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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Lynette Bradley    Date of development: 12/10/2014  For the annual period from: 11/1/2014 to 11/1/2015  Name and title of person completing the *CSSP Addendum*: AnnaMarie Martino, Program Coordinator  Legal representative: Amy Girling is guardian  Case manager: Kevin McLane  Other support team members: Aisha Beaty  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: Lynette Bradley  DOB: 9/16/1988  Sex: Female  Weight: 185 lbs.  Eye Color: Brown  Race: African American  Height: 5’2”  Hair Color: Black | Address: 3108 James Ave. N., Minneapolis, MN  Phone: 612-407-0227  Religious Preference: None | |
| **SERVICE DATA** |
| Intake Date: 10/31/2014  Legal Status: Amy Girling is guardian  Service Initiation Date: 11/1/14  County of Financial Responsibility: Hennepin County  County of Service Responsibility: Hennepin County |
| **FINANCIAL RESOURCES** |
| Social Security Number: 360-82-1901  Medical Assistance Number: 00471527  Medicare Number:  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: Ambulatory. Lynette utilizes a scooter for long distances or prolonged periods of standing.  Use of Public Transportation: Lynette uses Metro Mobility.  Self-Cares: Semi-independent, Lynette needs support with self-cares.  Domestic: Semi-independent, Lynette needs support with domestic tasks.  Eating: Lynette is able to eat independently.  Primary Mode of Communication: Lynette speaks English.  Adaptive Equipment or Appliances: Lynette utilizes an electric scooter.  Is able to drink alcohol? No.  Identify form of Personal Identification (card, bracelet, necklace...) MN ID card. |
| **DESCRIBE CONSUMER INTERESTS** |
| Lynette enjoys community outings such as bowling. She has enjoyed participating in Special Olympics events. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Anxiety disorder, Mild Mental Retardation, Cerebral Palsy, Recent Gallbladder Surgery, Periodic Migraine Headaches, Chronic Pain from CP.  **Seizures**: Lynette has a history of seizures in the past.  **Protocol on file**: No. |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | Baclofen Tablet | 15mg | 3x Daily | Muscle Relaxer | | Caltrate +D Tablet | 600mg | 2x Daily | Calcium Supplement | | Cymbalta Capsule | 60mg | Daily | Depression/Anxiety | | Flovent HFA Inhaler | 44mcg | 2x Daily | Asthma | | Konsyl Capsule 2 caplets | 520mg | Daily | Bowel Regulation | | Denta Gel | 1.1% | 2x Daily | Fluoride | | Tab-a-Vite Tablet | 1 tablet | Daily |  | | Pataday Eye Drops, 1 drop | 0.2% | Daily | Eye Allergies | | Clonazepam Tablet | .5mg | 2x Daily, PRN | Anxiety | |
| **Allergies:** Ibuprofen, Seasonal Allergies  **Special Diet:** None. |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s):** Aisha Beaty  Address: 3108 James Ave. N., Minneapolis, MN  Cell: 612-407-0230  Fax:  E-Mail: Beaty.Aisha@yahoo.com | **Family Choice of Alternate Emergency Contact:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Legal Representative:** Amy Girling  Address: 300 S. 6th St., MC 150, Minneapolis, MN  Phone Number: 612-543-0166  Cell: 612-207-5104  Fax: 612-632-8713  E-Mail: Amy.Girling@Hennepin.us | **Parents:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Residential Provider: NA**  Address:  Phone Number:  Cell:  Fax:  E-Mail:  Contact Person: | **County Case Manager:** Kevin McLane  Address: 7051 Brooklyn Blvd. Brooklyn Center, MN 55429  Phone Number: 612-275-5870  Cell:  Fax:  E-Mail: Kevin.McLane@Hennepin.us | | **County Financial Worker:** HSPH Team 254  Address:  Phone Number: 612-596-1300  Cell:  Fax:  E-Mail: | **Behavioral Analyst:** David Quam (Crisis only)  Address: 18986 Lake Drive East, Chanhassen, MN 55317  Phone Number: 612-869-6811  Cell: 952-767-3681  Fax:  E-Mail: | | **Current Work:** Byerly’s Ridgedale  Address:13081 Ridgedale Dr., Hopkins, MN 55305  Phone: 952-541-1414  Fax:  E-mail:  Contact Person: Tisha or Chris | **Physician:** Dr. Lewis  Address: 409 W. Dunlop St., St. Paul, MN  Phone Number: 612-290-9200  Cell:  Fax:  E-Mail: | | **Hospital of Preference:** HCMC  Address: 730 S. 8th St., Minneapolis, MN 55415  Phone Number: 612-873-3000  Cell:  Fax:  E-Mail: | **Dentist:** Open Cities Health Center  Address: 409 W. Dunlop St., St. Paul, MN  Phone Number: 612-290-9200  Cell:  Fax:  E-Mail | | **Attorney for Guardianship:** Melanie Liska  Address: 1539 Grand Ave., St. Paul, MN 55105  Phone Number: 651-698-7975  Fax: 651-698-5703 | **Psychiatrist:** Cassidy Peterson (MORA)  Address: 1603 Old Shakopee Rd. W., Bloomington, MN 55431  Phone Number: 952-401-4868  Cell:  Fax:  E-Mail: | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: AnnaMarie Martino**  Cell: 612-730-2130  Office: 612-977-3117  E-mail: AnnaMarie.Martino@High QualityServices.org  **Program Director: Jessica Reno**  Office: 612-977-3105  E-mail: Jessica.Reno@High QualityServices.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** |
| Police were called to Lynette’s previous residence when she and Aisha (Girlfriend) were having a dispute. Lynette also had fraudulent transactions at her bank. |
| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| Lynette has been working at Byerly’s Ridgedale. She recently moved in with her girlfriend, Aisha, and her family. Lynette also experienced a service transition recently. |
| **REVIEW OF ASSESSMENTS/EVALUATIONS** |
| |  |  | | --- | --- | | Annual Physical: | Recall Date: 1/13/14 | | Dental Exam: | Recall Date: 1/9/14 | | Vision Exam: | Recall Date: | | Hearing Eval: | Recall Date: | | Psychological Eval: | Recall Date: 6/16/11 | | Neurological Eval: | Recall Date: 7/22/13 | | Psychiatric Eval: | Recall Date: 10/14/14 | | Speech Assessment: | Recall Date: | | OT Assessment: | Recall Date: 3/21/14 | | PT Assessment: | Recall Date: 3/21/14 | | Tetanus Vaccination: | Recall Date: 9/13/13 | | Depo-Provera Shot: | Recall Date: | | Individual Service Plan: | Recall Date: | | Flu Shot: | Recall Date: | | Other: | Recall Date: 10/1/13 | |

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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 |
| 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: Lynette’s independence is important to her. Lynette’s team has determined that Lynette’s job, housing, and medical appointments are important for Lynette’s well-being.  Status of social relationships and natural supports: Lynette’s social relationships and natural supports are adequate. Lynette expressed that she does not currently have a relationship with her mother.  Recent inclusion and participation in the community: Lynette works most days of the week at Byerly’s.  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication: Lynette’s staff offers her choices with her receipt of services, as well as the scope of her services.  Description of relevant behavioral issues: No updates at this time.  Description of relevant health issues: Lynette has been having problems securing her medications. Lynette’s team will follow-up.  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: Anxiety, mood swings  Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms: Changes in target symptoms will be tracked in shift summaries, which will be completed following each shift. |

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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: Lynette utilizes a scooter for long distances due to Cerebral Palsy. Staff will remind Lynette to bring her walker with her when activities may require walking long distances. |
| The scope of the services to be provided to support the person’s daily needs and activities include: Lynette will receive support in the form of IHS and SES services. |
| Can this person use **dangerous items or equipment**?  Yes  No  If yes, address any concerns or limitations: Lynette does not use knives, as they are a trigger. |
| The person’s **preferences for how services and supports are provided**: Lynette prefers a more laid-back staff. |
| 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?  Lynette and her support team will meet annually to coordinate care and 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:  **County Case Manager:** Kevin McLane  Address: Northwest Family Service Center  7051 Brooklyn Blvd. Brooklyn Center, MN 55429  Phone Number:  Cell: 612-275-5870  E-Mail: [Kevin.mclane@co.henepin.mn.us](mailto:Kevin.mclane@co.henepin.mn.us)  **Legal Representative:** Amy Girling  E-Mail: Amy.Girling@Hennepin.us |
| 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: Staff must respect Lynette’s boundaries. Do not ask her too many questions or get in her business. When Lynette swears, it is a sign that she is upset. |
| 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):   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: 12/15/14  Meeting Attendance: AnnaMarie Martino, Kevin McLane, Amy Girling, Lynette Bradley, Aisha Beaty  Description of Consumer’s participation in conference process: Lynette was an active participant in her meeting.  Review of Guardianship or Conservatorship Status: Lynette’s guardianship is appropriate at this time.  Review of Placement and Appropriateness: Lynette’s placement is appropriate at this time. |

**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: |