Dislikes:</b> <u>CHIPS, CARBONATED DRINKS, SPICY FOODS, CAMELUCKY FOODS</u>		
<b>Communication Style:</b> <u>SIGNS, GESTURES, FEW VERBAL WORDS PHRASES</u>		
<b>Learning Style:</b> <u>ROUTINE / REPETITION</u>		

Staff: Aija Sims  
 Date: \_\_\_\_\_



Service Recipient: Kelsey M  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>bite size diet to prevent choking. staff assist in cutting up her foods. drinks from sippy cup</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>chorea, hypotonia, neuromuscular scoliosis, mild left hemiparesis.</u>	BNR/DNI? <input type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>If the need did arise, a trained staff would administer the med taken in small food followed w/ drink</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*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>can transfer to toilet using a gait belt and staff assistance. wears disposable brief and needs help w/ cleaning and changing.</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>manual wheelchair when in the community. can walk w/ assistance. AFO's on legs and is supported by gait belt.</u>	
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>delayed response to sounds/speech. legally blind and wears glasses. items presented at close range and time will be allowed to process.</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>anxiety like behaviors and has trouble regulating her emotions, may bite her wrist, rub thumbs until raw, and grind or clench her teeth. staff will reassure Kelsey and offer quiet space.</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>maintaining her quality of life and staying happy and healthy.</u>		
<b>Important for:</b> <u>staying busy and engaged in her community w/ peers.</u>		
<b>Likes:</b> <u>fish, cheeseburgers, ice cream, fries, ice cream, cheetos, shopping for jewelry, going out to eat, horseback riding church</u>		
<b>Dislikes:</b> <u>chips, carbonated drinks, spicy foods, garlicky foods</u>		
<b>Communication Style:</b> <u>signs, gestures, few verbal words. can choose between two items offered</u>		
<b>Learning Style:</b> <u>routine and repetition.</u>		

Staff: Laura Stacken  
 Date: April 11th 2023



Service Recipient: Kelsey M.  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>N/A</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite sized diet to prevent choking</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, hypotonia, neuromuscular scoliosis, mild left hemiparesis,</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>If the need did arise. we are trained</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>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>can transfer to toilet needs assistance</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Manual wheelchair. When in community, walk w/ assistance. wears AFOs on both legs.</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Delayed response to sound/speech. Legally blind &amp; wears glasses</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety like behaviors &amp; can have trouble regulating her breathing her emotions. may bite her wrist, rub thumbs (with) raw</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>Maintaining her quality of life &amp; staying happy &amp; healthy</u>		
<b>Important for:</b> <u>staying busy &amp; engaged in her community &amp; w/ her peers</u>		
<b>Likes:</b> <u>Fish, Pizza, Cheesburgers, fries, Ice cream. Cheetos, shopping for jewelry, going out to eat, horseback riding, church</u>		
<b>Dislikes:</b> <u>chips, carbonated drinks, spicy foods, garlicky foods</u>		
<b>Communication Style:</b> <u>Signs, gesturing. few words / phrases</u>		
<b>Learning Style:</b> <u>Practice &amp; repetition</u>		

Staff: Elie  
 Date: 4/11/23



Service Recipient: Kelsey M  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Staff will not give medication</u>	Medication Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes <small>*Listed on MAR, only administer meds per dr. order*</small>
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports:	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite size stuff will help eat food can eat some finger foods</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea hypotonia neuromuscular scoliosis</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <small>*Located in main file, share with EMT in emergency*</small>
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>will be taken with soft food / drink</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>
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Can transfer to the toilet using a gait belt staff assistance requires time on the toilet to have a bite</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>manual wheelchair when in community can walk with assistance</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>ill 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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>delayed response to sound and speech legally blind wears glasses</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety like behaviors trouble regulating her emotions may bite her wrist rub thumbs till raw</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>maintaining her quality of life and staying happy and healthy</u>		
<b>Important for:</b> <u>staying busy and engaged in her community with peers</u>		
<b>Likes:</b> <u>fish, pizza fries ice cream chexes shopping for jewelry going out to eat horseback riding church</u>		
<b>Dislikes:</b> <u>chairs carbonated drinks spray foods garlic foods</u>		
<b>Communication Style:</b> <u>Signs gestures few verbal words can choose between items</u>		
<b>Learning Style:</b> <u>routine and repetition.</u>		

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



Service Recipient: Kelsey Martin  
 Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin</u>	Medication Allergies? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports: <u>NA</u>	
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite size diet. Cutting up her food. Can eat finger foods. Fork/spoon if put on for her. Drinks sippy cup.</u>	
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea. Hypotonia. Neuromuscular scoliosis. Mid left hemiparesis.</u>	DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Trained staff would administer the medication.</u>	Daily medication at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Can transfer to the toilet using gait belt. Time on toilet BMS. Briefs changing &amp; cleaning.</u>	
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Manual wheelchair. Walk w/assistance. Wears ATOS both legs. Support gait belt.</u>	
<b>Community Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Delayed response to sound/speech. Legally blind. Wears glasses. Close range.</u>	
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety like behaviors. May bite her wrist. rub thumbs until raw. grind/clench her teeth. Melt out, Cry, hyperventilate.</u>	
<b>Unsupervised time while at PAI?</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes		
<b>Important to:</b> <u>Maintaining her quality of life. Staying happy &amp; healthy.</u>		
<b>Important for:</b> <u>Staying busy. Engaged in her community with her peers.</u>		
<b>Likes:</b> <u>Fish. Pizza. Cheeseburgers. Pries. Ice cream. Cheetos. Shopping jewelry. Eating. Horseback. Church. Olympic. etc.</u>		
<b>Dislikes:</b> <u>Chips. Carbonated drinks. Spicy food. Garlicy Foods.</u>		
<b>Communication Style:</b> <u>Signs. Gestures. Verbal words/phrases. Two item choice.</u>		
<b>Learning Style:</b> <u>Routine &amp; Repetitions.</u>		

Staff: Ralph Yernalds



Service Recipient: Kelsey Martin

Date: 4-11-2023

Service Span: \_\_\_\_\_

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

<b>Allergies:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Amoxicillin</u> Medication Allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes *Listed on MAR, only administer meds per dr. order*
<b>Seizures:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A	Describe Supports:
<b>Choking/ Specialized Diet:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Bite size diet to prevent choking. Staff will assist in cutting up his food.</u>
<b>Chronic Medical Conditions:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Chorea, Hypotonia Neuromuscular Scoliosis mild Left hemiparesis, Staff food is put on for him</u> DNR/DNI? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes *Located in main file, share with EMT in emergency*
<b>Medication:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>if the meds did give a trained staff would administer</u> Daily medication at PAI? <input type="checkbox"/> No <input type="checkbox"/> Yes *A trained staff will administer meds per a signed dr. order*
<b>Personal Cares:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Car transfer to the toilet using a gait belt and staff assistance. Requires time on toilet</u>
<b>Mobility/Fall Risk:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	Describe Supports: <u>Manual wheelchair when in the community can walk w/ assistance</u>
<b>Community Support:</b> <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
<b>Sensory Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A	List & Describe Supports: <u>Delayed response to speech. Legally blind</u> <u>to con sounds and</u>
<b>Behavior Support:</b> <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	List & Describe Supports: <u>Anxiety like behaviors and can have trouble regulating her emotions, may bite her wrist, may yell out</u>

Unsupervised time while at PAI?  No  Yes

Important to: maintaining the quality of life

Important for: staying busy, engaged in the community

Likes: Fish, Pizza, Cheeseburgers, Fries, Cheetos. Shopping for jewelry going to eat

Dislikes: chips carb smothered drinks spicy food, garlicky foods

Communication Style: Signs, verbal words / phrases

Learning Style: Routine and repetition