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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Joshua Mormon    Date of development: 6/12/2015  For the annual period from: 12/23/2014 to 12/22/2015  Name and title of person completing the *CSSP Addendum*: Jessica Reno, Program Director  Legal representative: Arletha Washington is guardian.  Case manager: Amber Jepperson  Other support team members: Laura Boss and Catherine Breuer  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: Joshua Mormon  DOB: 7/20/92  Sex: Male  Weight: 159 lbs  Eye Color: Brown  Race: African American  Height: 5’8”  Hair Color: Brown | Address: 2902 Polk St NE, Apt. #9  Minneapolis, MN 55418  Phone: 612-367-4552 (H), 763-443-4870 (C)  Religious Preference: Christianity | |
| **SERVICE DATA** |
| Intake Date: 10/31/2013  Legal Status: Arletha Washington, mother is guardian.  Service Initiation Date: 11/08/2013  County of Financial Responsibility: Hennepin  County of Service Responsibility: Hennepin |
| **FINANCIAL RESOURCES** |
| Social Security Number: 323-88-2366  Medical Assistance Number: 01634341  Medicare Number:  Type: SSI  Amount/Month: $700 per month  Savings Account Balance: Financial Institution:  Checking Account Balance: Financial Institution:  Burial Account Balance: Financial Institution: |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory  Use of Public Transportation: Joshua utilizes Metro Mobility services for transportation.  Self-Cares: Independent  Domestic: Independent  Eating: Independent  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: None  Is able to drink alcohol? No, Joshua cannot drink alcohol due to potential harmful interactions with medications.  Identify form of Personal Identification (card, bracelet, necklace...) MN state ID |
| **DESCRIBE CONSUMER INTERESTS** |
| Joshua enjoys playing and watching basketball, lifting weights, and riding his bicycle. Joshua has expressed an interest in going back to school in order to become a basketball coach. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Schizoaffective Disorder-Bipolar Type, Constipation, Agitation  **Seizures**: None  **Protocol on file**: NA |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | Polethylene Glycol Powder | Mix 17gm in at least 8oz of liquid | **Daily** |  | | Lithium Carb | 300mg | **3 tabs at night** |  | | Clozapine | 100mg | 2 tabs (200mg) orally every HS with 50mg tab to equal 250mg total |  | | Clozapine | 50mg | 1 tab orally every HS with 2 (200mg) tabs to equal 250mg |  | | Olanzapine | 20mg | 1 tab orally every HS |  | | Senna-docusate | 8.6-50mg | 2 tabs (17.2-100mg) orally twice daily |  | | Vitamin D3 | 2000unit- | 1 tab orally daily |  | |
| **Allergies:** Abilify, Clozaril (causes blood cells count to drop)  **Special Diet:** None |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person:** Arletha Washington, mother  Address: 4536 58th Avenue N.  Brooklyn Center, MN 55429  Phone Number: 612-695-3350  Cell:  Fax:  E-Mail: | **Family Choice of Alternate Emergency Contact:** Latasha Washington, sister  Address: 7137 Grimes Ave. N.  Brooklyn Center, MN 55429  Phone Number: 763-742-0299  Cell:  Fax:  E-Mail: latashawash7411@gmail.com | | **Legal Representative:** Arletha Washington, mother  Address: 7137 Grimes Ave. N.  Brooklyn Center, MN 55429  Phone Number: 612-695-3350  Cell:  Fax:  E-Mail: | **CADI Case Manager:** Ka Thao, MCIL  Address: 530 N Robert Street, St. Paul, MN 55101  Phone: 651-603-2027  Cell:  Fax: Same as phone  E-Mail: kathao@mcil-mn.org | | **Residential Provider:** Jackson Square, High Quality Services  Address: 2902 Polk St NE  Minneapolis, MN 55418  Phone Number: 612.208.1369  Cell: 612-418-6343  Fax: 612.259.7441  E-Mail: Laura.Boss@High QualityServices.org  Contact Person: Laura Boss | **Behavioral Health Case Manager:** Catherine Breuer, Spectrum  Address: 7000 57th Ave N., Suite 100  Crystal, MN 55428  Phone: 612-752-8306  Cell:  Fax: 612-752-8301  E-Mail: cbreuer@resource-mn.org | | **County Financial Worker:** Team 254  Address:  Phone: 612-596-1300  Cell:  Fax: 612-288-2981  E-Mail: | **Current School/Day Program/Work:** NA  Address:  Phone:  Fax:  E-mail:  Contact Person: | | **Hospital of Preference:** Fairview Riverside  Address: 2450 Riverside Avenue  Minneapolis, MN 55454  Phone: 612.273.3000  Cell:  Fax:  E-Mail: | **Physician:** Northpoint Health and Wellness Center  Address: 1313 Penn Avenue North  Minneapolis, MN 55411  Phone: 612.543.2500  Cell:  Fax: 612.302.4872  E-Mail: | | **Dentist:** Northpoint Health and Wellness Center  Address: 1313 Penn Avenue North  Minneapolis, MN 55411  Phone: 612-543-2500  Cell:  Fax: 612-302-4872  E-Mail: | **Therapist:** Dr. Michael Thomas, Northpoint Health and Wellness Center  Address: 1313 Penn Avenue North  Minneapolis, MN 55411  Phone: 612-543-2500  Cell:  Fax: 612-302-4872  E-mail: | | **Psychiatrist:** Dr. Olson, University of Minnesota Fairview  Address: West Building Second Floor, Suite F-275 2450 Riverside Ave. Minneapolis, MN 55454  Phone: 612-273-8700  Cell:  Fax: 612-273-8727  E-Mail: |  | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Director: Jessica Reno**  Phone: 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  **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 |
| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
| None |
| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| Joshua started working with a new staff member recently. As a result, Joshua started attending the Salvation Army’s basketball program in the community. |
| **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: 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: Joshua has reported that it is important to him workout, play watch basketball, and long term enroll in school. As well as, utilize money management skills and savings to purchase new items for his apartment. It is important for Joshua to maintain all scheduled nursing visits and comply with doctors’ orders to maintain his health.  Status of social relationships and natural supports: Joshua has the support of family and friends in the community.  Recent inclusion and participation in the community: Joshua has recently started attending basketball at the Salvation Army and also works out at the YMCA on his own or with peers.  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: 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 Describe the target symptoms the psychotropic medication is to alleviate: Agitation Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms: ILS staff at High Quality are not contracted to document or monitor Josh’s psychotropic medication or 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:  Joshua is able to access the community independently. Joshua has a history of inappropriate interactions with others. Staff will monitor Joshua’s behavior and remind him of proper interactions with strangers when needed.  Joshua has a history of thoughts of self-harm, but has not acted on those thoughts. Staff will encourage Joshua to utilize his support systems to process his thoughts of self-harm in an appropriate manner.  Joshua has a history of throwing items when upset. Staff will verbally redirect Joshua when he is displaying escalated behavior.  Joshua has a history of making inappropriate comments to peers and staff, including swearing at others, and making loud outbursts. Staff will verbally redirect Joshua when he is demonstrating a lack of respect for the privacy of his peers, or when he is attempting to engage in conversations that violate the privacy of others. |
| The scope of the services to be provided to support the person’s daily needs and activities include: Staff will transport Joshua in the community and maintain a consistent schedule to reinforce time management skills. |
| 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**: Joshua prefers that staff have a flexible schedule and work with him in a patient and consistent manner. |
| 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?    Joshua and his support team will meet semi-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:** Latasha Washington, sister  Address: 7137 Grimes Ave. N. Brooklyn Center, MN 55429  Phone Number: 763-742-0299  E-Mail: latashawash7411@gmail.com  **Family Choice of Alternate Emergency Contact:** Arletha Washington, mother  Address: 4536 58th Avenue N. Brooklyn Center, MN 55429  Phone Number: 612-695-3350  **Residential Provider:** Jackson Square, High Quality Services  Address: 2902 Polk St NE  Minneapolis, MN 55418  Phone Number: 612.208.1369  Cell: 612-418-6343  Fax: 612.259.7441  E-Mail: Laura.Boss@High QualityServices.org  Contact Person: Laura Boss  **CADI Case Manager:** Ka Thao, MCIL  Address: 530 N Robert Street, St. Paul, MN 55101  Phone: 651-603-2027  Cell:  Fax: Same as phone  E-Mail: kathao@mcil-mn.org  **Behavioral Health Case Manager:** Catherine Breuer, Spectrum  Address: 7000 57th Ave N., Suite 100 Crystal, MN 55428  Phone: 612-752-8306  Fax: 612-752-8301  E-Mail: cbreuer@resource-mn.org |
| 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: 6/24/2015  Meeting Attendance:  Description of Consumer’s participation in conference process:  Review of Guardianship or Conservatorship Status:  Review of Placement and Appropriateness: |
| Other discussion: |

**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: |