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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Derek Cody    Date of development: April 21st, 2015  For the annual period from: May 27nd, 2015 to May 26st, 2016  Name and title of person completing the *CSSP Addendum*: Jessica Reno, Program Director  Legal representative: Siri Khalsa  Case manager: Blair Henning  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: Derek Cody  DOB: 11-25-1995  Sex: Male  Weight: 180lbs  Eye Color: Blue  Race: Caucasian  Height: 5’10”  Hair Color: Sandy Blonde | Address: 430 Mount Ida St.  St. Paul, MN 55130  Phone: 651-431-4618 (Siri work)  612-839-9768 (Siri Cell)  651-955-6327 (Derek Cell)  Religious Preference: None | |
| **SERVICE DATA** |
| Intake Date: 04-13-2006  Legal Status: Siri Khalsa (mother) is legal guardian.  Service Initiation Date: 04-13-2006  County of Financial Responsibility: Ramsey County  County of Service Responsibility: Ramsey County |
| **FINANCIAL RESOURCES** |
| Social Security Number: 469-31-9276  Medical Assistance Number: 01700493  Medica Number: 5203810070447746  Type: (MSA, RSDI, SSI, wages)  Amount/Month:  Savings Account Balance: N/A Financial Institution: N/A  Checking Account Balance: N/A Financial Institution: N/A  Burial Account Balance: N/A Financial Institution: N/A |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory  Use of Public Transportation: Derek can use public transportation independently.  Self-Cares: Derek is independent with his self-cares; however, he may need reminders or cues to initiate them.  Domestic: Derek has chores that he is supposed to work on weekly. Derek occasionally cooks simple meals independently. He may need assistance with meal preparation.  Eating: Derek eats very well.  Primary Mode of Communication: Derek is verbal and speaks English.  Adaptive Equipment or Appliances: None.  Is able to drink alcohol? No, Derek is underage.  Identify form of Personal Identification (card, bracelet, necklace...) Derek has a State ID. |
| **DESCRIBE CONSUMER INTERESTS** |
| Derek likes to play basketball, baseball, video games, go swimming, ride his bike, and go to the Movies. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Autism Spectrum Disorder, Learning Disability, Attention Deficit Hyperactivity Disorder  **Seizures**: No.  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** None.  **Special Diet:** None. |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s): Siri Khalsa (Mother)**  Address: 430 Mount Ida St.  St. Paul, MN 55130  Phone Number: 651-431-4618 (work)  Cell: 612-839-9768  E-Mail: sirik@comcast.net | **Family Choice of Alternate Emergency Contact: Justin Kline (Step-father)**  Address: 430 Mount Ida St.  St. Paul, MN 55130  Phone Number: 612-387-5924 | | **Family Choice of Alternate Emergency Contact: Megan Cody (Sister)**  Address: 430 Mount Ida St.  St. Paul, MN 55130  Phone Number: 651-447-3228 | **Legal Representative: Siri Khalsa (Mother)**  Address: 430 Mount Ida St.  St. Paul, MN 55130  Phone Number: 651-431-4618 (work)  Cell: 612-839-9768  E-Mail: sirik@comcast.net | | **Parents: Siri Khalsa**  Address: 430 Mount Ida St.  St. Paul, MN 55130  Phone Number: 651-431-4618 (work)  Cell: 612-839-9708  E-Mail: sirik@comcast.net | **County Case Manager: Blair Henning**  Address: 1535 Livingston Ave  West St Paul, MN 55118  Phone Number: 651-789-4519  Fax: 651-451-6185  E-Mail: [blairh@thomasalleninc.com](mailto:blairh@thomasalleninc.com)  As of 10/26/15 confirmed that Bao Vang new case manager, 651-789-1213 | | **Mental Health County Case Manager: Ebony Gums, Thad Wilderson & Associates**  Address: Rule 29 Mental Health Clinic  475 University Ave.  St. Paul, MN 55103  Phone Number: 651-225-8997  Fax: 651-225-1697 | **County Financial Worker: Youa Yang**  Address: 160 E. Kellogg Blvd.  St. Paul, MN 55101  Phone Number: 651-266-4677 | | **PICS: Melissa Peterson**  Address:  Phone Number: 651-967-5060 ext. 2455 | **Current School/Day Program/Work:**  Address:  Phone:  Fax:  E-mail:  Contact Person: | | **Physician: Health Partners Wabasha**  Address: 205 S Wabasha St  Saint Paul, MN 55107  Phone Number: 651-293-8100 | **Hospital of Preference – Mental Health: Fairview Medical Center**  Address: 420 Delaware St. SE  Minneapolis, MN 55454  Phone Number: 612-672-6000 | | **Hospital of Preference – Medical Health: Regions Hospital**  Address: 640 Jackson Street  St. Paul, MN 55101  Phone Number: 651-254-3456 | **Dentist: Park Dental**  Address: 917 Grand Ave  Saint Paul, MN 55105  Phone Number: 651-221-1902 | |
| **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** |
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| **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 Derek to be actively engaged in sports, as well as have relationships with his family, friends, and his girlfriend. It is important for Derek to increase money management skills, appropriate communication skills, and maintain health and safety.  Status of social relationships and natural supports: Derek has a strong support structure with family and friends.  Recent inclusion and participation in the community: Derek attends school regularly and enjoys hanging out with friends win the community.  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: Derek has been staying out overnight and leaving home without notifying his parent.  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 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: Derek does not administer medications independently, but is not currently on any medication. High Quality Services is not responsible for medication administration during ILS shifts.  Derek can swim and demonstrates good water safety skills. Derek and ILS Staff will only go to bodies of water with a lifeguard present. |
| The scope of the services to be provided to support the person’s daily needs and activities include: High Quality staff will assist Derek in improving his independent living skills, specifically, participation in community integration activities, managing his anger, cooking, and obtaining his driver’s license. |
| 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**: Derek works best with a more laid back staff. Derek does not like to be pushed too hard, and responds best when criticism or feedback is phrased as a suggestion, rather than a command. |
| 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?  Derek and his team will meet annually to ensure coordination of Derek’s 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): Siri Khalsa (Mother)**  Address: 430 Mount Ida St.  St. Paul, MN 55130  Phone Number: 651-431-4618 (work)  Cell: 612-839-9768  E-Mail: sirik@comcast.net  **County Case Manager: Blair Henning**  Address: 1535 Livingston Ave  West St Paul, MN 55118  Phone Number: 651-789-4519  Fax: 651-451-6185  E-Mail: blairh@thomasalleninc.com |
| 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:   1. When Derek gets angry, staff will verbally remind Derek that he has chosen to work on reducing/eliminating maladaptive behaviors such as physically aggressing toward others or destroying property. 2. Staff will start counting cues to keep Derek’s hands to himself. 3. Staff will attempt to block any aggressions towards others or towards property. 4. Staff will continue to use a calm voice and cue Derek to calm down. 5. Staff will verbally cue Derek to calm down, then staff will back up and allow Derek to process the information.   Once Derek is calm, staff will discuss the situation and come up with alternatives to the behavior. |
| 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: 5/27/2015  Meeting Attendance: Siri Khalsa, Jessica Reno, and Derek Cody  Description of Consumer’s participation in conference process: Derek participated in part of the meeting and reviewed his ILS goals in detail. Identifying a desire to establish new goals to increase money management and housing acquisition skills.  Review of Guardianship or Conservatorship Status: Appropriate at this time.  Review of Placement and Appropriateness: Appropriate at this time. |
| Other discussion: None. |

**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: |