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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Tyrus Brown    Date of development: 2/2/15  For the annual period from: July 2015 to July 2016  Name and title of person completing the *CSSP Addendum*: Jessica Reno, Program Director  Legal representative: Wanda Austin, mother is the guardian.  Case manager: Ellen Gabrielson  Other support team members: Trinka Owens  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: Tyrus Brown  DOB: 9/19/1979  Sex: Male  Weight: 150lbs  Eye Color: Brown  Race: African American  Height: 5’2”  Hair Color: Black | Address: 6743 Humboldt Ave. N. #203, Brooklyn Center, MN 55430  Phone: 612-559-9583  Religious Preference: Pentecostal | |
| **SERVICE DATA** |
| Intake Date: 4/9/2007  Legal Status: Mother, Wanda Austin, is Tyrus’ legal guardian.  Service Initiation Date: 4/7/2007  County of Financial Responsibility: Hennepin  County of Service Responsibility: Hennepin |
| **FINANCIAL RESOURCES** |
| Social Security Number: 473-94-4036  Medical Assistance Number: 00485900  Medicare Number: N/A  Type: (MSA, RSDI, SSI, wages)  Amount/Month:  Savings Account Balance: Financial Institution:  Checking Account Balance: Financial Institution:  Burial Account Balance: Financial Institution: |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Tyrus is ambulatory.  Use of Public Transportation: Tyrus does not use public transportation, but utilizes the accessibility van for his day program services.  Self-Cares: Tyrus requires assistance with personal cares from his family.  Domestic: Tyrus may need verbal prompts with domestic tasks from High Quality staff and his family.  Eating: Tyrus eats independently.  Primary Mode of Communication: Tyrus speaks English to communicate verbally.  Adaptive Equipment or Appliances: None.  Is able to drink alcohol? No.  Identify form of Personal Identification (card, bracelet, necklace...): Tyrus lost his State ID, so the case Manager will get Tyrus new ID. |
| **DESCRIBE CONSUMER INTERESTS** |
| Tyrus enjoys playing golf and basketball. He also likes to dance, watch movies, and go bowling. Tyrus enjoys music and would like to tour a radio station. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Moderate MR and Down Syndrome.  **Seizures**: No.  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | N/A |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** Eggs.  **Special Diet:** None at this time. |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s):** Wanda Austin  Address: 6743 Humboldt Ave. N. #203, Brooklyn Center, MN 55430  Phone: 612-559-9583 (Robert’s Cell)  Cell: 763-614-6402 (Wanda’s Cell)  Work: 612-302-1463  E-Mail: Wandaaus@msn.com | **Family Choice of Alternate Emergency Contact:** Deborah Thames (PCA/Sister)  Address: 6743 Humboldt Ave. N. #203, Brooklyn Center, MN 55430  Cell: 612-940-4071  E-Mail: | | **Legal Representative:** Wanda Austin  Address: 6743 Humboldt Ave. N. #203, Brooklyn Center, MN 55430  Phone: 612-559-9583  Cell: 612-220-3473  Work: 612-302-1463  E-Mail: Wandaaus@msn.com | **Parents:** Wanda Austin  Address: 6743 Humboldt Ave. N. #203, Brooklyn Center, MN 55430  Phone: 612-559-9583  Cell: 612-220-3473  Work: 612-302-1463  E-Mail: Wandaaus@msn.com | | **Residential Provider:** Integrity Home Care (PCA)  Address: 2100 Plymouth Ave. North #115, Minneapolis, MN 55411  Phone Number: 612-827-1479  Cell: 612-290-9605  E-Mail:  Contact Person: Cynthia Buffington | **County Case Manager:** Ellen Gabrielson  Address: MC 150, 300 S. 6th St., Minneapolis, MN 55487  Phone Number: 612-348-8810  Fax: 612-466-9631  E-Mail: Ellen.Gabrielson@hennepin.us | | **Current School/Day Program/Work:** AccessAbility  Address: 360 Hoover St. NE, Minneapolis, MN 55413  Phone: 612-331-5958  Fax: 612-331-2448  E-mail:  Contact Person: Kim Lepper | **Dentist:** Community Dental  Address: 3359 W Broadway Ave, Robbinsdale, MN 55422  Phone Number: 763- 201-5776  Fax:  E-Mail | | **Hospital of Preference:** HCMC  Address: 701 Park Ave., Minneapolis, MN 55416  Phone Number: 612-873-3000 | **Physician:** HCMC, Dr. Molly  Address: 701 Park Ave., Minneapolis, MN 55416  Phone Number: 612-873-3000 | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Director: Jessica Reno**  Phone: 612-977-3105  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  **Chairman: Nic Thomley**  Phone: 612-977-3110  E-mail: [Nic.Thomley@High QualityServices.org](mailto:Nic.Thomley@PinnacleServices.org) |
| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
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| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| Tyrus and his family moved to Brooklyn Center this year. |
| **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: | |

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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”: NA 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: NA Medication set up  Medication assistance  Medication administration  NA |
| 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: It is important to Tyrus to attend church. It is important for Tyrus to maintain his health and safety.  Status of social relationships and natural supports: Tyrus has a string support system through family and his church.  Recent inclusion and participation in the community: Tyrus participates in the Men’s Ministry and cleans the church with his dad on Saturdays  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication: None  Description of relevant behavioral issues: No relevant behavioral issues.  Description of relevant health issues: No relevant health issues.  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 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: |

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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:   * Tyrus is not currently on any medication; however, if and when he is prescribed medication, his mother will administer it. * Tyrus may pick at his scabs. In the past, he has taken his own stitches out. Staff will redirect Tyrus when he engages in self-injurious behavior. * Tyrus has been physically and verbally aggressive towards others in the past. |
| The scope of the services to be provided to support the person’s daily needs and activities include: In Home Services staff meets Tyrus in his home and in the community, working on his personalized goals during these times. |
| 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**: Tyrus does best with staff members who are gentle but stern. |
| 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?    Tyrus’ team will meet annually to discuss Tyrus’ services and ensure coordination.  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:     |  |  | | --- | --- | | **Legal Representative:** Wanda Austin  Address: 6743 Humboldt Ave. N. #203, Brooklyn Center, MN 55430  Phone: 612-559-9583  Cell: 612-220-3473  Work: 612-302-1463  E-Mail: Wandaaus@msn.com | **County Case Manager:** Ellen Gabrielson  Address: MC 150, 300 S. 6th St., Minneapolis, MN 55487  Phone Number: 612-348-8810  Fax: 612-466-9631  E-Mail: Ellen.Gabrielson@hennepin.us | | **Current School/Day Program/Work:** AccessAbility  Address: 360 Hoover St. NE, Minneapolis, MN 55413  Phone: 612-331-5958  Fax: 612-331-2448  E-mail: TOwens@AccessAbility.org  Contact Person: Trinka Owens | **Residential Provider:** Integrity Home Care (PCA)  Address: 2100 Plymouth Ave. North #115, Minneapolis, MN 55411  Phone Number: 612-827-1479  Cell: 612-290-9605  E-Mail:  Contact Person: Cynthia Buffington | |
| 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. |

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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 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*: |

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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): NA   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 |

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| **CONFERENCE MINUTES (Summary of team discussion/determinations)** |
| Meeting Date: 07/29/2015  Meeting Attendance: Ellen Gabrielson (case manager), Wanda Austin, Kim (Accessibility), Tyrus (consumer) and Jessica Reno (High Quality)  Description of Consumer’s participation in conference process: Tyrus self-advocated for his goals and needs.  Review of Guardianship or Conservatorship Status: Appropriate  Review of Placement and Appropriateness: Appropriate |
| Other discussion: During the meeting, the team discussed that High Quality’s employment policies must be followed by In Home Services staff to ensure licensing and waiver compliance. |

**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: | Date: |
| Case manager: | Date: |
| Licensed provider contact: | Date: |
| Other support team member (name and title): | Date: |
| Other support team member (name and title): | Date: |