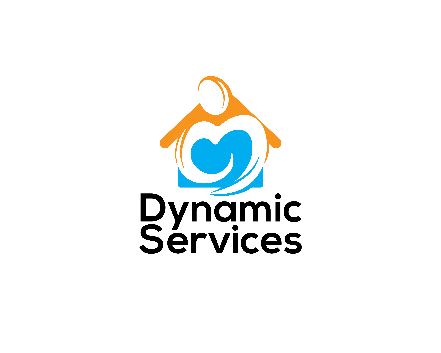
**COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM**

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| Name of person served:    Date of development:  For the annual period from: to  Name and title of person completing the *CSSP Addendum*: **Fahad Abdalla, Program Coordinator**  Legal representative:  Case manager:  Other support team members:  Current meeting: Intake 45-day  Annual  Semi-annual  Quarterly  Request to meet:  Annually  Semi-annually  Quarterly |
| Dates of development:   * Within 15 days of service initiation, the license holder must complete the preliminary *Coordinated Service and Support Plan Addendum* based upon the *Coordinated Service and Support Plan.* * Within 45 calendar days of service initiation, the license holder must meet with the support team and make determination regarding areas listed in this addendum. * Annually, the support team reviews the *Coordinated Services and Support Plan Addendum.* |
| **CLIENT IDENTIFYING INFORMATION** |
| |  |  | | --- | --- | | Consumer Name:  Address:  Phone:  Cell: | DOB:  Sex:  Race: | |
| **SERVICE DATA** |
| Intake Date:  Legal Status:  Service Initiation Date:  County of Financial Responsibility: County  County of Service Responsibility: County |
| **FINANCIAL RESOURCES** |
| PMI:  Waiver Type: |
| **CLIENT SPECIFIC INFORMATION** |
| **Mobility**:  **Use of Public**:  **Self-Cares**:  **Eating**:  **Primary Mode of Communication**:  **Adaptive Equipment or Appliances**:  **Is able to drink alcohol**? |
| **DESCRIBE CONSUMER INTERESTS** |
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| **HEALTH INFORMATION** |
| **Diagnosis**:  **Seizures**:  **Protocol on file**: |
| Current Prescription Medications: **Quality Care does not provide medical services to Consumer and is not responsible for his/her medications.** |
| **Allergies:**  **Special Diet:** |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s):**  Address:    Phone Number:  Cell:  Fax:  E-Mail: | **Alternate Emergency Contact:**  Address:    Phone Number:  Cell:  Fax:  E-Mail: | | **Legal Representative:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **Parents:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Residential Provider:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **County Case Manager:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **County Financial Worker:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **Behavioral Analyst:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Current School/Day Program/Work:**  Address:  Phone:  Fax:  E-mail:  Contact Person: | **Physician:**  Address:    Phone Number:  Cell:  Fax:  E-Mail: | | **Hospital of Preference:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **Dentist:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Physical Therapy:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **Other:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | |
| **QUALITY CARE CONTACTS** |
| **Founder & CEO: Ammar Abdalla**  Phone: 651-760-8331  E-mail: Ammar.Abdalla@qualitycaremn.org |
| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
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| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
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| HEALTH NEEDS |
| Indicate what health service responsibilities are assigned to this license holder and which are consistent with the person’s health needs. If health service responsibilities are not assigned to this license holder, please state “NA”: N/A If health service responsibilities are assigned to this license holder, you will be promptly notified of any changes in the person’s physical and mental health needs affecting the health service needs. |
| If the license holder is assigned responsibility for medication assistance or medication administration, the license holder will provide medication administration or assistance (including set up) according to the level indicated here: Medication set up  Medication assistance  Medication administration  N/A  **\*Quality Care is not assigned for medication assistance or medication administration to Consumer and is not responsible for his/her medications.** |
| The following information will be reported to the legal representative and case manager as they occur, unless otherwise indicated here:  * Any report made according to 245D.05, subdivision 2, paragraph (c), clause (4) * The person’s refusal or failure to take or receive medication or treatment as prescribed. * Concerns about the person’s self-administration of medication or treatments. |
| **Description of the person’s status** |
| **What is currently important to the person and for the person**:  **Status of social relationships and natural supports**:  **New or ongoing opportunities, inclusion and/or participation at home or in the community**:  **Description of relevant behavioral issues**:  **Description of relevant health issues**:  **Other information as requested by the support team, please indicate**: N/A |
| PSYCHOTROPIC MEDICATION MONITORING AND USE |
| If this person is prescribed psychotropic medication and this license holder has been assigned responsibility for medication administration, the following information will be maintained by the license holder. Please refer to the Behavior Outcome and Psychotropic Medication Monitoring Data Report for more information. Is this person prescribed psychotropic medication?  Yes  No  N/A  **Quality Care does not provide medical services to Consumer and is not responsible for his/her psychotropic medications.** Describe the target symptoms the psychotropic medication is to alleviate: N/A Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms: |

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| **SERVICES AND SUPPORTS** |
| Describe the **general and health-related supports** necessary to support this person based upon the *Self-Management Assessment* and the requirements of person-centered planning and **service delivery**: |
| **The scope of the services to be provided to support the person’s daily needs and activities include**:  Quality Care will provide ILS (Independent Living Skills) services to Consumer during the times she finds appropriate. |
| Can this person use **dangerous items or equipment**?  Yes  No  If yes, address any concerns or limitations: |
| The person’s **preferences for how services and supports are provided**: |
| Is the current service setting the **most integrated setting available and appropriate** for the person?  Yes  No If no, please describe what will be done to address this: |
| How will services be **coordinated across other 245D licensed providers** **and members of the support team or expanded support team** serving this person to ensure continuity of care and coordination of services?  Quality Care and Consumer’s team will connect via phone, email or in person at least annually and as requested by the team.  If there is a **need for service coordination** between providers, include the name of service provider, contact person and telephone numbers, services being provided, and the names of staff responsible for coordination:  **Founder & CEO: Ammar Abdalla**  Phone: 651-760-8331  E-mail: Ammar.Abdalla@qualitycaremn.org  **County Case Manager:**  Phone Number:  Fax:  E-Mail:  **Other:**  Phone Number:  Fax:  E-Mail: |
| Does the person require **staff presence** at the service site while services are being provided?  Yes  No  If no, provide information on when staff do not need to be present with this person (include community, home, or work) and for the length of time. If additional safety plan information regarding is needed, also provide: |
| Does the person require a **restriction of their rights** as determined necessary to ensure the health, safety, and well-being of the person?  Yes  No  If yes, indicate what right(s) are restricted:  Refer to the attached *Rights Restrictions* form for all additional requirements and documentation. |

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| PERMITTED ACTIONS AND PROCEDURES |
| Has it been determined by the person’s physician or mental health provider to **be medically or psychologically contraindicated to use an emergency use of manual restraint** when a person’s conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety?  Yes  No  If yes, the company will not allow behavioral intervention/manual restraint to be used for the person. |
| Is a restraint needed as an **intervention procedure to position this person** due to physical disabilities?  Yes  No  If yes, please specify the manner in which the restraint is/will be used: |
| What **positive support strategies** may be attempted as a means to de-escalate the person’s behavior before it poses an imminent risk of physical harm to self or others?  NA – this person does not have behaviors that would pose an imminent risk of physical harm to others. |
| Does the person require the **use of permitted actions and procedures or instructional techniques and intervention procedures on a continuous basis** as identified in 245D.06, subdivision 7, paragraphs (b) and (c)?  Yes  No  If yes, please address how these are used as part of service provision according to 245D.07 and 245D.071, *Service Planning and Delivery*: |

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| **STAFF INFORMATION** |
| Are any **additional requirements** requested for staff to have or obtain in order to meet the needs of the person?  Yes  No  If yes, please specify what these requirements are: |
| Does a staff person who is **trained in cardiopulmonary resuscitation (CPR)** need to be available when this person is present and staff are required to be at the site to provide direct service?  Yes  No |

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| **FREQUENCY OF REPORTS AND NOTIFICATIONS** |
| \*Information received regarding the frequency of reports and notifications is completed with the person served and/or legal representative and case manager.   1. Frequency of *Progress Reports and Recommendations*, at a minimum of annually:   Quarterly  Semi-annually  Annually   1. Frequency of progress review meetings, at a minimum of annually:   Quarterly  Semi-annually  Annually   1. Frequency of receipt of *Psychotropic Medication Monitoring Data Reports*, this will be done quarterly unless otherwise requested or specified by prescriber:   Quarterly  Other (specify):  N/A   1. Frequency of medication administration record reviews, this will be done quarterly or more frequently as directed (for licensed holders when assigned responsibility for medication administration):   Quarterly  Other (specify):  N/A   1. The legal representative and case manager will receive notification within 24 hours of an incident or emergency occurring while services are being provided or within 24 hours of discovery or receipt of information that an incident occurred, or as otherwise directed. Please indicate any changes regarding this notification: 2. Request to receive the *Progress Report and Recommendation*:   At the support team meeting; or  At least five working days in advance of the support team meeting.   1. Frequency of receiving a financial statement that itemizes receipt and disbursements of funds.   Quarterly  Semi-annually  Annually  Other (specify):  NA |

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| **CONFERENCE MINUTES (Summary of team discussion/determinations)** |
| Meeting Date:  Meeting Attendance:  Description of Consumer’s participation in conference process: Participated  Review of Guardianship or Conservatorship Status:  Review of Placement and Appropriateness: Appropriate. |
| Other discussion: |

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**SIGNATURE PAGE**

**By signing below, I am indicating the completion and approval of *Coordinated Service and Support Plan Addendum*.**

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| Person served: | Date: |
| Legal representative/guardian: | Date: |
| Case manager: | Date: |
| Licensed provider contact: | Date: |
| Other support team member (name and title): | Date: |
| Other support team member (name and title): | Date: |