|  |
| --- |
| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Daniel Daly    Date of development: 11/19/2015  For the annual period from: 11/24/2015 to 11/23/2016  Name and title of person completing the *CSSP Addendum*: Dhimbil Ali, Program Manager  Legal representative: Self Guardian  Case manager: Cailje Lorsung, Thomas Allen, Inc.  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: Daniel Daly  DOB: 9/24/1992  Sex: Male  Weight: 285 LBS  Eye Color: Brown  Race: Caucasian  Height: 5’ 8”  Hair Color: Reddish | Address: 907 Lakewood Court South  Maplewood, MN 55119  Phone: 651-730-9727  Religious Preference: Lutheran | |
| **SERVICE DATA** |
| Intake Date: November 17, 2009  Legal Status: Own Guardian  Service Initiation Date: November 17, 2009  County of Financial Responsibility: Ramsey  County of Service Responsibility: Ramsey |
| **FINANCIAL RESOURCES** |
| Social Security Number:  Medical Assistance Number:  Medicare Number:  Type: (MSA, RSDI, SSI, wages) N/A  Amount/Month: N/A  Savings Account Balance: Not Provided Financial Institution: Not Provided  Checking Account Balance: Not Provided Financial Institution: Not Provided  Burial Account Balance: Not Provided Financial Institution: Not Provided |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory  Use of Public Transportation: Daniel is able to utilize public transportation.  Self-Cares: Daniel requires verbal prompts  Domestic: Daniel requires verbal prompts  Eating: Independent: Daniel requires supervision to prevent over eating, as he has a tendency to shovel food into his mouth.  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: None  Is able to drink alcohol? No  Identify form of Personal Identification (card, bracelet, necklace...) State ID |
| **DESCRIBE CONSUMER INTERESTS** |
| Daniel Daly likes to play the Magic game. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Asperger’s, ADHD, mood disorder, and Tic disorder  **Seizures**: No  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** Daniel is allergic to cashews, brazil nuts, hazel nuts, pistachios, lactose.  **Special Diet:** None |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s):** Debra Daly **(**Mother)  Address: 907 Lakewook Court S  Maplewood, MN 55119  Phone Number: 651-730-9727  Cell: 651-398-3116  Fax:  E-Mail: ddaly@helsbriscoe.com | **Family Choice of Alternate Emergency Contact:** Billy Daly (Father)  Address: 907 Lakewood Court S  Maplewood, MN 55119  Phone Number: 651-730-9727  Cell: 651-226-6973  Fax:  E-Mail: wdaly3@msn.com | | **Legal Representative: Self Guardian**  907 Lakewood Court South  Maplewood, MN 55119  Phone: 651-730-9727  Cell:  Fax:  E-Mail: | **Parents: Debra Daly**  Address: 907 Lakewood Court S  Maplewood, MN 55119  Phone Number: 651-730-9727  Cell: 651-398-3116  Fax:  E-Mail: | | **Residential Provider: Daniel Lives at Home**  Address: 907 Lakewook Court S  Maplewood, MN 55119  Phone Number: 651-730-9727  Cell:  Fax:  E-Mail:  Contact Person: | **County Case Manager: Cailje Lorsung, Thomas Allen**  Address: 1535 Livingstone Ave., West  St. Paul, MN 55118  Phone Number: 651-900-1194  Cell:  Fax: 1-888-479-3182  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: Cravings Restaurant**  Address: 755 Bielenberg Dr #108,   Woodbury, MN 55125  Phone: (651) 528-6828  Fax:  E-mail:  Contact Person: | **Physician: Dr. Peter Lowenson: Woodwinds Hospital**  Address: 1925 Woodwinds Drive,  Woodbury MN 55124  Phone Number: 651-232-0228  Cell:  Fax:  E-Mail: | | **Hospital of Preference: Woodwinds Hospital**  Address: 1925 Woodwinds Drive,  Woodbury MN 55124  Phone Number: 651-232-0228  Cell:  Fax:  E-Mail: | **Dentist: Park Dental Highpoint**  Address: 8980 Hudson Blvd.,  Lake Elmo, MN 55042  Phone Number: 651-735-9057  Cell:  Fax:  E-Mail | | **Other:** (Psychologist, Psychiatrist, Neurologist, OT, PT, Speech, etc.)  Behavioral Health Services  Address: 2497 7th Avenue East, Suite 101  North Saint Paul, MN 55109  Phone: 651-760-5120  Fax: 651-769-6449 |  | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: Dhimbil Ali**  Cell: 612-730-2130  Office: 612-977-3950  E-mail: [Dhimbil.Ali@High QualityServices.org](mailto:Dhimbil.Ali@PinnacleServices.org)  **Program Director: Jessica Reno**  Cell: 612-723-5895  Office: 612-377-3105  E-mail: [Jessica.Reno@High QualityServices.org](mailto:Jessica.Reno@PinnacleServices.org)  **Program Administrator: Jamie Fann**  Phone 612-977-3115  E-mail: [Jamie.Fann@High QualityServices.org](mailto:Jamie.Fann@PinnacleServices.org)  **Chief Executive Officer: Jill Cihlar**  Phone: 612-977-3111  E-mail: [Jill.Cihlar@High QualityServices.org](mailto:Jill.Cihlar@PinnacleServices.org)  **Chairman: Nic Thomley**  Phone: 612-977-3110  E-mail: [Nic.Thomley@High QualityServices.org](mailto:Nic.Thomley@PinnacleServices.org) |
| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
|  |
| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| Daniel likes to compete in Magic game competition at game stores. |
| **REVIEW OF ASSESSMENTS/EVALUATIONS** |
| |  |  | | --- | --- | | Annual Physical: | Recall Date: | | Dental Exam: | Recall Date: | | Vision Exam: | Recall Date: | | Hearing Eval: | Recall Date: | | Psychological Eval: | Recall Date: | | Neurological Eval: | Recall Date: | | Psychiatric Eval: | Recall Date: | | Speech Assessment: | Recall Date: | | OT Assessment: | Recall Date: | | PT Assessment: | Recall Date: | | Tetanus Vaccination: | Recall Date: | | Depo-Provera Shot: | Recall Date: | | Individual Service Plan: | Recall Date: | | Flu Shot: | Recall Date: | | Other: | Recall Date: | |

|  |
| --- |
| 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 |
| 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: Daniel Enjoys playing Airsoft.  Status of social relationships and natural supports: Daniel has a strong network of family support.  Recent inclusion and participation in the community: Daniel works at Cravings Restaurant.  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication: Daniel works on his goals whenever he can.  Description of relevant behavioral issues: None  Description of relevant health issues: None  Other information as requested by the support team, please indicate: None |
| 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 Describe the target symptoms the psychotropic medication is to alleviate:   Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms: High Quality is not contracted to monitor or measure the symptoms of psychotropic medications. |

|  |
| --- |
| **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:  High Quality staff remind Daniel to be aware of his surroundings so he doesn’t bump into people. High Quality staff also ensure Daniel carries his Epi-pen with him when he’s out in the community.  High Quality staff will verbally prompts Daniel to take small bites, slow down and chew his food. High Quality staff has been trained in first aid and CPR if Daniel were to ever choke on food. High Quality staff will follow first aide techniques and report to guardian and program manager.  Staff will verbally remind Daniel of good choices, and will verbally review with Daniel consequences to his actions when teachable moments arise. |
| The scope of the services to be provided to support the person’s daily needs and activities include:  High Quality Services staff provide independent living services to Daniel in the community. |
| 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**: Daniel is happy with the services he’s being provided and likes working with his staff, Danny. |
| 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?    Daniel and his team will meet annually to ensure coordination of services.  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:    **Emergency Contact Person(s):** Debra Daly **(**Mother)  Address: 907 Lakewook Court S  Maplewood, MN 55119  Phone Number: 651-730-9727  Cell: 651-398-3116  E-Mail: ddaly@helsbriscoe.com  **County Case Manager: Cailje Lorsung**  Address: 1535 Livingstone Ave., West  St. Paul, MN 55118  Phone Number: 651-789-4545  Fax: 651-451-6185 |
| Does the person require the **presence of staff** at the service site while services are being provided?  Yes  No  If no, please 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 information regarding safety plan 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. |

|  |
| --- |
| 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 the use of the 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.  **Positive support strategies** include: |
| 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*: |

|  |
| --- |
| **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 |

|  |
| --- |
| **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): NA   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 |

|  |
| --- |
| **CONFERENCE MINUTES (Summary of team discussion/determinations)** |
| Meeting Date: 11/24/2015  Meeting Attendance: Daniel Daly, Dhimbil Ali, Debra Daly  Description of Consumer’s participation in conference process: Daniel participated in the annual and vocalized his needs.  Review of Guardianship or Conservatorship Status: Daniel is his own Guardian.  Review of Placement and Appropriateness: Current placement in parent’s home is appropriate |
| Other discussion: |

**SIGNATURE PAGE**

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

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